

This is a post-peer-review, pre-copyedit version of an article published in Couple and Family Psychology: Research and Practice. The final authenticated version is available online at: <http://dx.doi.org/10.1037/cfp0000048>

Attachment in Patients With Mental Health Disorders: Associations With Patient and Partner's Adjustment

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Abstract

Within the context of mental health disorders, the research examining the association between attachment and couples' adjustment in general has been disappointingly lean. This includes consideration of the attachment representations of both members, as well as the dyadic attachment styles. This study analyzed the association between attachment and patient and partner's individual and dyadic adjustment, as well as the associations between dyad attachment styles and patient and partner's adjustment. The sample consisted of 54 couples, in which one member had been diagnosed with a mental health disorder (clinical groups), and 54 couples from the general population (control group). Participants completed the following self-report measures: Brief Symptom Inventory (BSI); the quality of life (QoL) questionnaire EUROHIS-QOL-8; the Revised Dyadic Adjustment Scale (RDAS), and the Experiences in Close Relationship-Short Form (ECR-SF). The results depict that couples from the clinical groups presented lower levels of QoL and dyadic adjustment and higher levels of depressive and anxious symptoms as compared to couples from the general population. Couples from the clinical groups also showed higher scores on attachment anxiety and avoidance. Women who possessed a clinical diagnosis, in particular reported higher scores in attachment anxiety whereas men with a clinical diagnosis were found to engage in attachment avoidance. Regarding both dyadic attachment styles, dyads in which the two partners were insecurely attached had significantly poorer individual and dyadic adjustment compared to dyads in which both partners were secure. The clinical implications of the results are considered, as well as some key directives for future research.

Key words: Attachment; Couples; Dyadic adjustment; Psychopathology; Quality of Life.

A growing body of research has documented the negative impact of mental health disorders of one partner on intimate relationships as well in the healthy partner's general sense of well-being (Heene, Buysee, & Van Oost, 2007; Whisman & Baucom, 2012). Depression has been the most studied disorder to date. Numerous studies suggest that the presence of depressive symptoms in one partner is related to a lower level of quality of life (QoL) (Ishak et al., 2013) and dyadic adjustment (Beach, Katz, & Brody, 2003; Whisman, Uebelacker, & Weinstock, 2004), as well as the partner's emotional distress (Benazon & Coyne, 2000; Heene et al., 2007; Idstad, Ask, & Tambs, 2010; Wittmund, Wilms, Mory, & Angermeyer, 2002). It is also associated with poorer QoL (Angermeyer, Kilian, Wilms, & Wittmund, 2006) and poorer dyadic adjustment (Beach et al., 2003; Coyne, Thompson, & Palmer, 2002; Heene et al., 2007; Whisman et al., 2004). Similar findings have been reported with patients who have other psychological disorders, including anxiety (Pankiewicz, Majkovicz, & Krzykowski, 2012), substance abuse (Homish, Leonard, & Cornelius, 2008; Homish, Leonard, & Kearns-Bodkin, 2006; Leonard & Eiden, 2007; Mudar, Leonard, & Soltysinski, 2001), eating disorders (Whisman, Dementyeva, Baucom, & Bulik, 2012), personality disorders (South, 2013), as well as with comorbid disorders (Whisman, 1999).

Although there is empirical support for the association between the presence of psychopathology and poorer individual and dyadic adjustment (Baucom, Whisman, & Paprocki, 2012; Whisman & Baucom, 2012), mental health problems do not affect all couples in the same way, since emotionality (e.g., Idstad et al., 2010) and relationship distress (e.g., Coyne et al., 2002) may vary in intensity. The professional literature suggests that the presence of factors such as the age of the couple and attributions to mental disorder (Coyne et al., 2002), along with attachment representations (Heene, Buysse, & Oost, 2005) may contribute to this adjustment as well. Among these factors, attachment seems to assume one

of the more important roles in relationship dynamics (Pietromonaco, Uchino, & Dunkel-Schetter, 2013). The presence of a mental health disorder and/or the negative relationship repercussions pose stressful situations in which the attachment system is commonly activated, leading to individual differences in the manner in which patients and partners feel and behave and, consequently, evolve with their individual and dyadic adjustment. Therefore, the main purpose of this study was to examine the association between attachment representations and individual and dyadic adjustment among couples in which one partner suffers from a mental health diagnosis.

A Brief Overview of Attachment Theory

In understanding the individual differences with the adjustment to a wide range of intrapersonal and interpersonal stressors, attachment theory has been accepted as a sound theoretical framework (Mikulincer & Shaver, 2007). Attachment styles are formed during early childhood and are generally stable throughout one's lifespan. In most cases, they determine how individuals relate to each other, and are particularly important to emotional regulation and management of stress-inducing life events (Bowlby, 1982). These styles are predicated on variations in internal working models regarding themselves and others, which are represented along two dimensions: anxiety and avoidance (Brennan, Clark, & Shaver, 1998). Attachment anxiety (conceptually related to the model of self) is related to a strong desire for proximity and felt security as well as intense worries about being underappreciated and possibly abandoned by their partners. Attachment avoidance (conceptually related to the model of others) is associated with a discomfort to closeness, dependency and emotional intimacy in relationships (Mikulincer & Shaver, 2007; Simpson & Rholes, 2012).

Based on the intersection of these two dimensions, Bartholomew and Horowitz (1991) distinguished four attachment styles: a secure style and three insecure styles (preoccupied, fearful and dismissing). Secure individuals (those who score lower on anxiety and avoidance)

tend to have more positive views of themselves and others, to rely on more constructive coping strategies, are comfortable with closeness, intimacy and autonomy, and trust in partner's availability, responsiveness and support. Insecure individuals (those who score high on measures of anxiety and/or on avoidance) are characterized by a propensity to rely on less effective strategies for coping, to be excessively concerned with their own distress, to seek distance from the stress-inducing life event and to avoid seeking support (Brennan et al., 1998; Mikulincer & Shaver, 2007).

