Attachment Style, Spirituality, and Depressive Symptoms Among Individuals in Substance Abuse Treatment

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ABSTRACT. Adult attachment styles and spirituality have been shown to be protective factors against depressive symptoms among individuals in treatment for substance use disorders. However, no studies to date have examined how these two factors simultaneously are related to depressive symptomatology in this population. Thus, this study aimed to examine how adult attachment styles (secure vs. insecure attachment styles) and 2 distinct spirituality dimensions (existential purpose and meaning in life and religious well-being or the perceived relationship with God) are associated with depressive symptoms. Using a cross-sectional design, 77 individuals receiving substance abuse treatment were asked to complete a battery of self-report questionnaires. Hierarchical multiple regression analyses indicated that secure attachment style and higher levels of existential purpose and meaning in life were significantly related to lower levels of depressive symptoms whereby the existential purpose and meaning in life was a stronger predictor of depressive symptoms. These results suggest that practitioners may consider addressing attachment issues during treatment; however, emphasizing ways to increase individuals’ purpose and meaning in life may further enhance treatment outcomes. Future research should utilize a larger sample size, include more comprehensive measures of attachment styles, and explore ways to increase purpose and meaning in life in this population.

KEYWORDS. Depressive symptoms, attachment styles, spirituality, meaning in life, substance use

There is consensus within the literature that there are high comorbidity rates between major depressive disorder and substance abuse disorder (Brienza et al., 2000; Grant et al., 2004; Klein, Schwartz, Rose, & Leader, 2000). Research has shown that individuals diagnosed with alcohol dependence are 4 times more likely to be diagnosed with a co-occurring depressive disorder than those without alcohol dependence (Grant et al., 2004). Furthermore, Regier et al. (1990) in their Epidemiological Catchment Area survey found the comorbidity of these disorders in the general population to be more than twice as high as would be expected by chance.

It is important to examine factors associated with depressive disorders among individuals with substance use disorders. Multiple negative effects have been reported among those in...
treatment for these comorbid conditions, including the presence of depressive symptoms preceding relapse (Miller, Westerberg, Harris, & Tognan, 1996; Strowig, 2000) and greater severity of substance use following relapse (Tate, Brown, Unrod, & Ramo, 2004). In addition, higher rates of high-risk injection use, continued drug use, and drug relapse across different types of addictive substances have also been found (Marlatt & Gordon, 1985; Stein, Solomon, Herman, Anderson, & Miller, 2003). Moreover, treatment dropout rates and poorer prognosis after substance abuse treatment have been found among individuals with comorbid depressive and substance use disorders (Rounsaville, Weisman, Crits-Christoph, Wilber, & Kleber, 1982).

Recent research concerning depression among individuals with substance abuse issues has focused on the protective value of spirituality. For example, spirituality has been shown to be an essential component of positive treatment outcomes and recovery for substance use disorders (Chen, 2006; Jarusiewics, 2000). In addition, it has been related to abstinence during or after treatment (Jarusiewics, 2000) and has been described as “a powerful antagonist of addiction” (Unterrainer, Huber, Stelzer, & Fink, 2012, p. 68).

In a recent study, Diaz, Horton, McIlveen, Weiner, and Williams (2011) explored the relationships among depressive symptomatology, spirituality, and several religious factors (the respondents’ perceived relationship or closeness to God, religious background/practices, and respondents’ image of God). Results indicated that the religious background/practices and respondents’ image of God were not significantly associated with levels of depressive symptoms. However, respondents’ perceived closeness to God was positively related to depressive symptoms, and spirituality was inversely related to depressive symptoms. Of the three spirituality measures employed in the study, the score on the Spiritual Well-Being Scale (SWB; Ellison, 1983) was the strongest predictor of depressive symptomatology.

