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Conceptualizing Depression: The Role of Attachment and Related Issues

Megan Green

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Conceptualizing Depression: The Role of Attachment and Related Issues

Dissertation submitted to the
Graduate College of
Marshall University

In partial fulfillment of the
requirements for
the degree of
Doctor of Psychology

by

Megan Green

Approved by

Marc Lindberg, Ph.D, Committee Chairperson

Pamela Mulder, Ph.D.

Marianna Footo-Linz, Ph.D.

Marshall University

Huntington, West Virginia

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ABSTRACT

Conceptualizing Depression: The Role of Attachment and Related Issues

By Megan Green

The purpose of this study was to examine relationships between depression, as measured by the Beck Depression Inventory (BDI-II) and attachment and related issues as measured by the Attachment and Clinical Issues Questionnaire (ACIQ). Individuals who had been diagnosed with Major Depressive Disorder in outpatient therapy and who indicated the presence of depressive symptoms on the BDI-II were compared to a control group comprised of individuals who had never engaged in therapy and who demonstrated minimal levels of depression as measured by the BDI-II. Therapy clients were assessed during the first two weeks of therapy. The experimental group demonstrated higher levels of pathology with regard to depressive symptoms, insecure attachments, and clinical issues. Significant correlations were found between scores on attachment scales and BDI-II scores, as well as between BDI-II scores and attachment-related clinical issue scales. Implications for clinical practice included the necessity of adopting a more comprehensive model of attachment, depression, and clinical issues.

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Introduction

Depression is a significant problem in the United States. According to the American Psychiatric Association (2000), the lifetime risk for Major Depressive Disorder is estimated to be between 10% and 25% for women and between 5% and 12% for men. Major Depressive Disorder is also associated with a high rate of mortality. Up to 15% of individuals with severe forms of the disorder die as a result of suicide. The purpose of this study was to examine risk factors in the development of depression, specifically factors related to problematic attachment patterns and related clinical issues. Relationships between attachment and depression were assessed using the Beck Depression Inventory (BDI-II) and the Attachment and Clinical Issues Questionnaire (ACIQ).

The participants in this study included a control sample of individuals who had never engaged in outpatient therapeutic intervention and who demonstrated minimal depression as measured by the BDI-II and a sample of outpatient therapy clients who were diagnosed with Major Depressive Disorder at intake and who reported the presence of mild, moderate, or severe depression as measured by the BDI-II. Both were administered the Beck Depression Inventory-II (BDI-II) and the Attachment and Clinical Issues Questionnaire (ACIQ). It was the purpose of the present investigation to first explore whether there would be significant correlations between scores on scales of the ACIQ and scores on the BDI-II. Secondly, differences between the experimental and control groups on scales of the ACIQ were examined. This study also attempted to critically evaluate current models of the relationship between attachment and depression with the goal of advocating a more comprehensive model based on the notion of multi-

causality.

Literature Review

Depression

Why do individuals develop depression? According to Cicchetti & Toth, (1998), depression may be best conceived in terms of the notion of multicausality which holds that there are diverse developmental pathways that result in the same condition or set of conditions. Borrowing from dynamic systems perspectives (Fischer & Bidell 1998; Granic & Hollenstein, 2003; Thelen & Smith, 1998) depression could also be considered in terms of equifinality, or as a set of conditions having several different manifestations. Even while conceptualizing depression according to these theoretical notions, it will be seen that one of the factors involved in the incidence of most cases of depression is that of insecure attachment and attachment-related issues.

Attachment Theory

Attachment theory grew out of the theories of Bowlby (1969/1982) and Ainsworth (1964). Attachment theory holds that one develops attachment relationships for survival, and some of the processes subjugated to survival are the learning of mechanisms to achieve feelings of security and predictability. According to Weinfield, Sroufe, Egeland, and Carlson (1999), normative development of an infant includes developing an attachment relationship with a caregiver. Almost every infant will develop such a relationship and will strive to use the caregiver as “a source of comfort and reassurance.” The nature of the relationship and the effectiveness of the caregiver in providing comfort and support in times of stress differ across infant-caregiver dyads, lending to various forms of secure and insecure attachment patterns. According to

Bowlby (1969/1982) and later researchers (Roberts, Gotlib, and Kassel, 1996), children at young ages form “working models” based on attachment relationships. Based on the child’s interactions with important caregivers, he or she constructs representations concerning the self and others. Specifically, working models reflect expectations about a caregiver’s availability (Dozier, Stovall, & Albus, 1999) and have implications for a child’s sense of self-esteem, self-efficacy, acceptability, and lovability (Bretherton, 1987). Expectations about attachment influence new relationships and maintain patterns of relating across the lifespan (Bowlby, 1979,1980; Bretherton, 1985, 1987; West & Sheldon-Keller, 1994).

When a child’s experiences with caregivers lead to a “confident expectation” that caregivers will respond to his or her needs, an infant develops a model of the self as loved and valued and a model of others as loving and dependable (Bretherton, 1985). As a result, children develop the expectation that their needs will be met and thus develop secure strategies for seeking out and maintaining the attention, security, and comfort of caregivers when in distress (Dozier, Stovall, & Albus, 1999). Secure patterns of relating that persist into adulthood result in a person who considers him or herself to be worthy of the care, concern, and affection of others and perceives others as reliable, trustworthy, and well-intentioned. Thus, secure interpersonal relationships in adulthood tend to be characterized by trust and intimacy (Eng, Heimberg, Hart, Schneier, & Leibowitz, 2001).

When infants have attachment experiences which result in the expectation that their needs will not be met and that caregivers will be rejecting or undependable, they develop a model of the self as unlovable and rejected and a model of others as unloving and rejecting (Dozier, Stovall, & Albus, 1999; Roberts, Gotlib, & Kassel, 1996).

Experiences with unresponsive caregivers may also result in a model of the self as unworthy of support and affection, or only worthy if certain conditions are met (Roberts, Gotlib, & Kassel, 1996). Based on the anticipation that caregivers will not help relieve the distress, it is theorized that such children will develop one of several different insecure attachment patterns to help them better cope with stress and unpredictability at that time in development.

Three patterns of insecure attachments were originally proposed by Ainsworth et al, 1964). The “anxious/resistant” or “ambivalent” pattern is marked by the tendency for intensification of attachment behavior during times of distress, unpredictability, and/or fear (Sable, 1997). Anxious-ambivalent patterns are marked by perceptions of others as difficult to understand; the ambivalently attached tend to desire extreme intimacy, seek lower levels of autonomy, fear rejection, and may display excess distress, anger, and controlling behavior (Feeney, 1999; Turner, 1991; Reder & Duncan, 2001). This pattern may also be marked by a negative working model of the self and positive working models of significant others, resulting in personal relationships that are characterized by worry about abandonment, hyper vigilance, and jealousy (Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987; Levy & Davis, 1988; Simpson, 1990).

A second pattern of insecure attachments has been termed “avoidant” which refers to denial and avoidance of attachment feelings and behavior (Sable, 1997). Adults who demonstrate avoidant attachment patterns may have negative working models of the self and others. They may lack confidence in social situations, deny their need for attachment, and perceive others as untrustworthy, limiting their capacity to become involved in intimate relationships (Feeney, 1999).

The “disorganized” pattern, first noted by Maine & Solomon (1990) may be marked by disorientation and may be particularly related to the loss of an attachment figure (Main & Hesse, 1990) or “frightening” or abusive parenting (Lyons-Ruth & Jacobovitz, 1999). Fear of a parent is theorized to create conflict for a child and also activates attachment-seeking behavior. Thus, the child is said to feel compelled to seek proximity to the very figure that frightens him or her. Proximity-seeking increases the level of fear, and the approach is “contradicted.” This paradox is theorized to result in the “collapse of behavioral strategies” resulting in disorganized attachment behavior or inhibition of attachment behavior (Lyons-Ruth & Jacobovitz, 1999).

The Relationship Between Attachment and Depression

Research suggests that insecure attachment in both children and adults is associated with depression. In a study done by Abela, Hankin, Haigh, Adams, Vinokuroff, and Trayhern (2005), children (ages 6 to 14 years) who exhibited high levels of insecure attachment and reassurance seeking, as assessed by a semi-structured clinical interview, experienced higher levels of depression than children who demonstrated only one or neither risk factor. Other research results indicated that adult participants with obsessive-compulsive disorder, bipolar disorder, or depression demonstrated greater attachment insecurity (Myhr, Spookman, & Pinard, 2004; Rosenfarb, Becker, & Khan, 1994; West, Rose, Verhoff, Spreng, & Bobey, 1998; Bifulco, Moran, Ball, & Bernazzani, 2002; Haaga, Yarmus, Hubbard, Brody, Solomon, Kirk, et al., 2002). In research done by Barnas and Pollina (1991) with elderly female participants, aged 65 to 87 years, attachment style, depression, social functioning, and physical well-being were assessed using a structured interview consisting of open-ended questions designed to assess

security in relationships, issues of avoidance and resistance, physical complaints, and other clinical issues. Women who exhibited insecure attachment to their adult children had lower scores on measures of social, psychological, and physical well-being and had to utilize more elaborate strategies to deal with stress. Insecurely attached women more often scored in the clinical range of depression than securely attached women. Besides being related to depression itself, attachment may also be related to negative treatment outcome. According to Dozier (1990), insecure attachment has been associated with poor treatment compliance in psychotherapy, more rejection of treatment providers, and less self-disclosure among clients with affective disorders.

Attachment and Depression: Explaining the Relationship

There have been several hypotheses as to the relationships between attachment and depression. According to Bowlby (1980), there are three types of circumstances that are most likely to be associated with the development of depressive symptoms. One occurs when a child's caregiver dies and the child has little control over the circumstances that ensue. Another occurs when a child is unable to form stable and secure relationships with caregivers and develops a model of the self as a failure. The third circumstance occurs when a caregiver gives a child the message that he or she is unlovable. Each set of circumstances contributes to a lack of a sense of personal control, and thus to negative affect as measured by depression scales when a person receives disappointing responses from attachment figures.

Another model of the relation between attachment and depression was offered by Roberts, Gotlib, and Kassel (1996). They theorized that negative internal working models are mediators between insecure attachment and depression. They asserted that adult

attachments appear to exert little or no direct influence on depression but instead operate indirectly through negative thinking about the self and others. For example, data presented by the authors suggested that insecurity in adult attachment was associated with dysfunctional attitudes, which contribute to lower self-esteem. Lower levels of self-esteem then more directly influence depressive symptoms. Insecurity in this case refers to beliefs that others are not available in times of need, feelings of discomfort in becoming close to others, and a fear of abandonment or the lack of love. Similar models were proposed by Enns (2000) who identified dysfunctional attitudes and self-criticism as mediators between attachment security and depression and by Shah and Waller (2000) whose results suggest that when parents of depressed patients are perceived as uncaring or overprotective, those patients have harmful core beliefs that involve defectiveness, shame, and insufficient self-control that ultimately result in depressive symptoms. Not surprisingly, El-Jamil (2003) found that shame is a powerful predictor of depression in American society.

Ingram (2003) also proposed a model that considered dysfunctional internal working models, attachments, and how they contribute to vulnerability in the development of depression. Persons who are insecurely attached may have internal working models that are organized in a way such that the person experiences distorted perceptions about interpersonal interactions and thus experiences increases risk for “maladaptive relations” with others. Ingram asserted that interpersonal relationships buffer against stress and provide support. If such relationships are problematic because of dysfunctional cognitive processes, the insecurely attached become vulnerable to depressive symptoms. If interpersonal relationships are problematic and characterized by

insecure attachments, excess conflict may be more likely to occur than would be the case in functional, securely attached relationships (Santor, 2003). According to Santor, if an individual is insecurely attached, he or she may view conflict as a threat to self-worth. In addition to relationship problems themselves, he or she may draw erroneous, negative conclusions about himself and others, creating vulnerability to depressive ideation.

Research that addresses the relationship between attachment and affective disorders has identified several other mediators between attachment insecurity and depression. Eng, Heimberg, Hart, Schneier, and Liebowitz (2001), using the Revised Adult Attachment Scale (Collins, 1996), found that participants who displayed anxious attachment patterns as opposed to secure attachment exhibited more severe social anxiety and avoidance as measured by the Liebowitz Social Anxiety Scale (Liebowitz, 1987), higher levels of depression as measured by the Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979), greater impairment in activities of daily functioning as measured by the Liebowitz Self-Rated Disability Scale (Schneier et al., 1994), and lower satisfaction with life as measured by the Quality of Life Inventory (Frisch, 1994). Eng et al. (2001) proposed that anxious working models of attachment are directly associated with the higher scores on the Liebowitz Social Anxiety Scale and that social anxiety may inhibit a person's ability to have rewarding social experiences, thus increasing the incidence of depression. Specifically, people who experience social anxiety and anxious attachment have negative beliefs about the self and the dependability of others. These beliefs may affect social functioning and predispose the person to feelings of hopelessness and ultimately to depression.

Rice and Mirzadeh (2000) identified perfectionism as a mediator between

insecure attachment patterns and depression. Participants in this study were administered the Multidimensional Perfectionism Scale (Frost et al., 1990) and the Inventory of Parent and Peer Attachment (Armsden & Greenberg, 1987). Attachment predicted type of perfectionism (adaptive vs. maladaptive), with adaptive perfectionists reporting more secure attachments than maladaptive perfectionists. According to the authors, children may develop “maladaptive perfectionism” in response to parents who have unrealistic expectations for them, are overly critical, and provide inadequate support and inconsistent responsiveness when children try to meet such excessive demands. This is in contrast to adaptive perfectionism that may result from secure attachment. Insecure attachment to parents may result in self-defeating, internalizing, unrealistic expectations of the self and of others that place a child at risk for affective disorders both in childhood and adulthood.

Wei, Mallinchrout, Russel, and Abraham (2004) also discussed perfectionism as a mediator between attachment and depression. The authors administered the Experiences in Close Relationships Scale (Brennan et al., 1998) and the Multidimensional Perfectionism Scale (Frost et al., 1990) to undergraduate students. They found that maladaptive perfectionism partially mediated the relationship between attachment anxiety and depressed mood and fully mediated the relationship between avoidant attachment style and depressed mood. In another study, Wei, Heppner, and Mallinchrout (2003) identified perceived coping in adulthood as a mediator between insecure attachment and depression. Participants in this study completed the Adult Attachment Scale (Collins & Read, 1990) and the Problem-Solving Inventory (Heppner, 1988). They found that perceived coping, or the belief that one can effectively deal with problems partially

mediated the relationship between avoidant attachment style and depression. The authors asserted that when people do not believe that they can solve problems effectively, they are likely to be more socially anxious, have less social support, and are likely to become hopeless and depressed.

Stober (2003) identified self-pity as a mediator between ambivalent attachment style and emotional distress. Participants in his study were college students who completed a six item self-pity scale developed by Janke et al. (1985), the Questionnaire on Competency and Control Beliefs (Levenson, 1974), and the UCLA Loneliness Scale (Russell, Cutrona, Rose, & Yurk, 1984). Attachment style was assessed using a clinical interview. In this study, self-pity was related to higher levels of ambivalence and worry regarding interpersonal relationships. According to the author, self-pity may result in loneliness and rumination that may put a person at risk for depression.