Attachment and Individual Adjustment

Secure attachment may serve as a psychological resource to many individuals (Mikulincer & Shaver, 2007), since it has been related to positive psychological adjustment during times of stress. In contrast, insecure attachment has been presented as a risk factor for negative affectivity, prolonged distress and psychopathology. Research has also recognized different effects of attachment anxiety and avoidance on psychological distress. Although both attachment-related anxiety and avoidance have been associated with symptoms of depression (Heene et al., 2005, 2007; Tasca et al., 2009; Wei, Heppner, & Mallinckrodt, 2003; Wei, Vogel, Ku, & Zakalik, 2005) and anxiety (Wei et al., 2003; Wei et al., 2005), some studies reveal that both dimensions influence emotional distress and are distinct (Tasca et al., 2009; Wei et al., 2005). In contrast, other studies indicate a stronger positive association with depression for attachment anxiety than for attachment avoidance (Wei, Mallinckrodt, Russell, & Abraham, 2004; Shaver, Schachner, & Mikulincer, 2005). The links between individual differences in attachment security and the development of a wide range of mental disorders are also well documented. These differences include depression (Conradi & de Jonge, 2009; Whiffen, Kallos-Lilly, & MacDonald, 2001), substance abuse (Caspers, Yucuis, Troutman, & Spinks, 2006; Finzi-Dottan, Cohen, Iwaniec, Sapir, & Wietzman,

2003), psychosis (Berry, Barrowclough, & Wearden, 2007) and borderline personality disorder (Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004).

Unfortunately, only a few studies have explored the effects that this dynamic has on partners. The findings have displayed differential effects of partner's attachment on their spouse's depression. For example, in a sample of couples where the wife was diagnosed with depression, it was found that the husbands' insecurity predicted the maintenance of their wives' depressive symptoms over the 6-months follow-up, suggesting that improvements in attachment bonds could lead to better individual functioning (Whiffen et al., 2001). In a study with couples from the general population (Whiffen, 2005), it was found that wives' avoidance of closeness was related to their husbands' depressive symptoms, suggesting that attachment insecurity in marital relationships may lead to feelings of depression. Concomitantly, these findings also emphasize the importance of adopting a dyadic perspective for a more enriched understanding of the association between attachment and emotional outcomes (Mikulincer & Shaver, 2007).

However, even though the association between insecure attachment and psychological distress has been well established, little is known about the individual contribution of attachment to the patients' QoL. To our knowledge, only one study explored this association (Ponizovsky & Drannikov, 2013). In a sample of patients diagnosed with adjustment disorder with depressed mood, the authors' have found a poorer QoL in insecurely attached patients compared to their securely attached counterparts. There are no studies to date that have examined the association between one's attachment and partner's QoL. Thus, assuming the role that attachment may play on intra and interpersonal aspects of functioning (e.g., psychological well-being, relationships) that are considered central features of QoL, there is clear cause to examine this association in more detail.

Attachment and Relationship Adjustment

The link between attachment and relationship adjustment has also been empirically supported in the literature (Mikulincer & Shaver, 2007). A secure attachment has been found to be positively associated with relationship satisfaction over time (Hirschberger, Srivastava, Marsh, Cowan, & Cowan, 2009) and other positive aspects of the relationship (e.g., intimacy, commitment; see Collins & Feeney, 2004, for review). In contrast, insecure attachment has been related to lower satisfaction in couple's relationships (Collins & Read, 1990; Heene et al., 2005; Kane et al., 2007), even in clinical samples (Heene et al., 2007). With regard to the different effects of attachment anxiety and avoidance on dyadic functioning, a recent meta-analytic review (Li & Chan, 2012) confirmed that both dimensions were detrimental for many aspects of relationship functioning, highlighting that higher avoidance was associated with poorer perceptions of relationship quality (e.g., overall satisfaction). Attachment anxiety was also more positively related to general conflict. Gender differences found in the literature have revealed that attachment anxiety and avoidance are equally predictive of women's dissatisfaction with the relationship, while interestingly avoidance tends to be associated more with men's dissatisfaction (Mikulincer & Shaver, 2007; Scott & Cordova, 2002).

Moreover, attachment dynamics also seem to be connected to partner-reported relationship satisfaction. Individuals with insecurely attached partners tend to report more distressed relationship experiences than those with secure partners (Mikulincer & Shaver, 2007). For example, Shaver et al. (2005) found that for both men and women, one partner's avoidance tended to predict the quality of their partner's relationship. In contrast, secure individuals feel that their marriage is more satisfying and have partners who report feeling more satisfied (Hirschberger et al., 2009). Studies have also shown differential gender effects of partner's attachment on relationship satisfaction. Some studies have found that women's satisfaction was more detrimentally affected by men's avoidance than by their anxiety, while men tend to be more adversely affected by women's anxiety than avoidance (Collins & Read,

1990; Feeney, 1994; Kane et al., 2007). It should be noted that the negative effects of women's avoidance was also reported to be significant as well (Shaver et al., 2005).

To the best of our knowledge, few studies have yet to examine the role of attachment in the emotional and dyadic adjustment among couples in which one member had a mental health disorder, since most research has been limited to the study of depression or failed to consider the couple as the unity of analysis. Moreover, to date, no studies have explored the specific combination of patient-partner attachment styles (dyad attachment styles) and patient and partner's individual and dyadic adjustment in the context of a mental health diagnosis. Some studies in the general population have shown that secure couples (i.e., couples in which both partners were securely attached) tend to report more positive outcomes (e.g., relationship satisfaction) compared to insecurely attached couples and/or mixed couples (in which one partner was secure) (Mikulincer & Shaver, 2007). For example, in the context of drug addiction, Finzi-Dottan et al. (2003) suggested that couples in which both partners were avoidant tend to engage in poorer coping strategies when facing the recovery process. Therefore, assuming the possibility of an additive effect of attachment insecurity, it is plausible that adjustment may be poorer when both partners have insecure attachment styles than when one or both partners are securely attached.

The Present Study

The present study was designed to examine the association between attachment and individual and dyadic adjustment in patients with a mental health disorder and their partners. Based on the literature review, it was hypothesized that (a) couples in which one member had a mental health diagnosis would report decreased individual and dyadic adjustment, as well as higher levels of attachment anxiety and avoidance, as compared to couples from the general population; (b) both patient and healthy partners who displayed lower levels of attachment anxiety and avoidance would be associated with spouses' improved individual

and dyadic adjustment; and (c) dyads in which both partners were insecurely attached would report poorer individual and dyadic adjustment as opposed to dyads in which one or both partners were securely attached.

Method

Participants

The sample in this study consisted of 54 couples (Clinical group), in which one member had a diagnosed mental disorder, and 54 couples of the general population (Control group – GGP). Twenty-seven women from the couples involving the clinical group were identified as the patient (CGWP), while in the remaining 27 couples, the man was the identified patient (CGMP). None of the couples recruited in this study declined to participate.

The characteristics of the sample are presented in Table 1. Overall, all participants were married or cohabiting at the time of the study. Subjects were all Caucasian, the majority of whom all had offspring. Significant group differences were found regarding professional status, educational level, age and relationship length. Specifically, couples from the general population were more likely to be employed and to have studied for a longer period of time than couples who were from the clinical groups. On the other hand, couples of the CGWP were older and were involved in a relationship for a longer period of time than couples of the CGMP and of the general population.