The SWB is composed of two subscales: Existential Well-Being (EWB; feelings of transcendent purpose and meaning) and Religious Well-Being (RWB; feelings of closeness to God). The researchers found that higher levels of existential spirituality were related to lower levels of depression as expected. However, they found the surprising results that higher levels of relational spirituality were related to higher levels of depressive symptoms. In explaining these counterintuitive results, the researchers speculated that the findings concerning respondents’ feelings of relatedness to God may have been largely explained by participants’ adult attachment style based on their ideas on work concerning attachment and spirituality by Granqvist (2002). Granqvist’s emotional compensation hypothesis proposes that individuals with histories of insecure attachments use their religion primarily to regulate their affect and to obtain a sense of security deriving from a relationship with a supportive God. Thus, Diaz and her colleagues (Diaz, Horton, McIlveen, Weiner, & Williams, 2011) speculated that the positive relationship between levels of depressive symptoms and levels of relatedness to God may have been due to poor relationships in respondents’ everyday lives associated with adult attachment style, not to their relationship with God.

A considerable amount of research has linked depressive symptoms to adult attachment styles, particularly insecure attachment styles (Fonagy et al., 1996; McMahon, Barnett, Kowalenko, & Tennant, 2006; Patrick, Hobson, Castle, Howard, & Maughan, 1994; Rosenstein & Horowitz, 1996). Attachment theory, developed by Bowlby (1977, 1980, 1982), is a widely accepted theory that explains social and relational aspects of individuals based on their interactions with significant others. According to Bowlby (1977), attachment behaviors are biologically driven in an instinctual effort to maximize survivability, and children engage in proximity-seeking behaviors with a primary caregiver. The quality of the child–caregiver relationship is encoded into implicit memory that defines an internal working model of self (IWM). The IWM determines children’s expectations for acceptance/rejection in future relationships throughout the life span.

Using Bowlby’s research on childhood attachment processes, Bartholomew and Horowitz (1991) developed a four-category model of adult attachment styles that includes secure style and
three insecure styles (preoccupied, dismissive, and fearful). According to these authors, adults with a secure attachment style are likely to have a positive view of both self and other. These individuals tend to have a strong sense of self-worthiness and to be willing to have emotional connections with others. In comparison, individuals with a preoccupied attachment style are likely to have a negative view of self and a positive view of others coming from feelings of low self-worth and anxiety and fear concerning abandonment by others. They rely on acceptance by others for their own acceptance of themselves and frequently engage in attention-seeking behavior to maintain proximity to others. Individuals with a dismissive style are likely to have a positive view of self and a negative view of others; they tend to see themselves as having a relatively high sense of self-worth but have little trust in intimate relationships. Lastly, individuals with a fearful style are likely to have a negative view of both self and others. They tend to lack a sense of personal worth and to have expectations of abandonment that interfere with their development of healthy intimate relationships.

Research has shown that individuals with an insecure attachment style are susceptible to depression due to their tendency to create negative life events again and again that bolster a sense of helplessness and hopelessness in what they perceive as inescapable adversity (Bemporad & Romano, 1992; Rholes & Simpson, 2004). Several studies have noted that the preoccupied adult attachment style is associated with depressive symptoms (Cole-Detke & Kobak, 1996; Eng, Heimberg, Hart, Schneier, & Liebowitz, 2001; Williams & Riskind, 2004). Others have noted a relationship between an avoidant attachment style and depression (Carnelley, Petromonaco, & Jaffe, 1994; Mickelson, Kessler, & Shaver, 1997). In addition, Flores (2003) has argued that inadequate parental availability and/or responsiveness during infancy results in impaired emotional regulation among individuals with substance abuse disorders; these individuals attempt to repair the impaired emotional regulation by using substances that regulate their emotions while reducing psychic pain and/or providing distractive stimulation. He argues that addiction is “both a consequence of and a solution to the absence of satisfying relationships” (Flores, 2003, p. 50) in the substance user’s life.

Even though attachment behaviors are mainly manifested toward the primary caregiver during infancy, individuals tend to form other relationships in adulthood that become an important part of their attachment hierarchy. Some of these attachments include relationships with a romantic partner, a close friend, a therapist, or even God/Higher Power (Kirkpatrick, 2005; Kirkpatrick & Shaver, 1992; Rowatt & Kirkpatrick, 2002). Thus, there is a body of knowledge that establishes the connection between adult attachment and spirituality; however, this literature focuses primarily on religiosity and does not integrate purpose and meaning in life as an important protective factor against depressive symptoms, particularly among individuals with substance use disorders.