Strodl and Noller (2003) examined participants using the Attachment Style Questionnaire (Feeney, Noller, & Hanrahan, 1994), the Beck Depression Inventory (Beck, 1978), and the Self-Efficacy Scale (Sherer et al., 1982). The authors found that insecure attachment dimensions of need for approval, preoccupation with relationships, and relationships as secondary to achievement were associated with depression and that self-efficacy partially mediated the relationship between need for approval and depression. “Need for approval” refers to the importance of being liked by others and worry that one will not live up to others’ standards. “Preoccupation with relationships” refers to worry about relationships and abandonment and the belief that one cannot cope alone, and “relationships as secondary” refers to the belief that achievement is more important than relationships and little importance is placed on getting along with others.

Low self-efficacy may be a mediator between need for approval and depression because of its association with the belief that one is unable to meet the standards of others and the resultant negative self-view.

Insecure attachment patterns could also involve behavioral strategies that may contribute to the development of depressive symptoms. According to Sable (1997), symptoms of depression are “responses to disruptions of personal bonds” in a manner that interferes with functioning and satisfying relationships with others. Pathology in adulthood indicates psychological development that has “followed a deviant pathway” where defensive attachment strategies distort interpretations of behavior and emotions of others and restrict flexibility in behavior regarding relationships. According to Sable, defensive strategies are processes that regulate negative affect and maintain an individual’s proximity to attachment figures that are unreliable or rejecting. Information about attachment experiences that is threatening to the self may be defensively excluded from conscious information processing. As a result, an individual may have difficulty accurately interpreting and expressing feelings. The person’s behavioral repertoire is thus limited, and he may thus have difficulty coping with stressful situations. Inability to cope with stress may act as a mediator between insecure attachment and the consequent attachment strategies and affective disorders such as depression.

Dozier, Stovall, and Albus (1999) also proposed a model of pathology based on attachment strategies. If a child anticipates that caregivers will not be available when he is in distress, he may develop insecure strategies for coping with such distress (Dozier, Stovall, & Albus, 1999). According to the authors, such strategies vary in the manner in which a person attempts to “minimize” or “maximize” the expression of attachment

needs (Dozier, Stovall, & Albus, 1999). The authors assert that when people employ minimizing strategies, they turn their attention away from attachment issues such as caregiver availability and have “limited access” to their own feelings, and when people employ maximizing strategies, they turn their attention toward their feelings about caregivers and toward their own distress, becoming enmeshed with attachment figures. Being enmeshed with caregivers may result in an individual who is unable to accurately appraise caregiver availability and threats to the attachment relationship. Minimizing strategies may put a person at risk for depression because attention is turned away from the self in a way that prevents the person from dealing with negative internal representations of the self, caregivers, and the relationship among them. Maximizing strategies may predispose an individual to internalizing problems such as depression because the individual’s attention remains focused on caregiver availability and negative representations of the self and others.

Another way in which attachment may influence depression could be through how internal working models associated with insecurity help create depressotypic states of mind and conscious processing of information. According to George, Main, and Solomon (1985), different attachment states of mind are associated with different patterns of processing attachment-related thoughts, feelings, and memories. The classification of these states of mind is based on discourse analysis of responses to the Adult Attachment Interview (George, Kaplan, & Main, 1985). An autonomous state of mind is characterized by straightforward, coherent representations of attachment experiences that are consistent with evidence presented. A dismissing state of mind is characterized by lack of recall of attachment experiences, idealization of caregivers, or derogation of

attachment experiences. Preoccupied states of mind are characterized by current angry relationships with attachment figures or by passive speech during the interview. According to George, Main, and Solomon, (1985), depression is associated with preoccupied or dismissing states of mind. Other studies found that different subtypes of depression were differentially related to attachment states of mind (Fonagy, Leigh, Steele, Steele, Kennedy, Mattoon, et al., 1996). Major depression was most commonly associated with an autonomous state of mind while dysthymia was most commonly associated with preoccupied or dismissing states of mind. According to the authors, these somewhat surprising results may have occurred because major depression “does not interfere with the maintenance of coherent states of mind” as much as dysthymia does. It should be noted that these studies suggest that life experiences may predispose a person to depression regardless of state of mind.

Hopelessness may be key clinical information in terms of the conceptualization of depression. According to Abramson, et al. (1989), “the expectation that highly desired outcomes will not occur or that highly aversive outcomes will occur and that one cannot change this situation-hopelessness- is a proximal sufficient cause of depressive symptoms” (p.269). Based on this theory, individuals who believe that desirable outcomes will not occur in the course of particular relationships may be at risk for depressive symptoms. Desirable outcomes may include getting love and approval from an attachment figure, resolving conflict with that figure, etc. Undesirable outcomes may include frequent conflict, the lack of approval, lack of intimacy, and unmet expectations of attachment figures.

From the above, it can be easily seen that both attachment and depression

literatures suggest a relationship between the two constructs. While there is value in illustrating the nomothetic relationships between attachment styles, affective disorders, and mediators among them, this approach may be short-sighted. Cicchetti and Toth (1998) proposed a more complex model of depression based on developmental systems theory and the notion of multi-causality. They asserted, “to comprehend human development, it is essential to understand the integration of developmental processes at multiple levels of biological, psychological, and social complexity within individuals over the life course.” Based on this idea, Cicchetti and Toth (1998) described a model of depression that contends that depressive symptoms are likely to result from various developmental pathways. Thus if one takes into account only a few risk factors for depression, one will provide only a partial model of the etiology and maintenance of affective symptoms. “Aberrations” in cognitive, social, emotional, representational, and biological domains are present to varying degrees in persons with depressive disorders and are not independent of each other and may involve issues of attachment, self-regulation, self-awareness, family and peer relations, and culture to name a few. These systems may interact in a way that Cicchetti and Toth (1998) refer to as a “depressotypic organization” that at some point in lifespan development can result in depression. Thus, the key to understanding depression is to understand the complex interplay between various domains of functioning. The key to treating depression might therefore be in the identification of pathology in various domains in order to conceptualize an ideographic model that illustrates that individual’s unique pathway to depression.

Depression and The Attachment and Clinical Issues Questionnaire (ACIQ)

Although Cicchetti and Toth (1998) have presented a model of depression that

emphasizes the importance of the interplay of parental attachment, cognitive representations, family issues, peer support, etc. in the development of depression, until recently there has been no measure capable of testing these diverse hypotheses. The Attachment and Clinical Issues Questionnaire (ACIQ) was developed by Lindberg and Thomas (2003) to help meet this clinical need. It was designed to measure adolescent and adult attachment and clinical issues that are theorized to contribute to the development of addictions, personality disorders, depression, and related clinical presentations. Instead of conceptualizing a single attachment style for an individual that is thought to characterize all of his or her relationships, the ACIQ assesses secure, avoidant, ambivalent/resistant, and codependent/enmeshed or preoccupied relations to mother, father, and partner, consistent with the notion of multi-causality and individual variation.

The ACIQ scales were developed to assess not only attachment patterns, but also other clinical domains that contribute to a systematic, ideographic conceptualization of depression as advocated by Cicchetti and Toth (1998). Examining various aspects of pathology and attachment simultaneously allows the clinician to better conceptualize the nature of a client's depression and the nature of insecure relationships. For example, according to the notion of multi-causality, some depressed participants who have significantly high levels of insecure attachment may also report a high level of jealousy while other depressed participants who report insecure relationships may not. In line with the notion of multi-causality, it should be noted that whereas the ACIQ addresses a variety of attachment-related difficulties that may contribute to depression, it is not presumed to address all routes to pathology in adulthood.

ACIQ scales were developed based on clinical literature illustrating both their associations with attachment patterns (for example, the mistrust, control, shame, and perfectionism scales) and thus the risk for depression. The abuser scale was included because, according to Lindberg and Thomas (2003), abusiveness is a common factor in many troubled relationships and thus may be related to depression. Crittenden (1985) and Main and Solomon (1990) proposed that disorganized and avoidant attachment styles may be related to abusiveness. Jealousy is related to insecure attachment patterns (Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987; Levy & Davis, 1988; Simpson, 1990; Dobrenski, 2001), and its more direct relationship to depression has been illustrated by Bringle (1995), who found that reactive jealousy is a significant predictor of anger, fear, and depression.

The ACIQ measures levels of sexual intimacy and sexual arousal, and depressed individuals appear to experience less sexual arousal than non-depressed individuals (Bartholomew & Horowitz, 1991). Sexual intimacy appears to be related to secure attachment, with securely attached individuals reporting more intimacy and more emotionally satisfying sexual relationships, while the lack of intimacy appears related to problematic relationship patterns (Bartholomew & Horowitz, 1991).

Other scales of the ACIQ include anxiety, anger, denial, family suppression of feelings, rumination, peer relations, religion, and social withdrawal. Anger is often observed in individuals with depression. Picardi, Morosini, Gaetano, Pasquini, and Biondi (2004) found that depressed outpatients scored higher on measures of anger and hostility than outpatients with anxiety disorders and somatoform disorders. Strong associations among anger, aggressiveness, and depression were found by several other

researchers (Picardi et al., 2004; Pasquini, Picardi, Biondi, Gaetano, & Morosini, 2004; Moreno, Fuhrman, & Selby, 1993; Robbins & Tanck, 1997). In these studies, anger was measured using a 10-item instrument designed for the rapid assessment of psychopathological dimensions and referred to as the SVARAD (Pasquini et al., 2004) and depression was measured by the Beck Depression Inventory (Beck, 1978). Anxiety was measured using the Hamilton Anxiety Rating Scale (Hamilton, 1959).

In a study conducted by Sperberg and Stabb (1998), female graduate and undergraduate students completed the Beck Depression Inventory (Beck, 1978) and the State-Trait Anger Expression Inventory (Spielberger, 1988). Higher levels of suppressed or inappropriately expressed anger were associated with higher levels of depression in a sample of college women. Deffenbacher, Dahlen, Lynch, Morris, and Gowensmith (2000) used the State-Trait Anger Expression Inventory (Spielberger, 1988), the Beck Depression Inventory (Beck, 1978), and the Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970) to assess aspects of anger and levels of depression and anxiety. The authors found that cognitive therapy aimed at anger reduction also lowered levels of anxiety and depression. Other studies suggest that denial of feelings and family suppression of feelings is significantly related to depressive symptoms (Yuan, Zhang, & Wu, 2002; Li, Dong, Xiao, Chen, Xu, and Zou, 2002).

Many studies have focused on the relationships among anxiety, ruminative thinking, and depression. Approximately half of the participants with anxiety disorders in a longitudinal study by Murphy, Horton, Laird, Monson, Sobol, and Leighton (2004) also suffered from depression. According to Gorman (1997) and Levine, Cole, Chengappa, & Gershon (2001), there are genetic and neurobiological similarities between depressive

and anxiety disorders. In Gorman's study, participants with panic disorder, generalized anxiety disorder, social phobia, and other anxiety disorders were also frequently clinically depressed. Studies by Goodwin and Gorman (2002) and Norton, Hayes, and Hope (2004) found an association between treatment for generalized anxiety disorder and lower incidence of depression. Research that illustrates the relationship between rumination and depression includes studies by Carter, Pollock, Suvak, and Pauls (2004), Roberts, Yeager, and Seigel (2003), and Moritz, Meier, Hand, Schick, and Jahn (2004). Specifically, the overall severity of ruminative thinking was related to depressive symptoms. Similarly, research by Spinella (2005) suggests a relationship between the severity of rumination as measured by the Yale-Brown Obsessive Compulsive Scale and the intensity of negative emotions and depression.

Social relationships as measured by the Peer Relations scale of the ACIQ may be important in buffering against depression. Batgos and Leadbeater (1994) proposed a relationship between secure attachment, positive peer relationships, and protection from depression. Similarly, La Greca and Harrison (2005) found that peer crowd affiliations protected adolescent participants against depressive affect and that negative qualities of best friendship predicted depressive symptoms. Depression may also be related to negative perceptions of peers (Garnefski, 2000). Social withdrawal as measured by the ACIQ scale "withdrawal/engagement" may be also be related to depression. Puura, Almqvist, Tamminen, Piha, Kumpulainen, Rasanen, et al. (1998) found that higher levels of social withdrawal were associated with higher levels of depression as assessed by the Children's Depression Inventory. Patterns of withdrawal have also been associated with a diagnosis of major depressive disorder in elderly veterans and elderly assisted living

residents (Baker & Miller, 1991; Watson, Garrett, Sloane, Gruber-Baldini, & Zimmerman, 2003). Religiosity as measured by the ACIQ Religion scale may protect individuals from depression (El-Jamil, 2003). Other studies suggest a more complex relationship. According to Baetz, Griffin, Bowen, Koenig, and Marcoux (2004), more frequent worship service attendance was associated with fewer depressive symptoms, but those who perceived themselves to be spiritual or religious had higher scores on measures of depression than those who did not.

The ACIQ is a continuous measure of attachment, so respondents are not forced into attachment categories. Rather, the examiner is able to draw conclusions about the relative strength of each attachment pattern and is able to identify various mixed patterns of attachment (Lindberg & Thomas, 2003). The ACIQ also allows the examiner to assess attachment styles with regard to several figures (mother, father, and partner) rather than with one set of attachment patterns that is assumed to be pervasive. Additionally, the ACIQ addresses both “actual beliefs” that people with different attachment patterns hold and systemic issues that are relevant to relationships. For example, the item “after an argument with my mother, I tried to avoid her” may be indicative of relationship dynamics while the item “some people deserve to be put in their place” refers more to an actual belief about others. Attachment scales are based on recollections of conditions in the family of origin and current patterns of behavior with romantic partners. Scales that address clinical issues related to attachment are based on the respondent’s current level of functioning.

Despite the shortcomings of self-report survey methodology in contrast to interview methods proposed by various authors (Carlson, Onishi, & Gjerde, 1997;

Crowell & Treboux, 1995; Bifulco, 2002), the ACIQ has predicted both partner satisfaction and parental warmth better than alternative self report measures such as the Experiences in Close Relationships Questionnaire as well as phenomena typically found by the Adult Attachment Interview (Lindberg & Thomas, 2003).

A Summary of Models of Attachment and Depression and Predictions for ACIQ Scales

Bowlby (1980) asserted that perceived lack of control, perception of the self as a failure, and the perception that one is unlovable as a result of dysfunctional attachment relationships with primary caregivers are all factors that contribute to depression. Based on this model, it would be expected that participants who demonstrate depressive symptoms as measured by the BDI-II would obtain high scores on the Ambivalent Attachment with regard to mother and father, Avoidant Attachment with regard to mother and father, Helplessness, Hopelessness, and Shame scales and low scores on the Secure Attachment: Mother and Secure Attachment: Father scales.