[Table_1_about_here]

In the group in which the woman was the identified patient, the majority of subjects were diagnosed with Mood Disorders (92.6%), especially depressive symptomatology. A minority were diagnosed with Mood Disorders comorbid with others mental disorders, such as Eating Disorders (3.7%) and Substance Use Disorders (3.7%). Regarding the group in which the man was the identified patient, the majority of men presented with Mood Disorders that were comorbid with Substance Use Disorders (mainly alcohol problems) (48.1%). A

minority were diagnosed with Substance Use Disorders (7.4%) or Substance Use Disorders comorbid with Personality Disorders (7.4%). There was also evidence of subjects diagnosed with Impulse Control Disorder (7.4%) as well. Seven participants had Mood Disorders (25.9%) and one referred Psychotic Disorder (3.7%). The average length of the mental disorder was 11 years ($SD = 8.25$) for the patients in the CGWP and 4.3 years ($SD = 4.50$) in the CGMP.¹

Procedure

The data collection took place between February 2012 and May 2013, with institutional approval. Inclusion criteria for all couples were as follows: both partners should be 18 years of age or over; be formally married or cohabiting for at least two years; have the ability to read and understand the Portuguese language in order to complete the assessment protocol; and have agreed to participate in the study. All couples who were accepted to participate in the study were contacted directly. All participants signed an independent consent form. Subjects received no compensation for their participation, monetary or otherwise.

The clinical sample was recruited by the process of convenience sampling in the Centro Hospitalar e Universitário de Coimbra (CHUC) and the Psychiatric Clinic São José (Lisbon). Couples from the clinical group were eligible for inclusion if only one of the partners had a diagnosed mental disorder, according to DSM-IV-TR criteria. Based on a prior analysis of the clinical records (to identify the potential participants), the identified patients (outpatients at the recruitment sites) were informed about this study by their psychologist (in most cases, the first and second author) at the end of an appointment. They were informed that their decision to participate or not would have no bearing on the therapeutic relationship.

¹ As an indication of symptom severity, respectively 59.3% and 77.8% of women and men with a mental disorder rose above the Portuguese threshold of 1.7 for the Global Severity Index (GSI) of the Brief Symptom Inventory (BSI).

The researcher subsequently presented the study aims to eligible patients (or couples, when both partners were present) and those who decided to participate. Two sets of questionnaires (one for each partner) were subsequently provided, at which point participants were instructed to complete sets of questionnaires separately at home without collaboration and return them at the next appointment.

The couples from the general population were recruited by the first and second authors, through convenience sampling. Couples were eligible if both members of the relationship were free of any mental health disorders. Information about the presence (or not) of a mental health disorder was obtained by using a self-report questionnaire. The participants were recruited in person and through social networking contacts (e.g., through an e-mail sent to colleagues, friends, relatives), who were requested to forward the e-mail. In this e-mail, information was provided about the objective of the study, as well as inclusion criteria, and ethical considerations, particularly the confidentiality and anonymity of the responses. Couples who decided to participate were asked to contact the researchers directly and to provide their address to receive a letter explaining more details about the study, the consent form and questionnaire package by mail or, when possible, in person. Couples were asked to complete the questionnaires independently and to return them by mail via a postage-paid, preaddressed envelope. As an alternative, they were also permitted to give it to the researcher directly.

Measures

Sociodemographic and clinical information. The sociodemographic data included the participant's gender, age, marital status, relationship length, educational level and professional status. The clinical data was self-reported and included the mental health diagnosis, past mental health history, duration of the formal diagnosis and duration of mental

health treatment. In addition, participants completed the Portuguese versions of the following self-reported measures.

Adult attachment. The Experience in Close Relationships – Short Form (ECR-SF; Wei, Russell, Mallinckodt, & Vogel, 2007) is a 12-item short form of the Experience in Close Relationships scale developed by Brennan et al. (1998). It was designed to assess attachment representations. Participants are asked to rate their agreement using six specific items measuring attachment anxiety and six items measuring attachment avoidance on a seven-point Likert scales (1 = *strongly disagree* to 7 = *strongly agree*). Higher scores on Anxiety and Avoidance subscales indicate higher levels of attachment-related anxiety and avoidance, respectively. In this study, the Cronbach's alpha for the ECR-SF anxiety and avoidance ranged from .55 (anxiety – CGWP) to .80 (avoidance – CGMP).

Psychological distress. The Brief Symptom Inventory (BSI; Derogatis, 1993) is a 53-item self-reported inventory associated with psychological distress. Respondents are asked to rate the extent to which each identified problem has caused discomfort in the past week, on a five-point scale ranging from 0 (*Never*) to 4 (*Very often*). The BSI measures nine symptom dimensions and three global indices. In this study, considering the theoretical relevance, only depression and anxiety were considered. Higher scores indicate greater levels of depressive and anxiety symptoms. As an indication of symptom severity, the Portuguese threshold of 1.7 or greater was used for the GSI (Canavaro, 2007). In the present study, the Cronbach's alpha of depression and anxiety ranged from .79 (anxiety – CGMP) to .92 (depression – CGWP).

Quality of life. The EUROHIS-QOL 8-index (Power, 2003) consists of eight items designed to assess quality of life. Each question is answered on a five-point scale, and each scale point is specified with a number and a verbal descriptor. The four response scales developed were concerned with intensity (for example from *not at all* to *completely*) and evaluation (for example from *very dissatisfied* to *very satisfied*). The overall score is

calculated by adding the scores of the eight items, with higher scores indicating better quality of life. In this study, the alpha reliability of the EUROHIS-QOL 8-index ranged from .77 (GGP) to .93 (CGMP).

Dyadic adjustment. The Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crane, & Larson, 1995) is a 14-item self-report measure used to assess marital adjustment. It has three subscales: Consensus, Satisfaction, and Cohesion. The consensus subscale assesses decision making, values, and affection. The satisfaction subscale covers stability and conflict items. Finally, the cohesion subscale addresses activities and discussion in the relationship. Participants are asked to mark their responses on a six-point scale ranging from 0 (*Always disagree*) to 5 (*Always agree*). Lower scores in this measure reflect higher marital distress. In the current study, the Cronbach's alpha ranged from .65 (Cohesion – GGP) to .95 (Total – CGMP).

