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Associations between adult attachment style and mental health care utilization: Findings from a large-scale national survey

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ABSTRACT

This study investigated the association between attachment style and the use of a range of mental health services controlling socio-demographic, physical and psychological risk factors. Using a large nationally representative sample from the US National Comorbidity Survey Replication (NCS-R), a total of 5645 participants (18+) were included. The majority of participants reported their attachment as secure (63.5%), followed by avoidant (22.2%), unclassified (8.8%), and anxious (5.5%). The percentages using different health services studied varied widely (1.1–31.1%). People with *insecure* (anxious and avoidant) attachment were more likely to report accessing a hotline, having had a session of psychological counselling or therapy, getting a prescription or medicine for mental and behavioural problems. Individuals with anxious attachment only were also more likely to report the use of internet support groups or chat rooms. This is a first analysis to explore relationships between self-reported adult attachment style and a wide range of health care services. *Insecurely* attached individuals were more likely to use a wide range of health care services even after controlling for socio-demographic factors, psychiatric disorders and chronic health conditions. These findings suggest that adult attachment plays an important role in the use of mental health care services.

1. Introduction

Psychiatric disorders are a significant public health problem. The Global Burden of Disease Study 2010 reported that (1) in 2010 mental disorders accounted for 183.9 million disability-adjusted life years (DALYs), or 7.4% of all DALYs worldwide; (2) the burden caused by mental disorders significantly increased between 1990 and 2010; and (3) psychiatric disorders had been continually adding pressure to health care systems both in developed and developing countries (Whiteford et al., 2013). A recent systematic review on 291 diseases and injuries in 21 regions of the world from 1990 to 2010 concluded that global disease burden had shifted from communicable to non-communicable diseases, and the increasing burden of mental and behavioural disorders, musculoskeletal disorders, and diabetes tax health care systems as they strive to meet the rising needs (Murray et al., 2012). Understanding developmental predictors which heighten the risk of mental illness is therefore of paramount importance. Childhood adversity, particularly psychological trauma impacting early attachment relationships is a risk factor for future physical and psychological conditions (Felitti et al., 1998, McWilliams et al., 2010, Bifulco et al., 2002a, Green et al., 2010, Widom et al., 2007). Attachment theory posits that individuals develop ways of relating based on the interactions they have, early in life, with their caregivers (Bowlby, 1988). The attachment system is reflected in thoughts and behaviours related to searching for proximity to attachment figures when the needs for comfort and safety become activated. These relatively stable patterns of relating have been broadly defined as *secure* and *insecure* attachment styles, and the latter being further categorized as *insecure–anxious* and *insecure–avoidant*, according to the type of coping used when an individual perceives an attachment threat. Insecure attachment is seen as a risk factor, predisposing individuals to relational stress, negative affectivity, prolonged distress, and psychopathology and, as a result, to mental and behavioural problems in general (Garcia-Ruiz et al., 2013; Ponizovsky and Drannikov, 2013; Pritchett et al., 2013). Insecure attachment styles have been repeatedly shown to be closely associated with a variety of mental health problems (Mikulincer and Shaver, 2010).

The presence of insecure attachment itself, has been identified as a determinant of health, likely to impact attitudes toward health, colour symptom expression and influence the use of health care services (Ahrens et al., 2012, Ciechanowski et al., 2002,

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Maunder and Hunter, 2008, McWilliams et al., 2010). Similarly, mental disorders are tightly linked to the use of health services, daily functioning, and quality of life (Crystal et al., 2003). While the influence of mental illness itself on the use of mental health services is recognized, the role of adult attachment in mental health care utilization has been minimally explored (Maunder and Hunter, 2008; Prins et al., 2008).

Although a growing body of research has investigated the association between attachment styles and mental disorders, as well as the relationship between mental disorders and the use of mental health services (Prins et al., 2008), little is known about the unique contribution of attachment insecurity to the use of a wide range of health care services. This comes as a surprise given the extensive research showing the impact of attachment style on health care utilization and health care costs in medical patients (Ciechanowski et al., 2002). A better understanding of psychosocial factors associated with health care utilization in patients with psychiatric needs is of increasing concern. Here, we investigate associations between adult attachment and mental health care utilizations, assess the strengths of those relationships after controlling socio-demographic, physical, and psychological risk factors, and explore the roles of physical and psychiatric diseases in influencing of those associations.

To the best of our knowledge, this is the first study that provides a perspective on the relationship between self-reported attachment style and the use of a wide range of mental health services. We aim to examine whether adult attachment styles are associated with the use of mental health care services in the general population.