According to Roberts, Gotlib, and Kassel (1996), depression is the result of dysfunctional attitudes, specifically low self-esteem and low self-efficacy, that stem from dysfunctional attachments. Enns (2000) and Shah and Waller (2000) proposed similar models that identify shame and self-criticism as the primary mediators between insecure attachment and depression. Based on these models, it was predicted that depressed participants (according to the BDI-II), would have high scores on the Shame scale as well as Helplessness and Hopelessness scales. It would also be predicted that depressed participants would score high on scales assessing insecure attachment patterns with regard to mother, father, and partner and low on scales measuring secure attachment patterns to mother, father, and partner.

According to Ingram (2003) and Eng et al. (2001), internal working models that result from insecure attachment result in maladaptive relations with others and the lack of rewarding social experiences. The ACIQ scales that address these issues include Withdrawal/Engagement and Peer Relations, as well as the attachment scales that represent insecure attachment to mother, father, and partner. Based on these models, depressed participants should have high scores on the Withdrawal/ Engagement scale and low scores on the Peer Relations scale, as well as high scores on insecure attachment scales pertaining to mother, father, and partner. Furthermore, depressed participants should have low scores on the Secure Attachment: Mother, Secure Attachment: Father, and Secure Attachment: Partner scales.

Rice and Mirzadeh (2000) and Wei, Mallinchrordt, Russel, and Abraham (2004) suggested that perfectionism serves as a mediator between insecure attachment and depression, which is a cognitive issue addressed by the Perfectionism scale. If this is a valid model, then depressed participants would be expected to obtain high scores on the Ambivalent Attachment scales, Avoidant Attachment scales, and the Perfectionism scale. They would be expected to have low scores on the secure attachment scales.

Wei, Heppner, and Mallinchrordt (2003) and Strodl and Noller (2003) theorized that self-efficacy in dealing with relationships is a primary factor in the development of depression. If this model were correct, then depressed participants would be expected to obtain high scores on Helplessness, Hopelessness, and Insecure Attachment scales and low scores on the secure attachment scales.

In contrast to the above models, Stober (2003) and Strodl and Noller (2003) theorized that preoccupation with relationships as another factor in the development of

depression. Preoccupation with relationships refers to consistent worry about relationships and abandonment and the belief that one cannot cope alone. These issues are assessed by the Rumination scale, and depressed participants would be predicted to obtain high scores on this scale as well as on the insecure attachment scales.

The model of depression proposed by Dozier, Stoval, and Albus (1999) included the idea that in an attempt to cope with the problems associated with insecure attachment, attention is either drawn away from attachment-related issues, resulting in limited access to one's feelings, or the insecurely attached individual becomes preoccupied with relationships. Based on this model, depressed participants should obtain high scores on the Ambivalent Attachment scales, the Avoidant Attachment scales, the Family Suppression of Feelings scale, the Denial scale, and the Rumination scale. Furthermore, depressed participants should obtain low scores on the secure attachment scales.

Finally, the model proposed by George, Main, and Solomon (1985) proposed that preoccupied or dismissing states of mind result in depressive symptoms. These phenomena are addressed by the attachment scales of the ACIQ, the Denial scale, and the Rumination scale. Depressed respondents should have profiles indicating high scores on these scales and low scores on scales indicating secure attachment.

Hypotheses

1. Based on relevant literature, it was hypothesized that the following scales of the ACIQ would correlate significantly and positively with scores on the BDI-II: Abuser, Ambivalent Attachment: Father, Ambivalent Attachment: Mother, Ambivalent Attachment: Partner, Anger, Anxiety, Avoidant Attachment: Father, Avoidant Attachment:

Mother, Avoidant Attachment: Partner, Control, Denial, Family Rigidity, Family Suppression of Feelings, Jealousy, Rumination, Perfectionism, Shame, Mistrust, Withdrawal, and all Helplessness and Hopelessness scales.

2. It was hypothesized that the following scales would correlate significantly and negatively with scores on the BDI: Peer Relations, Religiosity, Secure Attachment-Father, Secure Attachment-Mother, Secure Attachment-Partner, Sexual Arousal, and Sexual Intimacy.
3. It was hypothesized that individuals identified as depressed by the BDI-II would score significantly higher than individuals identified as non-depressed by the BDI-II on the scales hypothesized to correlate positively with depression: Abuser, Ambivalent Attachment-Father, Ambivalent Attachment-Mother, Ambivalent Attachment-Partner, Anger, Anxiety, Avoidant Attachment-Father, Avoidant Attachment-Mother, Avoidant Attachment-Partner, Control, Denial, Family Rigidity, Family Suppression of Feelings, Jealousy, Rumination, Perfectionism, Shame, Mistrust, Withdrawal, and all Helplessness and Hopelessness scales. It was hypothesized that depressed individuals would have lower scores than the non-depressed control group on the scales hypothesized to correlate negatively with depression as measured by the BDI-II: Peer Relations, Religiosity, Secure Attachment-Father, Secure Attachment-Mother, Secure Attachment-Partner, Sexual Arousal, and Sexual Intimacy.

Method

Participants

Participants in the experimental group were 46 outpatient psychotherapy clients diagnosed with Major Depressive Disorder and who reported mild, moderate, or severe depressive symptoms as assessed by the Beck Depression Inventory-II (BDI-II). Participants were at least 18 years of age. Twenty-eight of the 46 participants in the experimental group were aged 18-21, and 18 were aged 22 to 65. There were 16 males and 30 females in the experimental group. All participants identified themselves as Caucasian with regard to race. Data collection sites included a private practice in Barboursville, West Virginia, a university psychology clinic in Huntington, West Virginia, and a community mental health clinic in Ashland, Kentucky. Participants drawn from the private practice in Barboursville, West Virginia included six females and three males. Participants drawn from the university psychology clinic included two females and one male, and participants drawn from the community mental health clinic included twenty-two females and twelve males. Most clients who received dual diagnoses were not excluded, although clients who were diagnosed with Borderline Intellectual Functioning or Mental Retardation. Clients participated in the study during one of their first two outpatient sessions. Participants were excluded if they had received psychotherapy or medication to treat a psychological condition in the past year. The diagnosis of a psychological disorder was based on a clinical interview by the therapist. Criteria used to determine the diagnosis of a psychological disorder was drawn from the Diagnostic and Statistical Manual of Mental Disorders- Fourth Edition, Text Revision (DSM-IV TR) (American Psychiatric Association, 2000). Both experimental and control

participants were included in the study only if they had completed the ninth grade to ensure that their reading level allows adequate comprehension of the ACIQ. The reading level of the ACIQ based on the Flesch-Kincaid Scale was 6.8. Two hundred fifty three potential respondents refused participation.

The control group consisted of 27 males and 41 females. Forty-four participants were aged 18 to 21 and 24 participants were between the ages of 22 and 65. All participants identified themselves as Caucasian. Participants who had ever received outpatient therapy or medication for a psychological condition and those who had ever been hospitalized for a psychological problem were excluded from the study. Fifty-eight participants obtained scores on the Beck Depression Inventory-II (BDI-II) that indicated “minimal depression.” Ten control group participants obtained scores that indicated the presence of mild depressive symptoms and were excluded from between-groups data analysis. Twenty-two participants were employees of a local Social Security Administration office. Twelve were drawn from the faculty and staff of a local elementary school, and 34 were employees of a local hospital.

Chi square statistics were performed to compare the demographic characteristics of the therapy and control groups. With regard to age in the overall sample, there were 72 participants aged 18-21 and 42 participants aged 22-65. It was determined that there was a disproportionate number of participants aged 18-21 as compared to participants in the three older age groups, $\chi^2(1, N=114)=7.89, p=.01$. While younger individuals were disproportionately represented in the overall sample, the experimental and control groups did not differ in their respective proportions of younger and older participants, $\chi^2(1, N=114)=.17, p=.68$. There were fewer males ($N=42$) than females ($N=71$) in the overall

sample, which again indicates an unequal distribution, $\chi^2(1, N=114)=6.88, p=.01$.

Whereas females were disproportionately represented in the overall sample, groups did not differ in their respective proportions of males and females, $\chi^2(1, N=114)=.88, p=.35$.

Measures

Attachment and Clinical Issues Questionnaire.

The ACIQ consists of 264 items and uses a 4-point Likert response scale (A=never; B=sometimes; C=often; D= always) to assess the extent to which each statement is descriptive of a participant. Twelve of the scales measure ambivalent, avoidant, codependent-enmeshed, and secure attachments to father, mother, and partner. Partner refers to the participant's spouse, fiancé, steady date, or significant romantic interest. The remaining 17 scales measure other related clinical issues, such as abuse, anger, anxiety, control, denial, family rigidity/chaos, family suppression of feelings, jealousy, rumination, peer relations, perfectionism, shame, religion, sexual arousal, sexual relationships, mistrust, and withdrawal/engagement (Lindberg & Thomas, 2003). This instrument is included in Appendix 1.

Cronbach coefficient alphas were obtained for each scale of the ACIQ and correlations for each item with its respective scale were calculated. The 29 scales had a mean alpha coefficient of .79. The range for coefficient alphas was .66- .91. The average test-retest reliability coefficient was (N=59) $r=.79, p<.01$ (Lindberg & Thomas, 2003). Regarding convergent validity, relevant scales of the ACIQ correlated significantly with the paragraph measure of Shaver, Hazan, and Bradshaw (1988) and the Relationship Scales Questionnaire of Griffin and Bartholomew (1994).

The ACIQ was compared to the Experiences in Close Relationships Questionnaire (ECR) and the two measures were compared in their abilities to predict partner satisfaction and parental warmth and strictness (Lindberg & Thomas, 2003). Correlations were obtained between the ECR scales of overall Avoidance, overall anxiety, Partner Avoidance, and Partner Anxiety with the 29 ACIQ scales. The scales of the ACIQ and ECR correlated significantly with one another in expected directions, providing convergent validity for the ACIQ. For example, the Avoidant Attachment: Mother scale correlated significantly and positively with the Overall Avoidance scale on the ECR ($N=109$) $r=.26, p<.01$. Correlations are summarized in Table 7.

Correlations were also computed between ECR scales and the Partner Satisfaction scale and scales of Mother Warmth and Father Warmth (Lindberg & Thomas, 2003). The Partner Satisfaction and Parental Warmth scales were developed by Lamborn et al. (1991). Correlations between ACIQ attachment scales and Partner Satisfaction and Parental Warmth scales. Whereas the ACIQ attachment scales correlated significantly with ECR scales, the ACIQ had substantially higher correlations with both partner satisfaction and parental warmth. For example, the correlation between the ACIQ scale Avoidant Attachment: Partner and the Partner Satisfaction scale, ($N=109$) $r=-.43, p<.001$, was higher than the correlation between the ECR overall Avoidance scale and the Partner Satisfaction scale ($N=109$) $r=-.33, p<.001$. These results are summarized in Table 8.

In addition to the 29 existing ACIQ scales, 24 questions were added to the end of the instrument to assess hopelessness and helplessness in relationships with mother, father, partner, and friends for this study. This addition is based on the literature

presented by Abramson, et al. (1989) that proposes a relationship among helplessness and hopelessness in relationships and depression. These questions are listed in Appendix 3.

Beck Depression Inventory-II.

The BDI-II consists of 21 groups of statements. Each group of statements measures a particular depressive symptom as defined by the DSM. These include sadness, pessimism, past failure, loss of pleasure, guilty feelings, punishment feelings, self-dislike, self-criticalness, suicidal thoughts/wishes, crying, agitation, loss of interest, indecisiveness, worthlessness, loss of energy, changes in sleeping patterns, irritability, changes in appetite, concentration difficulty, tiredness/fatigue, and loss of interest in sex. The participant chooses the statement in each group that best describes the way he or she has been feeling during the past two weeks. Points for each item are then added to achieve a composite score, with higher scores representing greater severity of depression. Scores on the BDI-II ranging from 0 to 13 indicate minimal depression. Scores from 14 to 19 indicate mild depression, scores from 20 to 28 indicate moderate depression, and scores from 29 to 63 are considered representative of severe depression.

Regarding concurrent validity, correlations have been reported between the BDI-II and other measures of depression such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) diagnostic criteria, the Hamilton Psychiatric Rating Scale for Depression, the Zung Self-Reported Depression Scale, the Minnesota Multi-phasic Personality Inventory Depression Scale, the Multiple Affect Adjective Checklist Depression Scale, and clinicians' ratings of depth of depression. Correlation coefficients between the BDI and these measures ranged from .33 with major depression as defined by the DSM-III to .96 with clinicians' ratings (Katz, Katz, & Shaw, 1994).

Reliability of the BDI-II was assessed by Beck, Steer, and Garbin (1988) in a meta-analysis of 25 published papers using the BDI. The subject samples of these studies included schizophrenics, substance abusers, college students, and depressed patients. Internal consistency estimates were high, ranging from .73 to .95. Beck, Steer, and Garbin (1988) also demonstrated the stability of the BDI using ten studies that administered the BDI to the same clients on two occasions. Stability estimates ranged from .60 to .83 in non-psychiatric clients and from .48 to .86 in psychiatric clients.

Procedure

Members of both the experimental group and the control group were given an anonymous survey consent form which is included in Appendix 4. Experimental group participants were given the consent form following their first therapy session and control group participants were given the form at the designated data collection time. Members of both groups were instructed to keep the form for their records. Participants were instructed to read the instructions twice before completing the instruments and were instructed *not* to put their name on the response sheets. Administration of the ACIQ and the BDI were counterbalanced.

After receiving a consent form at the end of the intake session, experimental group participants were instructed to come an hour early to their next appointment to complete the instruments (the ACIQ and the BDI) if they chose to participate in the study. They were also allowed to complete the instruments on the same day as their first session, at the end of the session. They were given the instruments by an office assistant when they came to the office for their second therapy session.

Control group participants completed the instruments at designated data collection

times and locations. To ensure that participants had no history of outpatient psychological treatment including therapy and medication, they were asked to answer “yes” or “no” with regard to this information on an additional form included with the rest of the instruments. If they answered “yes,” they were excluded from the study and their response sheets were discarded.

Results

Data Analysis

Pearson correlations were calculated between scores on the BDI and each scale of the ACIQ, including the helplessness and hopelessness scales. Correlations were computed for the overall sample, the experimental group, and the control group. Intercorrelations for scores on all helplessness and all hopelessness scales were calculated using the overall sample, as well as correlations among helplessness and hopelessness scales and attachment scales of the ACIQ (ambivalent attachment with regard to mother, father, and partner, avoidant attachment in relationships with mother, father, and partner, and secure attachment with regard to mother, father and partner) for the overall sample, the experimental group, and the control group.

Twenty-nine 2 (therapy versus control group) X 2 (Sex) X 2 (Age) ANOVAs were performed with each scale of the ACIQ serving as a dependent variable. Similar ANOVAs were performed for the Helplessness scales, the Hopelessness scales, and the BDI. Age of participants was divided into two groups, with one group consisting of participants aged 18 to 21 and the second group consisting of participants aged 22 to 65. Age groups were collapsed because the three oldest age groups contained very few participants, and the youngest age group contained the majority of participants;

combining the three oldest groups for analysis made group size more comparable. Ten participants in the control group were excluded from this analysis because their BDI-II scores indicated depression. Of the 58 remaining control group participants, none had scores higher than 13, whereas all experimental group participants indicated mild, moderate, or severe symptoms.