Data Analysis

Data were analyzed using the Statistical Package for Social Sciences (IBM SPSS 20.0). Descriptive statistics were computed for all sociodemographic, clinical, and study variables. A χ^2 analysis was conducted to assess whether the three groups had statistically different proportions on categorical variables, and analysis of variance (ANOVA) was performed to compare groups on continuous variables. To account for the interdependency of a couple's observations and to allow for the investigation of gender differences within the couple, repeated-measures multivariate analysis of covariance (MANCOVA) were performed on the couple as a unit (the database was restructured to consider each couple as the subject of the analysis and each partner's score as a different variable). Groups (clinical vs. control) were considered as between-subjects factor and gender (male vs. female) as the within-subjects factor. The clinical groups (female patients vs. male patients) were considered separately in order to test if the examined associations vary according to the patient's gender.

Subsequent univariate tests were analyzed when the multivariate effects were significant.

Pearson correlations were used to assess the association between study variables. Regarding dyad attachment styles, participants were assigned to their respective attachment style based on whether their scores on attachment anxiety and avoidance were above or below the scale midpoint. Specifically, participant's attachment style was categorized into two styles: secure and insecure. Dyads were subsequently grouped into one of four categories: (a) both patient and partner are secure; (b) both patient and partner are insecure; (c) the patient is secure and the partner is insecure; and (d) the patient is insecure and the partner is secure.

Statistical significance was set at the alpha .05 level, and partial eta-squared (η_p^2) provided the estimate of the effect size for the ANOVA. Cohen's (1988) guidelines were used for describing the effect sizes of reported correlations (that is, small for correlations around 0.10, medium for those near 0.30, and large for correlations at 0.50 or higher). Post hoc power calculations (G*Power; Faul, Erdfelder, Lang, & Buchner, 2007) performed for analyses of variance, with a significance level of 0.05 and power of 0.80, demonstrated that medium to large effects could be detected.

Results

Individual and Dyadic Adjustment

Table 2 presents the descriptive statistics of the study variables according to group, gender and the group and gender interaction. A group effect was found for psychological distress [Wilks' Lambda = 0.46, $F_{(4, 202)} = 24.36$, $p < .001$, $\eta_p^2 = .33$], with couples of the clinical groups reporting higher depressive and anxiety symptoms than couples of the general population. No differences were found between males and females [Wilks' Lambda = 1.00, $F_{(2, 101)} = 0.12$, $p = .891$, $\eta_p^2 = .002$], however, a significant interaction between group and gender was found [Wilks' Lambda = 0.39, $F_{(4, 202)} = 30.79$, $p < .001$, $\eta_p^2 = .38$]. Post hoc tests showed that women of the clinical groups reported significantly higher psychological distress

than women of the control group ($p < .001$). Gender differences were only observed in the clinical groups ($p < .001$).

Regarding QoL, a significant group effect was found, with couples of the clinical groups reporting lower QoL than couples of the control group. The gender differences were not significant. The interaction between group and gender was statistically significant. The interaction effect showed that QoL of men from the CGWP only differed from the perceived QoL of men of the CGMP ($p < .001$) and from their spouses ($p < .001$). Women with a mental disorder as well as women living with a man with a mental disorder reported lower QoL than women for the general population ($p < .001$).

For dyadic adjustment there were a significant group difference [Wilks' Lambda = 0.60, $F_{(6, 200)} = 9.83$, $p < .001$, $\eta_p^2 = .23$] in all dimensions and for the total score. Post hoc tests showed that couples of the general population reported higher scores than couples of the clinical groups in all dimensions of dyadic adjustment. Moreover, the CGMP reported significantly lower scores on consensus and satisfaction than the CGWP, but not regarding cohesion ($p = .051$). With regard to satisfaction, there was also a significant gender difference [Wilks' Lambda = 0.85, $F_{(3, 100)} = 1.42$, $p = .001$, $\eta_p^2 = .15$]. The subsequent univariate analyses revealed that men scored higher in satisfaction than women. The interaction between group and gender was not significant [Wilks' Lambda = 0.89, $F_{(6, 200)} = 1.94$, $p = .076$, $\eta_p^2 = .06$].

[Table_2_about_here]

Adult Attachment

Regarding attachment, there was a significant effect by group [Wilks' Lambda = 0.75, $F_{(4, 202)} = 7.99$, $p < .001$, $\eta_p^2 = 0.14$], gender [Wilks' Lambda = 0.90, $F_{(2, 101)} = 5.84$, $p = .004$, $\eta_p^2 = 0.10$], as well as interaction between group and gender [Wilks' Lambda = 0.88, $F_{(4, 202)} = 3.32$, $p = .012$, $\eta_p^2 = 0.06$]. Concerning attachment anxiety, no significant differences were

found between the three groups in the univariate tests. The interaction effect showed that women with mental health diagnosis reported significantly higher scores on attachment anxiety than women of the general population ($p = .005$), but also than their partners ($p = .002$). Regarding attachment avoidance, subsequent analyses showed that couples of the general population reported lower scores than couples of the clinical groups. Moreover, men reported higher scores than women on attachment avoidance. The interaction effect showed that men with a mental disorder reported higher attachment avoidance than spouses of a woman with a mental disorder ($p = .049$) and men of the general population ($p < .001$).

Correlations Between Attachment Dimensions and Individual and Dyadic Adjustment

Correlations between attachment dimensions and individual and dyadic adjustment for the three groups are presented in Table 3. In the group where the woman was identified with the mental health diagnosis, no significant associations were found between partner's attachment dimensions and his own individual and dyadic adjustment, as well as with the woman's adjustment. As for the woman, higher attachment avoidance was significantly and negatively associated with their own lower dyadic adjustment (consensus, cohesion, and total score) and lower partner's total dyadic adjustment. In the group where the man was the one with the mental disorder, overall, results indicated that attachment avoidance was significantly associated with one's QoL and dyadic adjustment, as well as with his partner's individual and dyadic adjustment. Concerning attachment anxiety, results indicated that only partner's anxiety was positively correlated with her own depressive and anxiety symptoms.

In the group pertaining to the general population, among females, the results showed that higher individual attachment avoidance and anxiety were positively associated with their own depressive symptoms and negatively correlated with their QoL and dyadic adjustment (consensus and total score). Attachment anxiety was also positively correlated with anxiety symptoms and negatively correlated with satisfaction. With regard to partner effects, a

negative correlation was only observed between female's avoidance and male's QoL. Among males, attachment anxiety was significantly associated with their own individual adjustment and partner's depressive symptoms and QoL.

[Table_3_about_here]

Dyad Attachment Styles

Regarding dyad attachment styles, participants were classified into four categories. Among couples with the male with the mental disorder, most spouses were both insecure ($n = 17, 63\%$). In the group with the woman diagnosed with the mental disorder, most couples had different attachment styles (that is, Patient insecure-Partner secure) ($n = 10, 37\%$) or were both insecure ($n = 9, 33.3\%$). Couples from the general population were mostly secure ($n = 24, 44.4\%$) or secure-insecure ($n = 18, 33.3\%$). For practical reasons, and given the low number of couples in the clinical groups in the categories patient secure-partner insecure and patient insecure-partner secure, these two categories were collapsed into a single category, "secure-insecure".