2. Methods

2.1. Data source

We analyzed data collected in the National Comorbidity Survey Replication (NCS-R). The NCS-R is a large survey of the prevalence and correlates of psychiatric disorders in the general US population (Kessler and Merikangas, 2004). The target population of the NCS-R sample included all US adults aged 18 and older residing in household located in the coterminous 48 mainland states. Individuals who were in institutions, including prisons, jails, nursing homes, and long-term medical or dependant care facilities, were excluded. Adults who were not able to conduct the NCS-R interview in English were also excluded.

The NCS-R data had two components (Part 1 and Part 2). Part 1 covered the full participant sample ($N=9282$) and primarily dealt with assessments of psychiatric disorders, whereas Part 2 provided additional information of potential risk factors, but only covered a subsample of cases ($N=5692$). Part 2 included all of the Part 1 respondents with a lifetime psychiatric disorder and a probability subsample of the others (Kessler et al., 2004b). Ethics approval of the primary data collection of the NCS was provided by the University of Michigan. In the present study, we analyzed Part 2 of the NCS-R public use dataset.

2.2. Measures

2.2.1. Attachment style

Attachment style was measured by the Hazan and Shaver's self-report attachment style measure (Hazan and Shaver, 1987). The scale includes three brief statements describing attachment styles (secure, avoidant, and anxious). Respondents provided a self-rating to each of the three statements using a 4-point scale ranging from 1 (A lot like me) to 4 (Not at all like me). This is a widely used measure due to its ease of administration, reliability and validity (Ravitz et al., 2010). The statement – "I find it relatively easy to get close to other people. I am comfortable depending on others and having them depend on me. I do not worry about being abandoned or about someone getting too close to me" was used to represent *secure* attachment. *Avoidant* attachment was assessed with the statement "I am somewhat uncomfortable being close to others; I find it difficult to trust them completely and difficult to depend on them. I am nervous when anyone get too close to me". *Anxious* attachment was assessed by the statement "I find that others are reluctant to get as close as I would like. I often worry that people who I care about do not love me or will not want to stay with me. I want to merge completely with another person, and this desire sometimes scares people away". If one rating was higher or closer to "a lot like me", he or she was assigned to the corresponding category. If the secure and an insecure rating were tied, the respondent was assigned to the insecure rating. If both insecure ratings were tied, the respondent was assigned to the anxious category. If the rating was the same for all three, the respondent was unclassified. Based on three statements, attachment styles were classified into *secure, avoidant, anxious*, and *unclassified* (Mickelson et al., 1997).

2.2.2. Health care services

Health care services were measured by the following questions: (1) ever having an overnight stay in a hospital or other facility to receive help for problems with emotions, mental health, or use of drug or alcohol; (2) ever use an internet support group or chat room to get help for problems with emotions or nerves; (3) ever go to a self-help group for help with emotions or nerves; (4) ever use a hotline for problems with emotions or nerves; (5) ever have a session of psychological counselling or therapy that lasted 30 min or longer with any type of professional; and (6) ever get a prescription or medicine for emotions, nerves or mental health, or substance use from any type of professional.

2.2.3. Socio-demographic factors

Variables including age, sex, marital status, education, race, household income, country of birth, and race were considered in our analyses.

2.2.4. Psychiatric disorders

The World Health Organization Composite International Diagnostic Interview (CIDI) was used to diagnosis psychiatric disorders based on Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV). The CIDI is believed to have a good validity for diagnosing diseases (Kessler et al., 2004a). In this study, we used lifetime diagnoses of three large diagnostic groups: *depression* (major depressive disorder and dysthymia); *anxiety* (generalized anxiety disorder, panic disorder, agoraphobia, social phobia, specific phobia, posttraumatic stress disorder); and *substance abuse* (alcohol abuse, alcohol dependence, drug abuse and drug dependence).

2.2.5. Chronic health conditions

Lifetime history of chronic health conditions was measured by the presence of the following diseases, arthritis, chronic back or neck problems, frequent or severe headaches, chronic pain, seasonal allergies, stroke, heart attack, heart disease, high blood pressure, asthma, chronic lung disease, diabetes or high blood sugar, ulcers, epilepsy or seizures, and cancer.

2.3. Statistical analyses

The NCS-R used a stratified, multistage area probability sampling frame. All analyses were weighted to adjust for variation in probabilities of selection using STATA (StataCorp, College Station,