Correlations.

With regard to the overall sample, scores on the following Attachment and Clinical Issues Questionnaire scales were positively correlated with scores on the BDI-II: Ambivalent Attachment: Father ($r=.32, p<.01$), Ambivalent Attachment: Mother ($r=.41, p<.001$), Ambivalent Attachment: Partner ($r=.39, p<.001$), Anger ($r=.51, p<.001$), Anxiety ($r=.78, p<.001$), Avoidant Attachment: Father ($r=.3, p<.01$), Avoidant Attachment: Mother ($r=.48, p<.001$), Avoidant Attachment: Partner ($r=.49, p<.001$), Codependent-Enmeshed Attachment: Father ($r=.26, p<.01$), Codependent-Enmeshed Attachment: Mother ($r=.24, p<.01$), Control ($r=.41, p<.001$), Denial ($r=.51, p<.001$), Family Suppression of Feelings ($r=.41, p<.001$), Jealousy ($r=.28, p<.01$), Rumination ($r=.66, p<.001$), Perfectionism ($r=.23, p<.05$), Shame ($r=.74, p<.001$), Mistrust ($r=.51, p<.001$), and Withdrawal ($r=.47, p<.001$). Also positively correlated with BDI-II scores were scores on all helplessness and hopelessness scales.

Scores on the following ACIQ scales were negatively correlated with scores on the BDI-II: Family Rigidity Versus Chaos ($r= -.23, p<.05$), Peer Relations ($r= -.44, p<.001$), Secure Attachment: Father ($r= -.22, p<.05$), Secure Attachment: Mother ($r= -.3, p<.01$), Secure Attachment: Partner ($r= -.31, p<.01$), and Sexual Intimacy ($r= -.26, p<.01$).

With regard to the experimental group, scores on the following Attachment and Clinical Issues Questionnaire scales were positively correlated with scores on the BDI-II: Ambivalent Attachment: Mother ($r=.37, p<.05$), Ambivalent Attachment: Partner ($r=.37, p<.05$), Anger ($r=.51, p<.001$), Anxiety ($r=.88, p<.001$), Avoidant Attachment: Father ($r=.33, p<.05$), Avoidant Attachment: Mother ($r=.47, p<.001$), Avoidant Attachment: Partner ($r=.49, p<.001$), Control ($r=.35, p<.05$), Denial ($r=.49, p<.001$), Family Suppression of Feelings ($r=.4, p<.01$), Rumination ($r=.78, p<.001$), Shame ($r=.83, p<.001$), Mistrust ($r=.53, p<.001$), and Withdrawal ($r=.44, p<.001$). Helplessness with regard to father ($r=.33, p<.05$), mother ($r=.39, p<.01$), partner ($r=.41, p<.01$), and friends ($r=.59, p<.001$) were positively correlated with BDI-II scores, as well as hopelessness with regard to relationships with mother ($r=.37, p<.05$), partner ($r=.51, p<.001$), and friends ($r=.47, p<.01$). Scores on the Peer Relations subscale were negatively correlated with BDI-II scores ($r= -.45, p<.01$), indicating that experimental group participants with more satisfying peer relationships reported less severe depression than those who reported lower levels of peer support.

With regard to the control group, the scores on the following Attachment and Clinical Issues Questionnaire scales were positively correlated with scores on the BDI-II: Ambivalent Attachment: Mother ($r=.34, p<.01$), Ambivalent Attachment: Partner ($r=.31, p<.05$), Anger ($r=.42, p<.001$), Anxiety ($r=.62, p<.001$), Avoidant Attachment: Mother ($r=.35, p<.01$), Avoidant Attachment: Partner ($r=.41, p<.001$), Codependent-Enmeshed Attachment: Mother ($r=.28, p<.05$), Codependent-Enmeshed Attachment: Father ($r=.31, p<.05$), Control ($r=.55, p<.001$), Denial ($r=.55, p<.001$), Family Suppression of Feelings ($r=.35, p<.01$), Rumination ($r=.57, p<.001$), Perfectionism ($r=.26, p<.05$), Shame ($r=.55,$

$p < .001$), Mistrust ($r = .25, p < .05$), and Withdrawal ($r = .38, p < .01$). Helplessness with regard to relationships with mother ($r = .36, p < .01$), and partner ($r = .32, p < .01$) were positively correlated with BDI-II scores, as well as hopelessness with regard to relationships with partner ($r = .34, p < .01$). Scores on the Peer Relations scale were negatively correlated with scores on the BDI-II, indicating that participants who reported more social support reported less depression ($r = -.32, p < .01$). A summary of these correlations can be found in Table 5.

The Helplessness: Mother scale was significantly positively correlated with the following scales: Helplessness: Father ($r = .39, p < .001$), Helplessness: Partner ($r = .44, p < .001$), Hopelessness: Mother ($r = .79, p < .001$), Hopelessness: Father ($r = .2, p < .05$), and Hopelessness: Partner ($r = .48, p < .001$). The Helplessness: Father was significantly positively correlated with the following scales: Helplessness: Partner ($r = .44, p < .001$), Hopelessness: Mother ($r = .29, p < .01$), Hopelessness: Father ($r = .73, p < .001$), and Hopelessness: Partner ($r = .35, p < .001$). Scores on the Helplessness: Partner scale were also positively correlated with scores on the following scales: Hopelessness: Mother ($r = .37, p < .001$), Hopelessness: Father ($r = .27, p < .01$), and Hopelessness: Partner ($r = .72, p < .001$). The Hopelessness: Mother scale correlated positively with the Hopelessness: Father scale ($r = .28, p < .01$) and the Hopelessness: Partner scale ($r = .48, p < .001$) in addition to all Helplessness scales. Significant positive correlations were found for scores on the Hopelessness: Father scale and scores on the Hopelessness: Partner scale ($r = .38, p < .001$). A summary of these results can be found in Table 1.

In the overall sample, scores on the Helplessness: Mother scale correlated positively with scores on the Ambivalent Attachment: Mother scale ($r = .77, p < .001$), the

Ambivalent Attachment: Partner Scale ($r=.24, p<.05$), the Avoidant Attachment: Mother scale ($r=.77, p<.001$), and the Avoidant Attachment: Partner scale ($r=.27, p<.01$). Scores on the Helplessness: Mother scale correlated negatively with scores on the Secure Attachment: Mother scale ($r=-.69, p<.001$) and the Secure Attachment: Partner scale ($r=-.24, p<.01$). Scores on the Helplessness: Father correlated positively with the Ambivalent: Father scale ($r=.69, p<.001$), the Ambivalent: Mother scale ($r=.29, p<.01$), the Ambivalent: Partner scale ($r=.21, p<.05$), the Avoidant: Father scale ($r=.52, p<.001$), the Avoidant: Mother scale ($r=.32, p<.001$), and the Avoidant: Partner scale ($r=.23, p<.05$). Scores on the Helplessness: Father scale correlated negatively with scores on the Secure Attachment: Father scale ($r=-.45, p<.001$) and scores on the Secure Attachment: Partner scale ($r=.28, p<.01$).

Scores on the Helplessness: Partner scale correlated positively with the following scales: Ambivalent Attachment: Father ($r=.25, p<.05$), Ambivalent Attachment: Mother ($r=.37, p<.001$), Ambivalent Attachment: Partner ($r=.63, p<.001$), Avoidant Attachment: Mother ($r=.36, p<.001$), and Avoidant Attachment: Partner scale ($r=.62, p<.001$). Scores on the Helplessness: Partner scale correlated negatively with scores on the Secure Attachment: Mother scale ($r=-.39, p<.001$) and the Secure Attachment: Partner scale ($r=-.56, p<.001$). Scores on the Hopelessness: Mother scale correlated positively with scores on the following scales: Ambivalent Attachment: Mother ($r=.6, p<.001$) and Avoidant Attachment: Mother scale ($r=.6, p<.001$). Scores on the Hopelessness: Mother scale were negatively correlated with scores on the Secure Attachment: Mother scale ($r=-.65, p<.001$). Scores on the Hopelessness: Father scale were positively correlated with scores on the Ambivalent Attachment: Father scale ($r=.62, p<.001$), the Ambivalent

Attachment: Partner scale ($r=.2, p<.05$), and the Avoidant Attachment: Father scale ($r=.48, p<.001$). Scores on the Hopelessness: Father scale were negatively correlated with scores on the Secure Attachment: Father scale ($r=-.47, p<.001$). Scores on the Hopelessness: Partner scale were positively correlated with scores on the Ambivalent Attachment: Father scale ($r=.21, p<.05$), the Ambivalent Attachment: Mother scale ($r=.34, p<.001$), the Ambivalent Attachment: Partner scale ($r=.57, p<.001$), the Avoidant Attachment: Mother scale ($r=.33, p<.001$), and the Avoidant Attachment: Partner scale ($r=.53, p<.001$). Scores on the Hopelessness: Partner scale were negatively correlated with scores on the Secure Attachment: Mother scale ($r=-.32, p<.001$) and the Secure Attachment: Partner scale ($r=-.51, p<.001$). These results can be summarized in Table 2.

Analyzing only the experimental group, significant positive correlations were found between Helplessness: Mother and the following scales: Ambivalent Attachment: Mother ($r=.83, p<.001$) and Avoidant Attachment: Mother ($r=.86, p<.001$). A significant negative correlation was found between this scale and the Secure Attachment: Mother scale, ($r=-.76, p<.001$). There were no significant correlations between the Helplessness: Mother scale and the following scales: Ambivalent Attachment: Father, Ambivalent Attachment: Partner, Avoidant Attachment: Father, Avoidant Attachment: Partner, Secure Attachment: Father, Secure Attachment: Partner, Codependent: Mother, Codependent: Father, and Codependent: Partner.

The Helplessness: Father scale correlated positively with the Ambivalent Attachment: Father scale ($r=.84, p<.001$), the Avoidant Attachment: Father scale ($r=.73, p<.001$), and the Avoidant Attachment: Mother scale ($r=.38, p<.05$). The scale correlated negatively with the Secure Attachment: Father scale ($r=-.61, p<.001$). No other

attachment scales correlated with The Helplessness: Father scale. The Helplessness: Partner scale correlated with the following scales: Ambivalent Attachment: Mother ($r=.32, p<.05$), Ambivalent Attachment: Partner ($r=.72, p<.001$), Avoidant Attachment: Partner ($r=.66, p<.001$), and Secure Attachment: Partner ($r=-.63, p<.001$).

Also for the experimental group, the Hopelessness: Mother scale correlated with the following attachment scales: Ambivalent Attachment: Mother ($r=.7, p<.001$), Avoidant Attachment: Mother ($r=.68, p<.001$), and Secure Attachment: Mother ($r=-.74, p<.001$). The Hopelessness: Father scale correlated with these attachment scales: Ambivalent Attachment: Father ($r=.75, p<.001$), Avoidant Attachment: Father ($r=.67, p<.001$), Avoidant Attachment: Mother ($r=.31, p<.05$), Secure Attachment: Father ($r=-.61, p<.001$), and Codependent Attachment: Mother ($r=.35, p<.05$). The Hopelessness: Partner scale correlated significantly with the following scales: Ambivalent Attachment: Partner ($r=.74, p<.001$), Avoidant Attachment: Mother ($r=.38, p<.05$), Avoidant Attachment: Partner ($r=.65, p<.001$), Secure Attachment: Mother ($r=-.32, p<.05$), Secure Attachment: Partner ($r=-.66, p<.001$), and Codependent Attachment: Father ($r=.32, p<.05$). These results are summarized in Table 3.

Correlations between ACIQ attachment scales and Helplessness and Hopelessness scales were computed for the control group. The Helplessness: Mother scale correlated significantly with the following scales: Ambivalent Attachment: Mother ($r=.61, p<.001$), Avoidant Attachment: Mother ($r=.59, p<.001$), Secure Attachment: Mother ($r=-.55, p<.001$), and Codependent Attachment: Father ($r=.28, p<.05$). The Helplessness: Father scale correlated with the Ambivalent Attachment: Father scale ($r=.41, p<.001$), the Avoidant Attachment: Father scale ($r=.25, p<.05$), the Secure Attachment: Mother scale

($r=-.24, p<.05$), and the Codependent Attachment: Father scale ($r=.26, p<.05$). The Helplessness: Partner scale correlated with the following scales: Ambivalent Attachment: Mother ($r=.34, p<.01$), the Ambivalent Attachment: Partner scale ($r=.51, p<.001$), the Avoidant Attachment: Mother scale ($r=.34, p<.01$), the Avoidant Attachment: Partner scale ($r=.53, p<.001$), the Secure Attachment: Mother scale ($r=-.4, p<.01$), and the Secure Attachment Partner scale ($r=-.42, p<.001$).

For the control group participants only, the Hopelessness: Mother scale correlated significantly with the following scales: Ambivalent Attachment: Mother, Avoidant Attachment: Mother, Secure Attachment: Mother, and Codependent Attachment: Father. The Hopelessness: Father scale correlated significantly with the Ambivalent Attachment: Father scale ($r=.41, p<.001$), the Avoidant Attachment: Father scale ($r=.26, p<.05$), and the Secure Attachment: Father scale ($r=-.31, p<.05$). The Hopelessness: Partner scale correlated with the following scales: Ambivalent Attachment: Partner ($r=.34, p<.01$), Avoidant Attachment: Partner ($r=.31, p<.05$), and Secure Attachment: Partner ($r=-.26, p<.05$). These results can be summarized in Table 4.

ANOVAs.

The experimental group had a significantly higher average BDI-II score than the control group, with the average for the therapy group 18.02 and the average for the control group 5.6, $F(1,104)=47.15, p<.001$. For each scale of the ACIQ and for each Helplessness and Hopelessness scale, the lowest possible score is one and the highest possible score is four. The experimental group had significantly higher scores on the Ambivalent Attachment: Father scale than the control group, with an average score of 2.1 compared to an average score of 1.7 for the control group, $F(1,104)=7.58, p<.01$. The

experimental group also had significantly higher average scores on the Ambivalent Attachment: Mother and Ambivalent Attachment: Partner than the control group. Average scores were 2.06 and 1.68, $F(1,104)=11.96, p<.001$, and 1.95 and 1.66, $F(1,104)=6.56, p<.05$, respectively. Participants in the experimental group reported significantly higher levels of anger than participants in the control group, with an average score of 2.17 compared to an average score of 1.84, $F(1,104)=10.26, p<.01$. The experimental group also reported higher levels of anxiety, with an average score of 2.21 compared to the control group's average score of 1.78, $F(1,104)=11.37, p<.01$.

Participants in the experimental group had significantly higher scores on all Avoidant Attachment scales compared to participants in the control group. On the Avoidant Attachment: Father scale, the average for the experimental group was 2.19 while it was 1.95 for the control group, $F(1,104)=5.02, p<.05$. On the Avoidant Attachment: Mother scale, the average score for the experimental group was 2.31 compared to an average score of 1.87 for the control group, $F(1,104)=19.38, p<.001$. Finally, experimental group participants had an average score of 2.08 and control group participants had an average score of 1.73 on the Avoidant Attachment: Partner scale, $F(1,104)=15.06, p<.001$.