The overall pattern of findings indicated that dyads in which both partners were secure reported significantly better individual and dyadic adjustment than dyads in which both partners were insecure (Table 4). Overall, the mean scores in dyads in which one partner was securely attached and one insecure were between those of the secure and insecure groups. For all variables, the means for the dyads in which only one partner was insecure were similar to those in which both partners were secure. In addition, dyads in which both partners were insecure reported significantly higher scores on depressive symptoms and lower scores on QoL and satisfaction than dyads in which only one partner was insecure.

[Table_4_about_here]

Discussion

The present study examined the association between attachment and individual and dyadic adjustment in subjects with a mental health disorder and their partners, as well as the association between attachment styles of both members considered simultaneously and patient and partner's adjustment. The main findings corroborate prior research by indicating the significant and negative impact of mental disorders (namely, depression and substance abuse disorders) on patients and partner's individual and dyadic adjustment. In addition, the findings extend prior research by showing that an association exists between attachment representations and individual and dyadic adjustment of both partners, also considering the attachment styles of both members simultaneously.

Supporting the first hypothesis, couples facing a mental disorder reported significantly higher psychological distress and lower QoL than couples of the general population. This is consistent with prior evidence suggesting that in the context of mental health problems couples experience significant emotional distress (Benazon & Coyne, 2000; Heene et al., 2007; Homish et al., 2006; Istad et al., 2010; Wittmund et al., 2002), poor QoL (Angermeyer et al., 2006; Ishak et al., 2013), and poor dyadic adjustment (Beach et al., 2003; Coyne et al., 2002; Heene et al., 2007; Homish et al., 2008; Leonard & Eiden, 2007; Mudar et al., 2001; Whisman et al., 2004). Regarding the differences in individual adjustment, and similar to previous studies (Wittmund et al., 2002), it was found that healthy partners of a woman with a mental health diagnosis seem to be less affected by the presence of a partner's disorder (i.e., those adjustments did not differ from men of the general population) than healthy partners of a man with a mental disorder, whose individual adjustment was similar to the adjustment of women with a mental disorder. One possible explanation for this is that, when the partner has a mental health diagnosis, women tend to experience more negative emotions (e.g., guilt, anxiety, loneliness), while men tend to be able to cope with symptomatology through more constructive problem-solving strategies (e.g., by focusing in

activities outside the home) (Dattilio, 2010). Either that, or men are just not comfortable expressing it overtly. The literature on gender differences and stress and coping suggests that women have a greater tendency to use relationship-focused strategies to cope with spouse's illness, in particular protective buffering (i.e., a form of relationship-focused coping that entails hiding concerns, denying worries, and yielding to the partner to avoid disagreements). This may have detrimental effects on their level of mental health. It is therefore possible that relying on such coping strategies may increase the spouses' distress, as it was found among women who cared for spouses suffering from chronic medical conditions (Zwicker & DeLongis, 2010). In this context, it is also important to consider that since the majority of male subjects present with substance abuse problems, it is plausible, as previously suggested (Homish et al., 2006), that in response to the shared stresses of couples, female partners tend to be more prone to experience negative affect (e.g., depressive symptoms) while their partner responds with an increased use of substances in order to self-medicate their feelings.

Gender differences in dyadic interactions may also help to understand the results of this study. For example, women tend to be more relationship-oriented than men and feel more responsibility for the resolution of relationship difficulties, tend to resort more often to problem-solving strategies focused on emotions and to worry and blame themselves more for problems experienced in the relationship. In contrast, men are usually more focused on independence. They tend to assume less responsibility when dyadic distress exists and also minimize the severity of their partner's concerns (Benazon & Coyne, 2000; Fincham, Beach, Harold, & Osborne, 1997; Heene et al., 2007). Research on gender-role personality traits and gender-role socialization may also provide an important input for contextualizing these results. Research on gender-role personality traits emphasize the notion that women who identified themselves with feminine personality traits (e.g., warmth, emotional expressiveness, concerns about others' needs) are more likely to engage in passive or

emotion-focused coping strategies and to present more depressive symptoms. When a stereotyped feminine gender orientation interacts with stressful experiences (e.g., the presence of mental disorders in one partner), it may make women more prone than men to the negative impact of life events and to experience emotional distress (Shea & Wong, 2012). The gender-role socialization perspective emphasizes the concept that women behave accordingly to traditional gender roles, in line with stereotypical notions of what is prevailing and acceptable to feminine behavior and attitudes (e.g., dependence and engagement in their relations with the romantic partners, caretaking, engagement in domestic work) (Shea & Wong, 2012). Accordingly, in the present study, it is likely that the higher distress found among women may relate to an increased burden resulting from caring for a man with a mental health problem, along with other responsibilities that are often attributed to women (e.g., women are usually the main caregivers of children, and 70.4% of the couples in our sample have children that are likely to be under their care).

With regard to dyadic adjustment, it was found that lower dyadic adjustment (in particular, low consensus and satisfaction) exists among couples where the male was the identified patient. Among these couples, it is possible that the poorer individual adjustment presented by women (namely, the higher depressive symptoms) may reflect more negative dyadic interactions (e.g., higher emotional self-disclosure, criticism), which is commensurate with previous studies (e.g., Beach & Bodenmann, 2010). Also, since the identified patient had substance abuse problems, these findings may be contextualized in the literature emphasizing the significant and negative consequences of substance abuse in the relationship (e.g., criticism, hostility, low intimacy). This is specifically the case when there are abuse discrepancies within a couple (Homish et al., 2008; Leonard & Eiden, 2007; Mudar et al., 2001) and/or comorbid disorders (Whisman, 1999). Moreover, the low relationship satisfaction reported by women, and given the gender differences in dyadic interactions and

gender roles features noted above, suggest that women seem to be more vulnerable in the presence of marital stressors (Fincham et al., 1997; Heene et al., 2007; Zwicker & DeLongis, 2010), and have more marital and parental requirements (e.g., traditional household labor; child caregiving), which may explain their lower levels of relationship satisfaction, when compared to their partners.

As expected, the results also showed that couples from the clinical groups reported higher scores of attachment avoidance and anxiety compared to couples of the general population. Overall, it was also found that, compared to women, men scored higher on attachment avoidance. Although the gender effect seems to be coherent with the relational needs – proximity vs. autonomy desires – as evidenced in the abovementioned dyadic interactions (e.g., Benazon & Coyne, 2000; Fincham et al., 1997; Heene et al., 2007) as well as in the literature on men's gender roles that typifies emotional distance of some men in close relationships (Dion & Dion, 2001), these results are partially inconsistent with those indicating that men reported higher satisfaction in the relationship than women. Individuals who score higher in avoidance tend to be uncomfortable with physical and emotional proximity, value more independence and self-sufficiency, worry less about the quality of their relationship and the support given to, and received from, partners (Mikulincer & Shaver, 2007; Simpson & Rholes, 2012). They often report lower relationship satisfaction (Li & Chan, 2012; Mikulincer & Shaver, 2007; Scott & Cordova, 2002). Thus, it is possible that the poor relationship satisfaction experienced by women may be explained by the aforementioned attachment dynamics in men. Indeed, as has been suggested, women's satisfaction is more detrimentally affected by men's avoidance than by their anxiety (e.g., Collins & Read, 1990; Feeney, 1994; Kane et al., 2007).

Also, the interaction effects suggested that women with mental health disorders produced higher scores in attachment anxiety, while men with mental health disorders had

higher scores in attachment avoidance. These results may be understood in the scope of the specificities of the prevalent clinical conditions in these groups. For example, among depressed patients, studies have shown that a mix of attachment anxiety and avoidance (translating into a *fearful* style) has been linked to severe depressive symptoms (e.g., Conradi & de Jonge, 2009; Whiffen et al., 2001). It is important to note that most women with mental health disorders in this study have a mood disorder (namely Depression). This may serve to explain this finding since the main concerns of depression (e.g., negative emotional expressivity, negative views of self, hypersensitivity) often leads individuals to overestimate negative events, to engage in more excessive proximity-seeking behaviors and more emotion-focused problem-solving strategies, to evaluate themselves as helpless, and to have more intense worries about being underappreciated by their partners. These have been identified as core features of attachment anxiety (Mikulincer & Shaver, 2007; Simpson & Rholes, 2012). On the other hand, most of the males with a mental health diagnosis in this study have a substance-use disorder, and report higher scores on attachment avoidance. This finding is consistent with prior work suggesting a prevalence of avoidant attachment styles in these conditions (e.g., Caspers et al., 2006; Finzi-Dottan et al., 2003), and in particular the evidence relating attachment avoidance to greater use of external regulators of affect. This result may be therefore explained by the emerging dysfunctional addictive behaviors that act as an emotional regulation mechanism alternatively to proximity-seeking behaviors from others (Schindler et al., 2005) and as a means of avoiding painful emotions and self-awareness (Mikulincer & Shaver, 2007).

An important finding of this study relates to the association between attachment representations and individual and dyadic adjustment. Interestingly, different patterns of association in the three groups have been found. Overall, the results suggest that, among couples facing a mental health disorder, insecure attachment representations, namely

avoidance, was related to poorer adjustment in multiple domains (individual and dyadic). As well, there were significant associations between partner's attachment representations and patient's adjustment, more consistently for the group where the man was the patient.

Among couples where the woman was the patient, our results only partially support our hypotheses, since women's higher attachment avoidance was significantly associated only with their lower dyadic adjustment and with their partner's lower dyadic adjustment. These findings are consistent with prior studies concerning both actor (Li & Chan, 2012; Mikulincer & Shaver, 2007) and partner effects of women's avoidance in dyadic adjustment (e.g., Shaver et al., 2005). Of note, no actor and partner effects were found with women's adjustment, and no significant associations were found between men's avoidance and anxiety and individual adjustment (their own and partner's). While attachment representations are generally activated by stressful events, they do not work exclusively and may interact with other factors, such as context (e.g., nature of the stressor, current information about the availability or unavailability of the attachment figures) and personal (e.g., personality traits, coping skills) dispositions (Mikulincer & Shaver, 2007; Simpson & Rholes, 2012). Since each of these women in the study developed a mental disorder (including those with a secure attachment style), it is likely that at any given moment, this resource could cease working. This would invariably affect the interaction with other factors, which could explain the lack of association between attachment and women's individual adjustment. Also, given the findings with regard to men's adjustment (which was similar to the adjustment of men of the general population), it is possible that these males may not be affected by the presence of a mental disorder in their spouses. In these couples, the women's mental disorder may not be an event stressful enough to activate their attachment system. It is possible that the relationship length (an average of 23 years), and in particular the length of partner's illness (an average of 11 years), may have led to a gradual adaptation over time and subsequently

influenced the observed associations. Indeed, some studies (e.g., Mudar et al., 2001) have shown that adjustment to partner's mental disorder may be influenced by the relationship length. Further research is needed to examine these variables as potential mechanisms in the association between attachment and individual and dyadic adjustment.

Among couples where the man had a mental disorder, our results globally support the initial hypotheses, as actor and partner effects were found for both patient's and partner's attachment avoidance. These findings are in line with the literature suggesting that either avoidant individuals (Li & Chan, 2012; Mikulincer & Shaver, 2007; Scott & Cordova, 2002), as well as partners of avoidant individuals (e.g., Collins & Read, 1990; Kane et al., 2007; Shaver et al., 2005) are more likely to experience lower dyadic adjustment. With regard to individual adjustment, these results are also in line with studies in the general population indicating that attachment avoidance is associated with one's (e.g., Tasca et al., 2009; Wei et al., 2003; Wei et al., 2005) and partners' emotional distress (e.g., Whiffen, 2005), as well with clinical samples (e.g., Whiffen et al., 2001). It is possible that the avoidant healthy partner presents more difficulties to assume the role of caregiver, and the avoidant patient is more likely to avoid partner's support and to feel uncomfortable with closeness, which in turn is reflected in their own and their partner's adjustment. Thus, the presence of avoidant attitudes and behaviors (characterized by lower responsiveness, availability and support to and from the partner) among both members may place these couples at higher risk for maladjustment. This is an issue that deserves attention in future research.

Regarding QoL, although understudied in this context, the observed associations reinforces the results relating to psychological distress, and are consistent with the suggestion that impairments in QoL are more likely to occur among individuals with insecure attachment styles (Ponizovsky & Drannikov, 2013). This is comprehensible considering the negative impact of insecure attachment on central domains of QoL (e.g., psychological well-being,

relationships). However, given the dearth of research on this topic, further studies are warranted, in order to also examine the potential effects of attachment security on different domains of QoL.