Participants in the experimental group reported significantly higher levels of denial than the control group did, with an average score of 2.56 compared to an average score of 2.27, $F(1,104)=7.09, p<.01$. They also reported higher levels of controlling behavior, with an average score of 2.14 compared to the control group's average score of 1.96, $F(1,104)=5.97, p<.05$. The experimental group reported significantly higher levels of suppression of feelings within their families as compared to the control group, with

respective average scores of 2.37 and 1.99, $F(1,104)=7.11, p<.01$. The control group reported significantly higher levels of interaction with peers than the experimental group, with an average score of 3.05 compared to the experimental group's average score of 2.71, $F(1,104)=8.51, p<.01$. The control group also scored significantly higher on the Religion scale, with an average score of 3.1 compared to the experimental group's average of 2.56, $F(1,104)=7.09, p<.01$. Control group participants, with an average score of 3.11, scored significantly higher on the Secure Attachment: Mother scale than experimental group participants, who reported an average score of 2.61, $F(1,104)=11.07, p<.01$. Control group participants also had a significantly higher average score on the Secure Attachment: Partner scale (3.15) than experimental group participants (2.69), $F(1,104)=7.89, p<.01$. The average score on the Sexual Intimacy scale was higher for the control group (3.17) than for the experimental group (2.84), $F(1,104)=7.98, p<.01$.

The experimental group reported significantly higher levels of sexual arousal than the control group, with an average score of 2.41 compared to 2.25, $F(1,104)=8.04, p<.01$. The average score on the Shame scale was significantly higher for the experimental group (1.9) than the average score for the control group (1.57), $F(1,104)=15.56, p<.001$. Participants in the experimental group reported significantly higher levels of mistrust than the control group did, with an average score of 2.49 compared to an average score of 2.01, $F(1,104)=18.39, p<.001$. The experimental group reported significantly higher levels of social withdrawal than the control group, with an average score of 2.5 compared to the control group's average score of 2.12, $F(1,104)=17.01, p<.001$.

Participants in the experimental group had significantly higher scores on all

Helplessness scales compared to participants in the control group, with the exception of the Helplessness: Friends scale. On the Helplessness: Father scale, the average for the experimental group was 1.86 while it was 1.41 for the control group, $F(1,104)=9.73$, $p<.01$. On the Helplessness: Mother scale, the average score for the experimental group was 1.76 compared to an average score of 1.31 for the control group, $F(1,104)=31$, $p<.001$. Finally, experimental group participants had an average score of 1.67 and control group participants had an average score of 1.37 on the Helplessness: Partner scale, $F(1,104)=7.77$, $p<.01$.

Participants in the experimental group had significantly higher scores on all Hopelessness scales compared to participants in the control group. On the Hopelessness: Father scale, the average for the experimental group was 1.65 while it was 1.34 for the control group, $F(1,104)=4.41$, $p<.05$. On the Hopelessness: Mother scale, the average score for the experimental group was 1.63 compared to an average score of 1.17 for the control group, $F(1,104)=17.19$, $p<.001$. The experimental group participants had an average score of 1.51 and control group participants had an average score of 1.13 on the Hopelessness: Partner scale, $F(1,104)=15.03$, $p<.001$. On the Hopelessness: Friends scale, the average for the experimental group was 1.45 while it was 1.16 for the control group, $F(1,114)=8.72$, $p<.01$.

No significant differences between the average scores of the experimental and control groups were found on the following scales: Abuser, $F(1,104)=.91$, $p=.34$; Codependent-Enmeshed Attachment: Mother, $F(1,104)=.23$, $p=.63$; Codependent-Enmeshed Attachment: Father, $F(1,104)=1.16$, $p=.29$; Codependent-Enmeshed: Partner, $F(1,104)=1.06$, $p=.31$; Family Rigidity Versus Chaos, $F(1,104)=.57$, $p=.45$; Jealousy, F

(1,104)=2.86, $p=.09$; Rumination, $F(1,104)=3.71$, $p=.06$; Perfectionism, $F(1,104)=1.04$, $p=.31$; Secure Attachment: Father, $F(1,104)=3.85$, $p=.05$; and Helplessness: Friends, $F(1,104)=3.34$, $p=.07$. These results are summarized in Table 6.

On the Avoidant Attachment: Mother scale, there was an interaction with regard to age and group. Older individuals in the experimental group scored significantly higher than younger individuals in the experimental group, and older individuals in the control group scored significantly higher than younger individuals in the control group, $F(1,104)=4.2$, $p=.04$. An interaction of sex and group was found for the Avoidant Attachment: Partner scale, with males in the experimental group obtaining significantly higher scores than males in the control group, $F(1,104)=8.17$, $p<.01$.

On the Denial scale, males in the experimental group scored significantly higher than males in the control group, whereas females in the two groups had comparable scores $F(1,104)=5.23$, $p=.02$. On the Peer Relations scale, an interaction with regard to sex and group was observed, with males in the experimental group reporting lower levels of peer support than any other group, $F(1,104)=6.08$, $p=.02$. There was also an interaction between group and sex on the Withdrawal/Engagement scale, with males in the experimental group reporting higher levels of withdrawal than any other group, $F(1,104)=12.69$, $p<.001$. An interaction was observed with regard to age and group on the Helplessness: Mother scale, with older participants in the experimental group reporting higher levels of helplessness than older participants in the control group, $F(1,104)=14.56$, $p<.001$. There was not a significant difference among younger individuals regardless of group membership. There was also an age by group interaction on the Hopelessness: Mother scale, with older participants in the experimental group

reporting higher levels of hopelessness than older participants in the control group, $F(1,104)=8.47, p<.01$. Younger participants did not differ significantly on this Mother Hopelessness scale, regardless of group membership.

Discussion

Consistent with hypotheses, ambivalent and avoidant attachment styles with regard to mother, father, and partner positively correlated with levels of depression in the overall sample, and secure attachment to mother, father, and partner correlated negatively with depression. It is interesting to note that correlations were stronger for attachment with regard to mother and partner than for attachment to father. Future research may focus on perceptions of paternal roles and the significance of the father-child relationship to the child. Do we “write off” our fathers and dismiss the paternal relationship more easily and more frequently than the relationship that we have with our mothers, resulting in a weaker relationship between ambivalent and avoidant insecure attachment patterns and pathology than the relationships observed among ambivalent and avoidant partner and mother relationships and pathology? When attachment difficulties exist within the maternal relationship, what are the differences in the psychological and social implications of these difficulties compared to implications of these specific attachment difficulties in the paternal relationship?

Codependent-enmeshed attachment styles with regard to mother and father correlated positively with levels of depression, whereas codependent-enmeshed attachment to partner did not predict depression in the overall sample. Future research could focus on the qualitative differences in enmeshment with parents and enmeshment with partners and the differences in implications of each. Is enmeshment with a romantic

partner perceived as more desirable than enmeshment with parents? Is partner enmeshment more socially acceptable than parent-child enmeshment and thus less likely to predict depression? What are the differences in the potential benefits and potential stresses of enmeshment with a partner compared to those associated with enmeshment with one or both parents? It is also interesting to note that codependent-enmeshed attachment style with regard to mother and father was positively correlated with depression in the control group, but not in the experimental group. Does the function of enmeshment change depending on the level of distress that a person experiences? The results suggested that participants in the experimental group reported significantly less peer support than participants in the control group, so it may be that when individuals experience depression, enmeshment with parents serves as a source of social support when other types of support is lacking and thus is not a significant predictor of depression.

Also consistent with hypotheses, anger, anxiety, control, and denial correlated positively with levels of depression. Scores on the Family Rigidity vs. Chaos scale correlated negatively with levels of depression, indicating that participants who reported more chaotic family environments reported higher levels of depression. Since the scale represents a continuum, interesting future research might examine variable psychopathology associated with family rigidity as opposed to chaos, which is associated with depression in this study. Suppression of emotion was associated with the presence of depression, as was jealousy and rumination. Scores on the Peer Relations scale correlated negatively with scores on the Beck Depression Inventory-II, indicating that participants who reported lower levels of peer interaction and support reported higher levels of

depression. Participants who reported more perfectionistic behavior and higher levels of shame reported higher levels of depression, and mistrust was associated with depression. Participants who reported experiencing less sexual intimacy reported higher levels of depression, and higher scores on the scale that measures social withdrawal predicted higher scores on the BDI-II. Helplessness and hopelessness in all types of relationships (mother, father, partner, and friends) were associated with higher levels of depression.

Contrary to predictions, participant reports of engaging in abusive behavior was not related to depressive symptoms. There was no relationship observed between levels of sexual arousal and levels of depression, although it was hypothesized that participants who reported higher levels of depression would report less sexual arousal. There was also no relationship observed between religiosity and depressive symptoms, despite research that suggests that individuals who engage in regular religious worship report lower levels of depression. However, the findings of this study are interesting considering extant literature that indicates that various aspects of religion are associated with less depression (regularly attending worship services), while other aspects seem to be associated with more depressive symptoms in the individual (spirituality in the absence of being part of a religious community). Since peer interaction and social engagement is associated with lower levels of depression, the facet of religiosity related to lower levels of depression may be the social interaction and peer engagement that organized religion provides.

When the experimental group consisting of depressed individuals as defined by the Beck Depression Inventory-II (BDI-II) was compared to non-depressed individuals who comprised the control group, the average depressed participant reported the presence of moderate depression. experimental group participants reported avoidant and

ambivalent attachment to both parents and partners at a higher rate than control patients, and control participants reported secure attachment with regard to mother and partner than did experimental participants. Contrary to predictions, experimental participants and control participants reported similar rates of secure attachment to their fathers. Groups did not differ significantly with regard to codependent-enmeshed attachment patterns. Future research may focus on examining the relationship among codependent attachment, psychopathology, and the decision to seek professional intervention. Are there aspects of codependent-enmeshed attachment that buffer against distress as evidenced by help-seeking behavior? What aspects of codependent attachment result in pathology and distress, if any?

Consistent with hypotheses, experimental group participants scored higher than controls on measures of anger, anxiety, denial, shame, mistrust, and suppression of emotion within the family of origin. Experimental group participants reported lower levels of peer support and interaction and higher levels of social withdrawal than controls. Although there was not a significant correlation between religiosity and depression in the control group and the experimental group, the control group reported levels of religiosity significantly higher than that of the experimental group. This finding may be related to high levels of social withdrawal observed in the experimental group; ACIQ questions such as “I attend a place of worship regularly” may assess social engagement as much as they assess religiosity. Considering these results, future research may examine the relationship between the decision to seek therapy and the quantitative and qualitative aspects of social support.

It is interesting to note that participants in the experimental group reported higher

levels of sexual arousal than the control group, since according to relevant literature, lack of or reduction in sexual arousal is associated with depression. However, control group participants did report significantly higher levels of sexual intimacy than experimental group participants. To clarify these findings, future research should examine the relationship among sexual arousal, sexual intimacy, and depression.

Consistent with hypotheses outlined in this study, experimental group participants scored higher than control group participants on measures of helplessness with regard to relationships with mother, father, and partner. Although it was predicted that experimental group participants would score higher on the scale that measures helplessness in relationships with friends, there was not a significant between-groups difference. Since experimental group participants reported few interactions with peers, then questions regarding peer relationships may be irrelevant to participants, and so scores on the Helplessness: Friends scale may not fall into expected patterns. Also consistent with the hypotheses of this study, experimental group participants scored significantly higher on all hopelessness scales than did control group participants, providing evidence that the sense of hopelessness results should be considered in the conceptualization of depression. In light of these findings, more comprehensive measures of hopelessness and helplessness specific to relationships with family members and romantic partners should be developed as assessments to aid the therapeutic process.

When Helplessness and Hopelessness scale scores were analyzed, all scales correlated significantly with each other. This may be evidence that all the scales are actually measuring the same construct of hopelessness and helplessness in relationships. When individuals demonstrate helplessness and hopelessness in one relationship, they

tend to demonstrate the same in other relationships. Future research should investigate the dynamics of hopelessness and helplessness in relationships, clarify their relationship with psychopathology, and identify behaviors and relationship circumstances that contribute to their presence.

When helplessness and hopelessness scales were analyzed according to their relationship with attachment scales, each scale correlated positively with its respective insecure attachment pattern and negatively with the secure attachment scale for the same attachment figure. For example, in the overall sample, the Helplessness: Mother and Hopelessness: Mother scales correlated positively with the Avoidant Attachment: Mother scale and the Ambivalent Attachment: Mother scale and negatively with the Secure Attachment: Mother scale. The same was found for the Helplessness and Hopelessness scales for father and partner. It is interesting to note that helplessness and hopelessness with regard to one attachment figure typically only predicted insecure attachment styles to that specific attachment figure in both the control group and the experimental group. For example, in the experimental group, the Helplessness: Mother scale and the Hopelessness: Mother scale correlated significantly with the Ambivalent Attachment: Mother scale, the Avoidant Attachment: Mother scale, and the Secure Attachment: Mother scale. These scales did not correlate significantly with any other attachment scales. These findings provide evidence that hopelessness and helplessness are significant aspects of insecure attachment that should be clinically assessed and included in case conceptualizations in addition to traditional aspects of problematic attachments.

The purpose of this study was to illustrate the relationship among problematic attachment patterns and related clinical issues and clinical levels of distress, specifically

depression. All clinical participants reported the experience of significant distress, as evidenced by a diagnosis of Major Depressive Disorder, a score indicating mild, moderate, or severe depressive symptoms on the BDI-II, and engagement in outpatient psychotherapy. While this group of individuals differed significantly from individuals in the control group with regard to depressive symptoms assessed by the BDI, they were also significantly different on many dimensions of attachment and related clinical issues. This provides evidence that conceptualization of client difficulties based on symptoms alone is insufficient clinical assessment, and attachment measures provide valuable client information relevant to treatment very quickly. Since this study examines client characteristics at the point of intake, an interesting follow-up study would involve examining therapeutic outcomes as they are related to attachment issues. For example, do individuals who tend to be engaged in securely attached relationships have better outcomes than insecurely attached individuals? How do securely attached individuals differ from insecurely attached individuals in how they perceive the therapist and the process of therapy? What are the implications of attachment patterns for the therapist-client relationship?

It should be noted that an important limitation of this study was the small sample size. Statistical analyses would have had more power if the sample size had been larger, so results should be interpreted with caution. Participant recruitment for this study was difficult, and most potential respondents declined to participate. With regard to the therapy population, many participants reported that they did not have enough energy to participate or believed that they were unable to concentrate long enough to complete the survey. This may have resulted in more severely depressed therapy clients being under-

represented in the clinical population, since lack of energy and difficulty concentrating are depressive symptoms measured by the BDI-II. It may be the case that individuals who chose to participate were less depressed or somehow differently depressed than those who chose not to participate, and the present results should therefore be cautiously interpreted.

Whereas research has provided evidence of the validity of the attachment scales of the ACIQ, a limitation of this study concerns the lack of validation of the clinical issues scales of the ACIQ (Abuser, Control, Denial, etc.) and the Helplessness and Hopelessness scales. There has been no data to suggest convergent, concurrent, or discriminant validity with regard to these scales. As a result, the results of this study should be interpreted with caution since there can be no assumption that the clinical issue scales and the Helplessness and Hopelessness scales are measuring independent phenomena.

Models of the Relationship Between Depression and Attachment: An Evaluation

Several models of the relationship between attachment and depression were presented and analyzed in this study. It was predicted, based on the model proposed by Bowlby (1980), that depressed individuals would have high scores on measures of insecure attachment to caregivers and low scores on measures of secure attachment. It was also predicted that depressed individuals would obtain high scores on measures of hopelessness, helplessness, and shame. This model was partially supported by the results of this study. Scores on the Ambivalent Attachment: Mother and the Avoidant Attachment: Mother scales correlated significantly with levels of depression in both groups and the overall sample, as did scores on the Shame scale. However, scores on the

Ambivalent Attachment: Father and Avoidant Father scales, although correlating with the BDI, did not seem to correlate as high as the corresponding mother scales, and this should be studied in larger groups of participants.

A weakness of Bowlby's model is that it neglects to differentiate types of insecure attachment as they relate specifically to depression. The correlations among the separate insecure attachment scales (ambivalent and avoidant) and scores on the BDI-II suggest that the relationship between insecure attachment and depression should be more clearly defined, recognizing the differences between the dynamics of ambivalent and avoidant attachment patterns as they are related to affective difficulties. Bowlby (1980) discussed circumstances that result in depressive symptoms, and all circumstances involved relationships with primary caregivers. Another weakness of Bowlby's model is that it fails to take into account partner relationships. Ambivalent attachment and avoidant attachment with regard to partner were related to the presence of depression, and secure attachment with regard to partner was related to lower levels of depression in the overall sample. Ambivalent attachment with regard to partner correlated significantly with depression in both groups and the overall sample, whereas ambivalent attachment with regard to father correlated significantly with depression in the overall sample only, suggesting that partner relationships may not necessarily be modeled after relationships with primary caregivers.

A third weakness of Bowlby's model lies in the conceptualization of helplessness and hopelessness in relationships. Bowlby (1980) suggested that depression is born of helpless and hopeless feelings, but did not provide specific information about different relationships. In this study, hopelessness in the paternal relationship correlated

significantly with depression in the overall sample, but not in individual groups.

Hopelessness in the maternal relationship correlated significantly with depression in the overall sample and in the therapy group. Hopelessness with regard to partner correlated significantly with depression in the overall sample, the therapy group, and the control group. These results suggest that the dynamics of hopelessness in relationships and depression differ according to attachment figure, and a more specific, detailed conceptualization of hopelessness as it is related to depression might be warranted.

The model proposed by Roberts, Gotlib, and Kassel (1996) identified low self-esteem and low self-efficacy as mediators between insecure attachment and depressive symptoms. The models proposed by Wei, Heppner, and Mallinchrordt (2003) and Strodl and Noller (2003) also identified self-efficacy as a mediator in the relationship between attachment and depression. The model proposed by Roberts and his colleagues was supported by this study in that shame as measured by the ACIQ correlated positively with depression in the overall sample, the control group, and the therapy group. Self-efficacy, as assessed by the Helplessness scales, was also related to depression. However, the relationship was not consistent. Whereas helplessness with regard to mother and partner correlated significantly with depression in the overall sample and both groups, helplessness with regard to father correlated significantly with depression only in the overall sample and the therapy group. The results suggest that the dynamics of depression and helplessness are more complicated than “across the board” helplessness as a predictor of depression. A strength of the models proposed by Roberts, Gotlib, and Kassel (1996), Strodl and Noller (2003) and Wei, Heppner, and Mallinchrordt (2003) was that they identified the partner relationship as a source of attachment difficulties independent of

attachment to primary caregivers. As the results of this study suggest, partner attachment is significantly related to depression and is an important component of its manifestations.

Ingram (2003) and Eng (2001) discussed the lack of rewarding social interactions as the primary factor in the development of depression. The results of this study supported this idea, since scores on the Peer Relations scale were significantly correlated with levels of depression; the higher the level of depression, the lower the score on the Peer Relations scale. It was also predicted that there would be a significant relationship between levels of withdrawal and depression. Higher levels of social withdrawal were related to higher levels of depression in the overall sample, the therapy group, and the control group, whereas higher levels of social engagement were related to lower levels of depression. A strength of these conceptualizations is that they take into account current patterns of social functioning, as opposed to limiting conceptualization to interactions with primary caregivers. A criticism of these models is that they did not take into account variability among different types of insecure attachment and the specific maladaptive social behaviors that result. They also did not take into account the possibility of variable contributions of attachment to mother, father, and partner to the development of social withdrawal.

The models of attachment and depression adopted by Rice and Mirzadeh (2000) and Wei, Mallinchrout, Russel, and Abraham (2004) identified perfectionism as a mediator in the relationship between insecure attachment and depression. It was predicted that perfectionism as measured by the ACIQ would correlate significantly with levels of depression. However, there were only modest positive correlations in the overall sample and the control group. An important limitation of this model was that it failed to identify

other cognitive patterns that were related to depression. For example, cognitions involving helplessness, hopelessness, and shame were related to the presence of depressive symptoms in this study.

Stober's model of attachment and depression (2003) and the model proposed by George, Main, and Solomon contended that preoccupation with relationships is the key factor in the development of affective symptoms. So, it was predicted that higher levels of rumination would be related to higher levels of depression. The results of this study partially supported this conceptualization since there were strong correlations in the overall sample, the therapy group, and the control group between preoccupied thinking as measured by the ACIQ and depression. These models were limited in that they lacked specificity regarding the nature of the insecure attachment. They also failed to address the relative effects and perhaps variable effects of attachment to primary caregivers and romantic partners.

Dozier, Stoval, and Albus's (1999) model of attachment and depression, based on minimizing strategies and suppression of feelings, predicted that depression would be related to suppression of feelings and denial as operationalized by the ACIQ. In support of this model, Family Suppression of Feelings correlated significantly with levels of depression in the overall sample, the therapy group, and the control group. Higher levels of denial were related to higher levels of depression in all three samples. For both the suppression of feelings and denial scales, individuals in the therapy group scored significantly higher than non-depressed controls. The idea that insecurely attached individuals employ maximizing strategies that result in preoccupation and depression was supported by the association between rumination as

measured by the ACIQ and BDI-II scores. Again, this model is limited in that it fails to address possible variable effects of relationships with different attachment figures (mother, father, and partner).

While most of the models of attachment and depression were at least partially supported by the results of this study, the results best serve to illustrate the lack of comprehensiveness of each model. While each model accounted for part of the relationship between attachment and depression, all of them neglected other important aspects of the relationship as assessed in this study. Thus, the data suggested a more comprehensive model of depression, based on attachment and related issues, that takes into account variability in insecure attachment patterns and variability in attachment to different figures. The results of this study suggest that there are many cognitive and behavioral phenomena that should be included in a comprehensive model of depression, and that current models are too simplistic in their conceptualizations.

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Appendix 1 The Attachment and Clinical Issues Questionnaire (ACIQ)

ACIQ

Thank you for agreeing to fill out this survey for Marshall University. Do not put your name on this, as all responses will be confidential. (We are interested in averaging your responses with others at this point in time).

The word "partner" refers to your most important spouse, fiancé, steady date or a significant romantic interest in your life. If you are not currently involved in such a relationship, think about your most significant past partner and answer the questions with that relationship in mind. If you never had a steady or meaningful relationship in your life, leave the questions on partners blank.

Questions about your family, mother, and father refer to the family you grew up in. When answering questions about members of your family, think about who or what was true, typical, or most important while you were growing up (during the school age years). If you didn't have a mother or father figure, leave those questions blank. Although it may seem as if you are answering the same questions over and over, you are not. It is just that the same question is asked about different people.

Write your answers on the scoring sheets by filling in the appropriate circle. When you get to item 201, please start on the next answer sheet with # 1. Please use the following scale to estimate how often these statements apply to you.

A = never B = sometimes C = often D = always

1. When my mother felt sad for days, I did too.
2. When it comes to anger, those close to me have a short fuse.
3. If I don't trust other people then I will not be disappointed.
4. I like to withdraw from people when I am stressed.
5. I satisfy my partner's sexual needs.
6. I feel scared.
7. I felt bad when I did not include my father in things.
8. I need a close relationship with my partner.
9. When I had an argument with my mother, I got very angry.
10. Some people deserve to be hit.
11. The same thoughts run through my head for days.
12. I am worthless.
13. When I have an argument with my partner, I get very angry.
14. My father had hostile feelings towards me.
15. Family rules were unclear.
16. I liked being taken care of by my mother.
17. I go to great lengths to prevent my partner from being angry with me.
18. My family followed rules.
19. I worry that my partner will find somebody else.
20. It was good to keep your feelings to yourself in our family.
21. I had a safe secure relationship with my father.
22. I like to be the best at things.
23. I change my feelings to make my partner happy.

24. I feel better about myself when I win.
25. A higher power/God is important to me.
26. My partner and I have a special sexual connection.
27. I was more committed than my mother in our relationship.
28. My family did things the same way each time.
29. I had a good relationship with my father.
30. I tried to please my mother.
31. I feel good when I change my partner for his/her own good.
32. I feel fearful.
33. I do not amount to much as a person.
34. My father tried to change me for my own good.
35. I can usually depend on other people when I need them.
36. I like to get away from everyone when there is too much confusion.
37. My mother got angry with me.
38. I try to figure out what my partner wants.
39. I created an image of who I thought I was supposed to be in my own family.
40. It is important for me to be right.
41. I tried to like the same things that my mother did.
42. My father and I were close in every way.
43. I feel like a punching bag for other people.
44. My family made decisions the same way every time.
45. I feel uncomfortable with my friends.
46. I am distracted in conversations with others because I am thinking about something else that is important.
47. I feel like hitting those people who are close to me.
48. When I was stressed, I liked to stay away from my father.
49. It was good to keep feelings from my family.
50. It is important for me to know what my partner is doing.
51. I feel resentful because I can not pursue my own interests.
52. I needed a close relationship with my father.
53. My partner makes me angry.
54. I went to great lengths to get my mother to like me.
55. A disagreement with my partner ends in a shouting match.
56. I like to be alone when I am troubled.
57. I had a safe secure relationship with my mother.
58. I feel guilty for not taking care of my family's duties.
59. My partner gets hostile feelings towards me.
60. I say I am fine when I am really not.
61. Being by myself without my father was painful.
62. When my partner feels sad for days, I do too.
63. After an argument with my father, I tried to avoid him.
64. I try harder in our relationship than my partner.
65. I feel tense.
66. I miss what others say because I am working on something else in my head.
67. I went to great lengths to prevent my mother from being angry with me.
68. I had the greatest father in the world.

69. I like to do things right or not do them at all.
70. I am turned on if I see a pornographic movie.
71. People in my family had firm expectations for how we were supposed to feel.
72. It is important for me to achieve.
73. I wish others would not call or talk to me when I am upset.
74. When it comes to anger I am patient.
75. When someone is mean to me I feel like hitting them.
76. I liked being taken care of by my father.
77. Other people should work hard.
78. I worry about what my partner is doing during the day.
79. I am turned on sexually when I see someone in a magazine half undressed.
80. It is good to trust other people.
81. Being by myself without my partner is painful.
82. My anger is a good cover-up for other feelings that I have.
83. If I am really upset, my partner is not good at helping me deal with it.
84. I trust other people.
85. My mother did not fully understand me.
86. I have a hard time getting my mind off of problems.
87. I say I am happy when I really am not.
88. Other people feel better about themselves when they win.
89. I tried to please my father.
90. After an argument with my partner, I try to avoid him/her.
91. It was important to look good in my family.
92. I worry about being left alone without my partner.
93. I was more committed than my father in our relationship.
94. When it comes to anger, I have a short fuse.
95. I tried harder in our relationship than my mother.
96. My family believed that family rules should not change.
97. My partner is there when I need to talk about a problem.
98. When I got angry with my father, I liked to get away from him for awhile.
99. I do not want others to know what is going on in my life.
100. My feelings for my father were confusing.
101. A higher power/God is not important to me.
102. When I was stressed, I liked to stay away from my mother.
103. My church/place of worship is important to me in my life.
104. When I had an argument with my father, I got very angry.
105. My partner and I are close in every way.
106. I am afraid of losing control.
107. I tried to like the same things my father did.
108. Some people deserve to be put in their place.
109. I say I am not angry when I really am.
110. My partner is sexually appealing to others.
111. When I was really upset, my mother was not good at helping me deal with it.
112. Some people deserve to be criticized.
113. A higher power/God guides my life.
114. I try to like the same things that my partner does.

115. I changed my feelings to make my mother happy.
116. Emotional extremes were frowned upon in my family.
117. I go to great lengths to get my partner to like me.
118. I have fun with friends.
119. When I was upset, my father helped me deal with it.
120. It is good to be suspicious about the motives of others.
121. I am easily turned on sexually.
122. My mother had hostile feelings towards me.
123. I wish others would leave me alone.
124. My partner does not fully appreciate me.
125. Sex is best when it is accompanied by warm feelings.
126. I had the greatest mother in the world.
127. I should work hard.
128. I worried about being left alone without my mother.
129. When I got really mad at my father, I felt cold and rejecting towards him.
130. Arguments with my mother involved a shouting match.
131. I hate it when my partner is around people who might flirt.
132. My friends know how I feel.
133. It is good to keep a stiff upper lip even when I hurt inside.
134. Once I start thinking about a problem, I think about it over and over again.
135. Basically I am good.
136. I have pressed for and gotten sex even though my partner wasn't interested at the time.
137. Being by myself without my mother was painful.
138. I am very concerned about details.
139. I went to great lengths to get my father to like me.
140. I am more strongly committed in our relationship than my partner.
141. I feel afraid, but do not know why.
142. I went to great lengths to prevent my father from being angry with me.
143. I tried to figure out what my mother wanted.
144. My partner does not understand me fully.
145. Others are turned on sexually when they see someone in a magazine half undressed.
146. I use a lot of energy trying to get people to do what I want them to do.
147. After an argument with my mother, I tried to avoid her.
148. I feel ashamed when I feel sad, rejected, fearful, lonely, dependent or hurt.
149. I feel comfortable with my friends.
150. I try to change my partner for his/her own good.
151. I needed a close relationship with my mother.
152. Other people like me.
153. If I have an argument with my partner, I want to run away from them for awhile.
154. It is hard to get some things out of my mind.
155. Keeping busy helps me ignore my feelings.
156. When I had an argument with my mother, I wanted to run away from her for awhile.
157. I changed my feelings to make my father happy.