Regarding dyad attachment styles, most couples in this study have similar styles (ranging from 51.8% - couples where the woman was the patient – to 70.4% - couples where the man was the identified patient). The presence of attachment insecurity in couples facing a mental disorder (81.4% and 91.6% when the woman and the man was the identified patient, respectively) was however higher than among couples of the general population (55.5%). This result may help understanding the dynamics mentioned above, particularly, those related to individual and dyadic adjustment. Indeed, since 70.4% of men with a mental disorder have an insecure partner (comparatively to 55.5% in the general population and 44.4% partners of women with a mental disorder), it is comprehensible why these women present such adjustment difficulties, but also may explain why the pattern of associations between attachment and individuals and partners' adjustment was much more consistent with this group.

As expected, the exploratory analysis of both dyadic attachment styles indicated that, for both patients and partners, being in a dyad in which both members of the couple were insecure was significantly associated with poorer individual and dyadic adjustment. This result is consistent, for example, with the results reported by Finzi-Dottan et al. (2003), who showed in a study with families of a drug-user husband during the recovery phase, that dyad avoidant attachment was related to poorer coping strategies face this challenging situation. Moreover, for all outcomes, dyads in which only one partner was insecurely attached had similar levels of adjustment as those in which both partners were secure, suggesting that patients/partners who are themselves insecure may be able to adapt more successfully if they are married to a partner who is securely attached. Not surprising, these findings support the

hypotheses derived from the attachment theory that individuals with insecure attachment, and those living with insecure partners, report increased levels of distress and poorer relational adjustment. This is particularly important since the presence of a secure partner sometimes buffers the untoward effects of the other partner's insecurity (Mikulincer & Shaver, 2007). While preliminary, these findings suggest that it may be also important to consider the attachment styles of patients as well as dyads, as the later may also be important factors affecting adjustment in multiple domains. This knowledge will be of major importance, particularly when designing psychological interventions within these contexts.

Strengths and limitations

Preliminarily, this study makes an important contribution to the professional literature, given its focus on the role of attachment on couples' individual and dyadic adjustment, and provides a more complete understanding of the adjustment to mental illness. The study also emphasizes the importance and need to, in the context of couple's adjustment to a mental disorder, examine the individual characteristics as well as those that exist between men and women (couple as unity of analysis). The results fill a gap consistently referred to in the research literature (Whisman & Baucom, 2012; Whisman et al., 2004).

Despite the strengths of the study, there are several limitations that need to be emphasized. First, the cross-sectional design does not permit us to draw causal relations between variables. Longitudinal studies in which measures are taken at various points in time would enable one to determine more definitely the nature of associations between attachment dynamics and patient and partner outcomes. Furthermore, longitudinal research is also needed to identify the specific causal processes or pathways by which the study variables are related.

Second, only self-report measures were used, particularly regarding attachment issues. Because attachment reflects the individual's subjective perceptions of their close

relationships, it is possible that participants may be vulnerable to a reporting bias. In addition, given the lower reliability in attachment anxiety in one of the clinical groups, some caution should be exercised when interpreting the observed effects. Replication of this study with other methods of data collection, such as the Adult Attachment Interview, would strengthen the validity of the findings reported herein. Third, the combining of attachment styles into “secure and insecure” was done for pragmatic reasons, particularly because of the small number of participants with preoccupied and dismissing styles. Further studies on large samples may indicate more specific associations between each of the styles and the assessed outcomes (as well as particular mismatches in dyad attachment styles). Fourth, the convenience sampling method as well as the limited sample size imposes some limitations regarding the comparison between clinical and control group, and the generalization of the results. Also, the clinical groups are not homogenous for clinical conditions, the gender of identified patients, and the average length of mental disorder, which challenges the interpretation of the findings. Additional studies with larger and homogenous samples and with patients with other types of mental disorders are warranted. Future research should also be considered, including couples in which both members experience a mental disorder. Fifth, for some participants, their psychologist was involved in the study, which may have undoubtedly introduced some bias. Although, any bias was likely minimal since caution was exercised not to incur any other undue influence to subjects/patients. Finally, given the focus of this study on marital questions, the results may reflect some social desirability and preservation of intimacy.

Practical implications

The findings of this study have some relevant implications for clinical practice. First, they highlight the importance of assessing negative and positive indicators of adjustment of both patient and healthy partner, in the domain of emotional distress and QoL. Particularly,

for women of partners with a mental health disorder, it is of utmost importance to also promote their emotional well-being and QoL, taking into account the potential role of gender expectations. These women may benefit from diverse psychological interventions (Wittmund et al., 2002), namely strategies involving coping skills training interventions, which are being demonstrated quite effective in decreasing emotional distress among women's of partners with addictive problems (Cox, Ketner, & Blow, 2013). Second, these results also suggest the need to consider the dyadic adjustment of both partners. When couples are confronted with an experience of partner's disorder, mental health professionals should assess for the presence of dyadic difficulties, as they share a common emotional climate. Interventions including both partners should be beneficial for couples on both emotional and relational well-being, and will allow them to deal more effectively with the problems posed by the mental disorder (Baucom et al., 2012). Those including cognitive-behavioral components are particularly preferred (Dattilio, 2010). Finally, these findings also support the idea that dyads with insecure attachment representations have more difficulties to cope (both individually and relationally) with the symptoms of partner's disorder. Thus, mental health professionals should consider exploring adult attachment dynamics as well. Assessing patients and partner's attachment styles before treatment will allow for the early identification of those couples who are at a higher risk for maladjustment and developing or referring patients and/or couples for structured interventions, especially when avoidant attachment representations are identified. In this context, emotionally-focused couple's therapy (Greenberg & Goldman, 2008) may be effective as an attachment-based approach, which seeks to help promote emotionally engaged interactions, through their potential to change rigid and negative cycles of interaction patterns.

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Table 1

Sociodemographic characteristics of the sample (N = 108 couples)

	CGWP		CGMP		GGP		χ^2	Cramer's V
	(n = 54)		(n = 54)		(n = 108)			
	n	%	n	%	n	%		
Gender							-	-
Male	27	50.0	27	50.0	54	50.0		
Female	27	50.0	27	50.0	54	50.0		
Marital status							17.67***	.29
Married	54	100.0	38	70.4	84	77.8		
Cohabiting	0	0.00	16	29.6	24	22.2		
Professional status							21.94**	.23
Employed	38	70.4	34	63.0	95	88.0		
Unemployed	8	14.8	15	27.8	7	6.5		
Retired	8	14.8	4	7.4	6	5.6		
Student	0	0.00	1	1.9	0	0.00		
Children							3.65	.13
No	8	14.8	16	29.6	22	20.4		
Yes	46	85.2	38	70.4	86	79.6		
	<i>M (SD)</i>		<i>M (SD)</i>		<i>M (SD)</i>		<i>F</i>	η_p^2
Age	49.48 (11.42)		41.31 (10.17)		43.24 (10.31)		9.20***	.08
Education	9.56 (4.43)		9.83 (3.53)		11.56 (3.81)		6.25**	.05
Relationship length	23.0 (11.71)		13.37 (9.37)		17.06 (11.2)		10.81***	.09