158. I avoid people who do not do what I expect them to do.
159. My feelings for my partner are confusing.
160. My mother was there when I needed to talk about a problem.
161. When my father felt sad for days, I did too.
162. I enjoy playing or going out with my friends.
163. Sex with my current partner is good.
164. When I am upset, my partner helps me deal with it.
165. I think about every little detail of a problem, and then think about it again and again.
166. My mother and I were close in every way.
167. When bad feelings come to me, I want to be by myself.
168. It is hard to know what my partner wants.
169. Arguments with my mother were like a love-hate kind of thing where feelings went back and forth.
170. I feel better about myself when I lose.
171. I tried harder in our relationship than my father.
172. I get angry when others flirt with my partner.
173. My father was there when I needed to talk about a problem.
174. I go from one thing to another trying to be satisfied.
175. I am concerned with being moral.
176. I like sex.
177. I want to be alone.
178. My partner and I are equally committed in our relationship.
179. My mother tried to change me for my own good.
180. I think about sex with others.
181. It is easy to ask my friends for help.
182. I can think about the same person or thing for days.
183. When I got angry with my mother, I liked to get away from her for awhile.
184. I worry about little things.
185. My father did not fully understand me.
186. Sometimes I fear getting too close to my partner.
187. It was hard to know what my mother wanted.
188. I worried about being left alone without my father.
189. My mother was supportive when I had a problem.
190. My partner gets angry with me.
191. It is best to avoid situations that I can not control.
192. I attend a place of worship/church.
193. Family rules were clear.
194. When I am sick or upset, I like to be with my partner.
195. I had a good relationship with my mother
196. My partner satisfies my sexual needs.
197. I repeat the same habits over and over.
198. I am a bad person.
199. My friends will always be there when I need them.
200. A disagreement with my mother ended in a shouting match.

GO TO NEXT ANSWER SHEET AND PUT QUESTION 201 ON 1, 202 ON 2 ETC.

A = never B = sometimes C = often D = always

201. When I had an argument with my father, I wanted to run away from him for awhile.
202. I feel bad when I do not include my partner in things.
203. When I was upset, my mother helped me deal with it.
204. If I get angry with my partner, I like to get away from him/her for awhile.
205. I felt good when I changed my father for his own good.
206. I feel ashamed when I have to stand up for myself.
207. I need to know where my partner is.
208. I wish others would come over and visit when I am upset.
209. When I got really mad at my mother, I felt cold and rejecting towards her.
210. I have a lot to be ashamed of.
211. My father was supportive when I had a problem.
212. When I get angry, I explode.
213. Arguments with my partner are like a love-hate kind of thing where feelings go back and forth.
214. I felt bad when I did not include my mother in things.
215. A disagreement with my father ended in a shouting match.
216. I use a lot of energy worrying about my problems.
217. My partner is supportive when I have a problem.
218. I talk about what turns me on sexually with my partner.
219. Arguments with my partner involve a shouting match.
220. My feelings for my mother were confusing.
221. I make my partner angry.
222. I feel that something bad is about to happen.
223. When I get really mad at my partner, I feel cold and rejecting towards him/her.
224. If people would just change a little bit then most of my problems would go away.
225. I try to please my partner.
226. I tried to figure out what my father wanted.
227. I avoid situations that I can not control.
228. When I was really upset, my father was not good at helping me deal with it.
229. It is important for me to know what my partner is doing.
230. When I am angry, I take it out on others.
231. My partner has a bad temper.
232. I have a lot of good friends.
233. When I was sick or upset, I liked to be with my mother.
234. I like being taken care of by my partner.
235. I hate it when someone does something the wrong way.
236. If someone treats you too well, it is wise to be suspicious of them.
237. I feel helpless when I try to get love from my mother.
238. I feel helpless when I try to get love from my father.
239. I feel helpless when I try to get love from my partner.
240. I feel helpless when I try to get love from my friends.
241. No matter what I do to get approval from my mother, nothing works.
242. No matter what I do to get approval from my father, nothing works.

243. No matter what I do to get approval from my partner, nothing works.
244. No matter what I do to get approval from my friends, nothing works.
245. I feel helpless in resolving conflict with my mother.
246. I feel helpless in resolving conflict with my father.
247. I feel helpless in resolving conflict with my partner.
248. I feel helpless in resolving conflict with my friends.
249. I believe that there is no hope that I will ever get love from my mother.
250. I believe that there is no hope that I will ever get love from my father.
251. I believe that there is no hope that I will ever get love from my partner.
252. I believe that there is no hope that I will ever get love from my friends.
253. I believe that there is no hope that I will ever get approval from my mother.
254. I believe that there is no hope that I will ever get approval from my father.
255. I believe that there is no hope that I will ever get approval from my partner.
256. I believe that there is no hope that I will ever get approval from my friends.
257. I believe that there is no hope that I will ever be able to successfully resolve conflict with my mother.
258. I believe that there is no hope that I will ever be able to successfully resolve conflict with my father.
259. I believe that there is no hope that I will ever be able to successfully resolve conflict with my partner.
260. I believe that there is no hope that I will ever be able to successfully resolve conflict with my friends.
261. I was answering the above questions about my relationship with my mother, based on our present relationship, I would still respond the same way.
262. If I was answering the above questions about my relationship with my father, based on our present relationship, I would still respond the same way.
263. If I was answering the above questions about my relationship with my family, based on our present relationship, I would still respond the same way.
264. Your sex: a) Male b) Female
265. Your age: a) 17-21 b) 22-35 c) 36-49 d) 50-65 e) 66+
266. Did either of your parents die while you were growing up?
a) mother b) father c) both d) neither
267. Were your parents divorced? a) Yes b) No
268. If yes on parental death or divorce, how long ago was it? a) 0-2yrs b) 3-5 c) 8-12
d) 13-20 e) 21+
269. If yes on parental death or divorce, who did you live with? a) mother b) father
c) relative d) friends e) others
270. How long did you live in a single parent home? a) 0 b) 1-2 yrs c) 2-5 yrs d) 6-10
yrs e) 11+ yrs
271. How many brothers and/or sisters do you have?
a) 0 b) 1 c) 2 d) 3 e) 4 or more
272. Were you the: a) oldest b) middle c) youngest
273. Your father's education a) 3-11 grade b) high school grad. c) some college d)
college grad e) graduate school.
274. Your mother's education a) 3-11 grade b) high school grad. c) some college d)
college grad e) graduate school.

- 275. Your race: a) Hispanic b) Black c) Native American d) White e) other
- 276. Are you married? a) Yes b) No c) Divorced d) widowed
- 277. If not married, are you currently in a relationship? a) Yes b) No
- 278. If yes, to the above questions (#276 or #277), how long? a) 0-6mo b) 7mo-1yr c) 1-2 yrs d) 2-4 yrs e) 5+ yrs
- 279. Your religion a) Christian b) Jewish c) Muslim d) other religion not listed e) no religion
- 280. Family income growing up a) \$1,000 - \$10,000 b) \$11,000 - \$20,000 c) \$21,000 - \$50,000 d) \$51,000 - \$100,000 e) \$100,000+
- 281. Family income now a) \$1,000 - \$10,000 b) \$11,000 - \$20,000 c) \$21,000 - \$50,000 d) \$51,000 - \$100,000 e) \$100,000+
- 282. Your education a) 3-11 grade b) high school grad. c) some college d) college grad e) graduate school.

Appendix 2 Scales, number of items in the scale, and representative items for each scale of the ACIQ.

1 ABUSER SCALE (ABUSER) (6)

I feel like hitting those people who are close to me.

Some people deserve to be put in their place.

2 AMBIVALENT ATTACHMENT - FATHER (AMBDAD) (6)

My feelings for my father were confusing.

Arguments with my father were a love-hate kind of thing.

3 AMBIVALENT ATTACHMENT - MOTHER (AMBMOM) (8)

My feelings for my mother were confusing.

Arguments with my mother were a love-hate kind of thing.

4 AMBIVALENT ATTACHMENT - PARTNER (AMBPART) (9)

My feelings for my partner are confusing

Arguments with my partner are a love-hate kind of thing.

5 ANGER (9)

I feel resentful because I can not pursue my own interests.

When I get angry, I explode.

6 ANXIETY (ANX) (6)

I feel that something bad is about to happen.

I use a lot of energy worrying about my problems.

7 AVOIDANT ATTACHMENT - FATHER (AVDAD) (7)

After an argument with my father, I tried to avoid him.

When I got really mad at my father, I felt cold and rejecting towards him.

8 AVOIDANT ATTACHMENT - MOTHER (AVMOM) (9)

After an argument with my mother, I tried to avoid her.

When I got really mad at my mother, I felt cold and rejecting towards her.

9 AVOIDANT ATTACHMENT - PARTNER (AVPART) (9)

After an argument with my partner, I tried to avoid him/her.

When I got really mad at my partner, I felt cold and rejecting towards him/her.

10 CODEPENDENCE-ENMESHED MOTHER (CODMOM) (14)

I changed my feelings to make my mother happy.

When my mother felt sad for days, I did too.

11 CODEPENDENCE-ENMESHED FATHER (CODDAD) (15)

I changed my feelings to make my father happy.

When my father felt sad for days, I did too.

12 CODEPENDENCE-ENMESHED PARTNER (CODPART) (14)

I change my feelings to make my partner happy.

When my partner felt sad for days, I did too.

13 CONTROL (CTRL) (11)

I avoid situations that I can not control.

If people would just change a little bit then most of my problems would go away.

14 DENIAL (5)

It is good to keep a stiff upper lip even when I hurt inside.

I say I am happy when I really am not.

15 FAMILY RIGIDITY VS CHAOS (FAMRIGID) (5)

My family believed that family rules should not change.

Family rules were clear.

16 FAMILY SUPPRESSION OF FEELINGS (FSUP) (6)

People in my family had firm expectations for how we were supposed to feel.

It was good to keep your feelings to yourself in our family.

17 JEALOUSY SCALE (JEAL) (8)

I worry that my partner will find somebody else.

I get angry when others flirt with my partner.

18 RUMINATION (RUM) (9)

Once I start thinking about a problem, I think about it over and over again.

I am distracted in conversations with others because I am thinking about something else that is important.

19 PEER RELATIONS (PEER) (7)

My friends will always be there when I need them.

My friends know how I feel.

20 PERFECTIONISM (PERF) (10)

I like to be the best at things.

I like to do things right or not do them at all.

21 RELIGION (RELG) (5)

I attend a place of worship/church.

A higher power/God is important to me.

22 SEXUAL AROUSAL (SAR) (6)

I am turned on if I see a pornographic movie.

- I am easily turned on sexually.
- 23 SECURE FATHER (SECDAD) (6)
- My father was there when I needed to talk about a problem.
- When I was upset, my father helped me deal with it.
- 24 SECURE MOTHER (SECMOM) (7)
- My mother was there when I needed to talk about a problem.
- When I was upset, my mother helped me deal with it.
- 25 SECURE PARTNER (SECPART) (5)
- My partner is there when I need to talk about a problem.
- When I am upset, my partner helps me deal with it.
- 26 SHAME (10)
- I feel ashamed when I feel sad, rejected, fearful, lonely, dependent or hurt.
- I do not amount to much as a person.
- 27 SEXUAL INTIMACY (SEXINT) (6)
- I talk about what turns me on sexually with my partner.
- Sex is best when it is accompanied by warm feelings
- 28 MISTRUST (MTR) (6)
- It is good to be suspicious about the motives of others.
- If I don't trust other people then I will not be disappointed.
- 29 WITHDRAW/ENGAGEMENT (WITHDRAW) (9)
- I like to withdraw from people when I am stressed.
- I do not want others to know what is going on in my life.

Appendix 3 Helplessness and Hopelessness scale questions.

A = never B = sometimes C = often D = always

I feel helpless when I try to get love from my mother.

I feel helpless when I try to get love from my father.

I feel helpless when I try to get love from my partner.

I feel helpless when I try to get love from my friends.

No matter what I do to get approval from my mother, nothing works.

No matter what I do to get approval from my father, nothing works.

No matter what I do to get approval from my partner, nothing works.

No matter what I do to get approval from my friends, nothing works.

I feel helpless in resolving conflict with my mother.

I feel helpless in resolving conflict with my father.

I feel helpless in resolving conflict with my partner.

I feel helpless in resolving conflict with my friends.

I believe that there is no hope that I will ever get love from my mother.

I believe that there is no hope that I will ever get love from my father.

I believe that there is no hope that I will ever get love from my partner.

I believe that there is no hope that I will ever get love from my friends.

I believe that there is no hope that I will ever get approval from my mother.

I believe that there is no hope that I will ever get approval from my father.

I believe that there is no hope that I will ever get approval from my partner.

I believe that there is no hope that I will ever get approval from my friends.

I believe that there is no hope that I will ever be able to successfully resolve conflict with my mother.

I believe that there is no hope that I will ever be able to successfully resolve conflict with my father.

I believe that there is no hope that I will ever be able to successfully resolve conflict with my partner.

I believe that there is no hope that I will ever be able to successfully resolve conflict with my friends.

My relationship with my mother will never be the way I want it to be.

My relationship with my father will never be the way I want it to be.

My relationship with my partner will never be the way I want it to be.

My relationships with my friends will never be the way I want them to be.

Appendix 4 Anonymous Survey Consent Form

Anonymous Survey Consent

You are invited to participate in a research project entitled “Conceptualizing Depression: Multi-Causality and the Attachment and Clinical Issues Questionnaire (ACIQ)” designed to analyze the relationship between attachment and depression in adulthood in order to better understand how to treat depression in adult therapy clients. The study is being conducted by Marc Lindberg, Ph.D., and Megan L. Green, M.A. from Marshall University. This research is being conducted as part of the doctoral dissertation for Megan Green.

This survey is comprised of the Attachment and Clinical Issues Questionnaire (the ACIQ) and the Beck Depression Inventory (the BDI) and will take approximately 45 minutes to an hour to complete. Your replies will be anonymous, so do not put your name anywhere on the form. There are no known risks involved with this study. Participation is completely voluntary and there will be no penalty if you choose to not participate in this research study or to withdraw. If you choose not to participate you may either return the blank survey or you may discard it. You may choose to not answer any question by simply leaving it blank. Returning the survey to the researcher at your behavioral health provider’s office indicates your consent for use of the answers you supply. If you have any questions about the study or in the event of a research related injury, you may contact Dr. Marc Lindberg at (304) 696-2769, or Megan Green at (304)696-6446.

If you have any questions concerning your rights as a research participant you may contact the Marshall University Office of Research Integrity at (304) 696-7320.

By completing this survey and returning it you are also confirming that you are **18** years of age or older.

Please keep this page for your records.

Table 1

Helplessness and Hopelessness Scale Correlations

	HelpM	HelpD	HelpP	HopeM	HopeD	HopeP
HelpM	—	.39***	.44***	.79***	.2*	.48***
HelpD	.39***	—	.44***	.29**	.73***	.35***
HelpP	.44***	.44***	—	.37***	.27**	.72***
HopeM	.79***	.28**	.37***	—	.28**	.48***
HopeD	.2*	.73***	.28**	.28**	—	.32**
HopeP	.48***	.43***	.41***	.41***	.38***	—

* Significant at the $p < .05$ level

**Significant at the $p < .01$ level

***Significant at the $p < .001$ level

Table 2

Correlations Among Helplessness and Hopelessness Scales and Attachment Scales:

Overall Sample

	HelpM	HelpD	HelpP	HopeM	HopeD	HopeP
AMBDAD	.16	.69***	.25*	.15	.62***	.21*
AMBMOM	.77***	.29**	.37***	.60***	.15	.34***
AMBPART	.24*	.21*	.63***	.19	.2*	.57***
AVDAD	.08	.52***	.18	.01	.48***	.09
AVMOM	.77***	.32***	.36***	.6***	.17	.33***
AVPART	.27**	.23*	.62***	.16	.11	.53***
SECDAD	-.08	-.45***	-.11	-.04	-.47***	-.1
SECMOM	-.69***	-.17	-.39***	-.65***	-.1	-.32***
SECPART	-.24*	-.28**	-.56***	-.15	-.18	-.51***
CODMOM	.01	.22*	.06	-.03	.22*	.20*
CODDAD	.24**	.25**	.27**	.24*	.09	.29**
CODPART	.05	.05	-.06	.06	.05	-.03

* Significant at the $p < .05$ level

**Significant at the $p < .01$ level

***Significant at the $p < .001$ level

Table 3

Correlations Among Helplessness and Hopelessness Scales and Attachment Scales:

Therapy Group

	HelpM	HelpD	HelpP	HopeM	HopeD	HopeP
AMBDAD	.13	.84***	.3	.17	.75***	.21
AMBMOM	.83***	.29	.32*	.7***	.23	.39
AMBPART	.25	.28	.72***	.15	.3	.74***
AVDAD	-.04	.73***	.2	-.06	.67***	.06
AVMOM	.86***	.38*	.3	.68***	.31*	.38*
AVPART	.22	.28	.66***	.05	.13	.65***
SECDAD	-.08	-.61***	-.18	-.06	-.61***	-.13
SECMOM	-.76***	-.02	-.3	-.74***	-.02	-.32*
SECPART	-.17	-.31	-.63***	-.1	-.21	-.66***
CODMOM	.001	.38	.14	-.08	.35*	.28
CODDAD	.23	.25	.32*	.24	.12	.32*
CODPART	.14	.15	-.03	.08	.2	.02

* Significant at the $p < .05$ level

**Significant at the $p < .01$ level

***Significant at the $p < .001$ level

Table 4

Correlations Among Helplessness and Hopelessness Scales and Attachment Scales:

Control Group

	HelpM	HelpD	HelpP	HopeM	HopeD	HopeP
AMBDAD	.09	.41***	.11	-.02	.41***	.07
AMBMOM	.61***	.21	.34**	.41***	-.01	.13
AMBPART	.14	.05	.51***	.14	.06	.34**
AVDAD	.14	.25*	.11	.01	.26*	.04
AVMOM	.59***	.13	.34**	.4***	-.07	.1
AVPART	.2	.04	.53***	.15	-.01	.31*
SECDAD	-.01	-.23	.03	.09	-.31*	.03
SECMOM	-.55***	-.24*	-.4**	-.47***	-.06	-.18
SECPART	-.19	-.11	-.42***	-.04	-.05	-.26*
CODMOM	.06	-.01	.01	.08	.06	.14
CODDAD	.28*	.26*	.22	.26*	.07	.26
CODPART	.03	.02	-.03	.13	-.05	-.01

* Significant at the $p < .05$ level

**Significant at the $p < .01$ level

***Significant at the $p < .001$ level

Table 5

Correlations Between BDI Scores and ACIQ Scale Scores: Overall Sample, Experimental Group, and Control Group

	Overall Sample	Therapy Group	Control Group
Sc1: Abuser	.17	.17	.16
Sc2: Ambivalent: Father	.32**	.29	.2
Sc3: Ambivalent: Mother	.41***	.37*	.34**
Sc4: Ambivalent: Partner	.39***	.37*	.31*
Sc5: Anger	.51***	.51***	.42***
Sc6: Anxiety	.78***	.88***	.62***
Sc7: Avoidant: Father	.3**	.33*	.2
Sc8: Avoidant: Mother	.48***	.47***	.35**
Sc9: Avoidant: Partner	.49***	.49***	.41***
Sc10: Cod./En.: Mother	.24**	.3	.28*
Sc11: Cod./En.: Father	.26**	.29	.31*
Sc12: Cod./En.: Partner	.09	.2	.17
Sc13: Control	.41***	.35*	.55***
Sc14: Denial	.51***	.49***	.55***
Sc15: Family Rigidity	-.23*	-.28	-.05
Sc16: Supp. of Feelings	.41***	.4**	.35**
Sc17: Jealousy	.28**	.23	.16
Sc18: Rumination	.66***	.78***	.57***
Sc19: Peer Relations	-.44***	-.45**	-.32**

Sc20: Perfectionism	.23*	.27	.26*
Sc21: Religion	-.1	.09	-.08
Sc22: Sexual Arousal	.08	.02	.07
Sc23: Secure: Father	-.22*	-.26	-.06
Sc24: Secure: Mother	-.3**	-.25	-.13
Sc25: Secure: Partner	-.31**	-.26	-.11
Sc26: Shame	.74***	.83***	.55***
Sc27: Sexual Intimacy	-.26**	-.25	-.01
Sc28: Mistrust	.51***	.53***	.25*
Sc29: With./Engage.	.47***	.44**	.38**
Helplessness: Father	.35***	.33*	.15
Helplessness: Mother	.44***	.39**	.36**
Helplessness: Partner	.43***	.41**	.32**
Helplessness: Friends	.47***	.59***	.21
Hopelessness: Father	.23*	.3	-.07
Hopelessness: Mother	.39***	.37*	.2
Hopelessness: Partner	.52***	.51***	.34**
Hopelessness: Friends	.43***	.47**	.21
Overall Helplessness	.53***	.59***	.28*
Overall Hopelessness	.51***	.57***	.15

* Significant at the $p < .05$ level

**Significant at the $p < .01$ level

***Significant at the $p < .001$ level

Table 6

ANOVA Results for Between-Group Comparison on Scales 1-29, the BDI, and

Helplessness and Hopelessness Scales

	Experimental Group	Control Group	MSE, F, p value
BDI	M=18.02	M=5.6	MSE=4081.38
	SD=13.82	SD=6.72	F=47.15
			<i>p</i> <.001
Sc1: Abuser	M=1.92	M=1.83	MSE=.26
	SD=.61	SD=.5	F=.91
			<i>p</i> =.34
Sc2: Ambivalent: Father	M=2.11	M=1.74	MSE=3.24
	SD=.78	SD=.54	F=7.58
			<i>p</i> <.01
Sc3: Ambivalent: Mother	M=2.06	M=1.68	MSE=2.78
	SD=.74	SD=.47	F=11.96
			<i>p</i> <.001
Sc4: Ambivalent: Partner	M=1.94	M=1.66	MSE=1.91
	SD=.57	SD=.51	F=6.56
			<i>p</i> <.05
Sc5: Anger	M=2.17	M=1.84	MSE=2.48
	SD=.56	SD=.44	F=10.26
			<i>p</i> <.01
Sc6: Anxiety	M=2.21	M=1.78	MSE=4.19
	SD=.81	SD=.38	F=11.37
			<i>p</i> <.01
Sc7: Avoidant: Father	M=2.19	M=1.94	MSE=2.24
	SD=.71	SD=.63	F=5.02

			$p < .05$
Sc8: Avoidant: Mother	M=2.31	M=1.87	MSE=4.81
	SD=.77	SD=.54	F=19.38
			$p < .001$
Sc9: Avoidant: Partner	M=2.08	M=1.73	MSE=3.36
	SD=.57	SD=.43	F=15.06
			$p < .001$
Sc10: Codependent- Enmeshed: Mother	M=2.23	M=2.21	MSE=.06
	SD=.62	SD=.39	F=.23
			$p = .63$
Sc11: Codependent- Enmeshed: Father	M=1.98	M=1.9	MSE=.27
	SD=.56	SD=.4	F=1.16
			$p = .29$
Sc12: Codependent- Enmeshed: Partner	M=2.14	M=2.5	MSE=.28
	SD=.55	SD=.48	F=1.06
			$p = .31$
Sc13: Control	M=2.14	M=1.97	MSE=1.08
	SD=.58	SD=.33	F=5.79
			$p < .05$
Sc14: Denial	M=2.56	M=2.27	MSE=2.45
	SD=.75	SD=.45	F=7.09
			$p < .01$
Sc15: Family Rigidity VS. Chaos	M=2.31	M=2.46	MSE=.21
	SD=.64	SD=.59	F=.57
			$p = .45$
Sc16: Family Suppression of Feelings	M=2.37	M=1.99	MSE=3.2
	SD=.82	SD=.59	F=7.11
			$p < .01$

Sc17: Jealousy	M=2.39 SD=.77	M=2.09 SD=.5	MSE=1.16 F=2.86 <i>p</i> =.09
Sc18: Rumination	M=2.58 SD=.8	M=2.35 SD=.49	MSE=1.5 F=3.71 <i>p</i> =.06
Sc19: Peer Relations	M=2.71 SD=.78	M=3.05 SD=.54	MSE=3.36 F=8.51 <i>p</i> <.01
Sc20: Perfectionism	M=3.01 SD=.48	M=2.95 SD=.41	MSE=.21 F=1.04 <i>p</i> =.31
Sc21: Religion	M=2.56 SD=.95	M=3.1 SD=.8	MSE=5.61 F=7.09 <i>p</i> <.01
Sc22: Sexual Arousal	M=2.41 SD=.57	M=2.25 SD=.45	MSE=1.39 F=8.04 <i>p</i> <.01
Sc23: Secure: Father	M=2.36 SD=.91	M=2.7 SD=.83	MSE=2.94 F=3.85 <i>p</i> =.05
Sc24: Secure: Mother	M=2.61 SD=.91	M=3.11 SD=.65	MSE=4.81 F=11.07 <i>p</i> <.01
Sc25: Secure: Partner	M=2.69 SD=.8	M=3.15 SD=.66	MSE=4.03 F=7.89 <i>p</i> <.01
Sc26: Shame	M=1.9	M=1.56	MSE=3.23

	SD=.58	SD=.36	F=15.56
			<i>p</i> <.001
Sc27: Sexual Intimacy	M=2.84	M=3.17	MSE=3.37
	SD=.76	SD=.54	F=7.98
			<i>p</i> <.01
Sc28: Mistrust	M=2.49	M=2.01	MSE=5.87
	SD=.67	SD=.48	F=18.39
			<i>p</i> <.001
Sc29:	M=2.5	M=2.12	MSE=3.24
Withdrawal/Engagement	SD=.58	SD=.44	F=12.17
			<i>p</i> <.001
Helplessness: Father	M=1.86	M=1.29	MSE=4.97
	SD=1	SD=.47	F=9.73
			<i>p</i> <.01
Helplessness: Mother	M=1.76	M=1.31	MSE=4.74
	SD=.87	SD=.43	F=31
			<i>p</i> <.001
Helplessness: Partner	M=1.67	M=1.32	MSE=2.23
	SD=.66	SD=.48	F=7.77
			<i>p</i> <.01
Helplessness: Friends	M=1.56	M=1.29	MSE=.75
	SD=.6	SD=.47	F=3.34
			<i>p</i> =.07
Hopelessness: Father	M=1.65	M=1.16	MSE=2.83
	SD=.97	SD=.31	F=4.41
			<i>p</i> <.05
Hopelessness: Mother	M=1.63	M=1.17	MSE=5.03
	SD=.9	SD=.41	F=17.19

			$p < .001$
Hopelessness: Partner	M=1.51	M=1.13	MSE=3.57
	SD=.66	SD=.34	F=15.03
			$p < .001$
Hopelessness: Friends	M=1.45	M=1.16	MSE=1.2
	SD=.61	SD=.31	F=5.22
			$p < .05$

Table 7

Correlations between the ECR scales of Avoidance Overall (Avoido), Anxiety Overall (Anxietyo), ECR Avoidance Partner (Avoidp), Anxiety Partner (Anxiety), with the 29 scales of the ACIQ. (See the appendix for abbreviations)

	Avoido	Anxietyo	Avoidp	Anxiety
Ambdad	.08	.21 *	.08	.11
Ambmom	.19 *	.17	.13	.13
Ambpart	.15	.23 **	.12	.28 **
Avoid dad	.10	.20	.06	.14
Avoid mom	.26 **	.24 **	.19 *	.24 **
Avoid partner	.35 ***	.15	.36 ***	.24 **
Cod/Preoc dad	-.13	.02	-.15	.04
Cod/Preoc mom	.01	.17	.03	.24 **
Cod/Preoc part	-.34***	.17	-.40 ***	.23*
Secure dad	-.25**	-.14	-.21 *	-.03
Secure mom	-.17	-.08	-.14	-.05
Secure partner	-.36***	-.19	-.37 ***	-.18
Abuser	.20 *	.04	.17	.1
Anger	.24 **	.19 *	.23 *	.21 *
Anxiety	.31 ***	.54 ***	.22 *	.45 ***
Control	.25 **	.30 ***	.16	.32 **
Denial	.49 ***	.38 ***	.37 ***	.45 ***
Famrigid	-.17	-.20 *	-.19 *	-.13

Fsupp of feelings	.42 ***	.16	.32 ***	.16
Jealousy	-.30 **	.27 **	-.22 **	.33 ***
Obses/Preoccupied	.35 ***	.46 ***	.23 **	.43 ***
Peer	-.43***	-.28 **	-.31 ***	-.22 *
Perfectionism	.04	.05	.01	.12
Religion	-.23 *	.03	-.17	.10
Sex arousal	.03	-.15	.04	-.09
Shame	.28 **	.38 ***	.20 *	.32 ***
Sex intimacy	-.34***	-.15	-.31 **	-.11
Mistrust	.58***	.25 **	.51 ***	.26 **
Withdrawal	.53***	.23 **	.48 ***	.30 ***

p < .05 * p < .01 ** p < .001 ***

Table 8

Correlations of the ECR scales and the ACIQ attachment scales with the Partner satisfaction scale, and scales of Mother Warmth (Mwarm) and Father Warmth (Dwarm).

	Partsat	Mwarm	Dwarm
ECR Avoido	-.33***	-.24**	-.28**
ECR Anxietyo	-.24	-.04	-.21*
ECR Avoidp	-.40***	-.21*	-.30***
ECR Anxietyp	-.30***	-.05	-.20*
Secure dad	.13	.12	.69***
Secure mom	-.01	.60 ***	.13
Secure part	.67 ***	.12	.11
Amb dad	-.06	-.08	-.06
Amb mom	.01	-.55 ***	-.14
Amb part	-.32 ***	-.08	-.11
Avoid dad	-.12	-.03	-.42***
Avoid mom	-.0	-.47 ***	-.12
Avoid part	-.43 ***	.11	-.06
Cod/preo dad	.18	.01	.37 ***
Cod/Preo mom	.0	.06	-.1
Cod/preo part	.39 ***	.13	.17
SexInt	.47***	.12	.08