Table 2

Means and standard errors of the study variables: Group, gender, and interaction effects (adjusted for covariates)

	CGWP (<i>n</i> = 27 couples)		GGMP (<i>n</i> = 27 couples)		GGP (<i>n</i> = 54 couples)		Group	Gender	Group X Gender			
	Male	Female	Male	Female	Male	Female						
	<i>M</i> (<i>SE</i>)	<i>M</i> (<i>SE</i>)	<i>M</i> (<i>SE</i>)	<i>M</i> (<i>SE</i>)	<i>M</i> (<i>SE</i>)	<i>M</i> (<i>SE</i>)						
<i>Psychological distress</i>												
Depression	0.71 (0.14)	2.02 (0.17)	2.77 (0.14)	1.87 (0.17)	0.51 (0.10)	0.74 (0.12)	60.63***	.54	0.04	.00	39.72***	.44
Anxiety	0.48 (0.11)	1.75 (0.13)	2.10 (0.11)	1.17 (0.13)	0.50 (0.08)	0.78 (0.09)	33.83***	.40	0.05	.00	79.97***	.61
<i>Quality of life</i>												
Total score	68.06 (2.83)	47.69 (2.94)	38.54 (2.83)	54.28 (2.94)	73.67 (2.00)	71.01 (2.08)	35.44***	.41	1.29	.01	33.22***	.39
<i>Dyadic adjustment</i>												
Consensus	3.67 (0.16)	3.42 (0.17)	2.82 (0.16)	2.72 (0.17)	3.92 (0.11)	3.94 (0.12)	18.70***	.27	0.02	.00	1.37	.03
Satisfaction	3.79 (0.16)	3.20 (0.18)	2.76 (0.16)	2.72 (0.18)	4.19 (0.11)	3.99 (0.13)	25.02***	.33	1.42**	.00	1.94	.08
Cohesion	2.30 (0.21)	2.31 (0.21)	1.69 (0.21)	1.58 (0.21)	3.18 (0.15)	3.35 (0.15)	26.07***	.34	3.98	.04	0.96	.02
Total score	46.42 (2.10)	42.56 (2.26)	34.73 (2.09)	33.52 (2.25)	52.96 (1.45)	53.02 (1.56)	28.8***	.36	0.91	.01	2.32	.04
<i>Attachment</i>												
Anxiety	3.67 (0.22)	4.46 (0.21)	4.01 (0.22)	4.17 (0.21)	3.53 (0.15)	3.60 (0.15)	4.23*	.08	2.13	.02	3.21*	.06
Avoidance	2.75 (0.21)	2.84 (0.19)	3.49 (0.21)	2.86 (0.19)	2.14 (0.15)	2.03 (0.13)	15.00***	.23	7.59**	.07	3.35*	.06

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 3

Intercorrelations between attachment dimensions and indicators of individual and dyadic adjustment

	Adjustment (patient/female partner GGP)						Adjustment (partner/male partner GGP)						
	DEP	ANX	QoL	CON	COH	SAT	DEP	ANX	QoL	CON	COH	SAT	DA
<i>Patient</i>													
CG	.15	.11	-.01	-.30	-.09	-.16	-.19	.004	.20	.06	-.06	.02	-.05
WP	.21	.05	-.02	-.56**	-.51*	-.52	-.21	-.21	.07	-.30	-.34	-.11	-.38*
MP	-.10	-.03	.09	-.13	-.05	-.26	.02	-.11	-.27	-.27	-.20	-.09	-.26
Patient	.05	.09	.11	-.08	-.10	-.14	.23	.18	-.16	-.20	.05	-.23	-.17
<i>Partner</i>													
CG	-.04	-.25	.13	-.02	-.04	-.15	.03	.004	-.02	.02	-.04	-.06	.01
WP	.38	.31	-.65***	-.63**	-.67**	-.63**	.41*	.56**	-.47*	-.68**	-.59**	-.48*	-.61**
MP	.16	.08	-.14	-.30	-.17	-.30	.42*	.40*	-.30	-.24	-.26	-.32	-.27
Partner	.37	.43*	-.47*	-.52**	-.57**	-.42*	.30	.59**	-.59**	-.60**	-.50**	-.35	-.54**
<i>Female partner</i>													
CG	.43**	.33*	-.35*	-.38**	-.18	-.33*	.23	.25	-.19	-.23	-.16	-.03	-.20
WP	.40**	.20	-.32*	-.37**	-.04	-.17	.08	-.07	-.34*	-.25	-.26	-.11	-.27
MP	.33*	.14	-.39**	-.24	-.05	-.12	.36**	.29*	-.36**	-.10	-.15	-.08	-.16
P	.25	.06	-.23	-.15	.25	-.10	.09	.02	-.13	-.16	-.16	-.22	-.21

Note: DEP = depression; ANX = anxiety; QoL = quality of life; CON = Consensus; COH = Cohesion; SAT = Satisfaction; DA = Total dyadic adjustment.

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 4

Means and standard errors of the study variables regarding dyadic attachment styles (adjusted for covariates)

	Both secure (<i>n</i> = 31 couples)	Secure-Insecure (<i>n</i> = 39 couples)	Both insecure (<i>n</i> = 38 couples)	Group	
	<i>M</i> (<i>SE</i>)	<i>M</i> (<i>SE</i>)	<i>M</i> (<i>SE</i>)	<i>F</i>	η_p^2
<i>Psychological distress</i>					
Depression ^{a,b}	0.95 (0.13)	1.09 (0.11)	1.62 (0.11)	9.18***	.15
Anxiety ^a	0.91 (0.10)	0.88 (0.08)	1.23 (0.09)		
<i>Quality of life</i>					
Total score ^{a,b}	66.29 (2.49)	65.01 (2.11)	56.10 (2.20)	5.85**	.10
<i>Dyadic adjustment</i>					
Consensus ^a	3.93 (0.15)	3.56 (0.13)	3.22 (0.13)	6.05**	.11
Satisfaction ^{a,b}	3.90 (0.15)	3.71 (0.13)	3.26 (0.13)	5.48**	.10
Cohesion ^a	3.03 (0.18)	2.57 (0.15)	2.32 (0.16)	4.14*	.08
Total score ^a	51.31 (1.95)	46.46 (1.65)	41.62 (1.72)	6.55**	.12

^a Both insecure significantly different from Both secure.

^b Both insecure significantly different from Secure-Insecure.

* $p < .05$; ** $p < .01$; *** $p < .001$