Although this review of the literature indicates that researchers have explored the relationships between attachment styles and depressive symptoms and between spirituality and depressive symptoms, no studies have yet examined these factors together to determine their relative importance as they relate to depressive symptoms in this population. Therefore, the current study was designed to expand upon the existing knowledge base in an effort to reduce this gap in the literature. It was hypothesized first that adults with secure attachment styles would have lower levels of depressive symptoms than would individuals with insecure attachment styles. In regard to the two spirituality dimensions, it was hypothesized that higher levels of existential purpose and meaning in life would be related to lower levels of depressive symptoms. In addition, and based on previous findings in the literature, higher levels of religious well-being or perceived closeness to God would be related to higher levels of depressive symptoms. The findings from this study could have clear implications for social service providers who may consider the relative importance of attachment styles and spirituality to help them determine the focus of clinical treatment for clients with comorbid depressive and substance use disorders. Furthermore, the results may provide useful information about the protective quality of the two different
dimensions of spirituality—purpose and meaning and the perceived relationship with God. These are two distinct constructs that may contribute in different ways to clinical outcomes. Thus, findings from this study may assist practitioners in tailoring treatment to better address the specific needs of their dually diagnosed clients.

METHOD

Participants

This study used a convenience sample of individuals attending a substance abuse treatment center located in Florida. This is a for-profit facility that provides detoxification services, inpatient rehabilitation, residential, partial hospitalization, and intensive outpatient and outpatient services to self-pay and insurance-pay clients; the majority of the clients pay through their individual insurance. Attendance to this center is voluntary. All clients recruited for this study were receiving residential services. After researchers received approval from the institutional review board, participants were recruited from two different satellite sites of the treatment center from September 2012 to December 2012. Inclusion criteria included clients who were 18 years or older and those who had completed the detoxification phase of treatment. Clients were asked to fill out a questionnaire packet that contained the informed consent during one of their morning group meetings at the treatment center. It took approximately 45 min to complete all the self-reported questionnaires. All clients who attended the meeting on the date the questionnaires were administered participated in the study. Seventy-seven clients volunteered to participate in the study; 52 clients were recruited from Site 1 and 25 were recruited from Site 2. Participants did not receive monetary incentives for their participation in this study. The majority (89.6%, n = 69) self-identified as White Non-Hispanic. More than half of the participants reported being single and never having been married (53.2%, n = 41), while another 22.1% (n = 17) reported being currently married, 10.4% (n = 8) reported being divorced, 5.2% (n = 4) were separated, and 7.8% (n = 6) were cohabitating with an unmarried partner. Fifty percent of participants reported having full-time employment (n = 38), while 17.1% (n = 13) had part-time employment, 26.3% (n = 20) were unemployed, 2.6% (n = 2) were retired, and 3.9% (n = 3) were homemakers. In terms of religious affiliation, most participants reported being Catholic (44.2%, n = 34) or having no religious affiliation (28.9%, n = 22), while smaller proportions identified as Protestant (7.8%, n = 6) and other (18.4%, n = 14). There were no statistically significant differences between participants attending the two sites on any of the demographic variables, and thus, the analyses were conducted on the entire sample from the two sites. None of the demographic variables were significantly correlated with depressive symptoms.

Measures

The Spiritual Well-Being Scale

The SWB (Ellison, 1983) was used to assess for spiritual well-being. The SWB is a 20-item self-report scale that contains two subscales: a) the EWB (“I don’t know who I am, where I came from, or where I am going”); and b) the RWB (“I have a personally meaningful relationship with God”). The SWB has a 6-point Likert-type scale that includes SA = strongly agree, MA = moderately agree, A = agree, D = disagree, MD = moderately disagree, and SD = strongly disagree. These items were scored from 1 to 6, with a higher number indicating more well-being, 1 = SD, 2 = MD, 3 = D, 4 = A, 5 = MA, and 6 = SA. It has demonstrated psychometric properties. Coefficient alphas of .97 and a test–retest coefficient of .93 have been reported for the RWB, while the EWB obtained .90 and .80, respectively (Saunders, Lucas, & Kuras, 2007). Cronbach’s alphas for this sample were .91, .94, and .86 for the SWB, RWB, and EWB, respectively.

Relationship Questionnaire

The Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991) uses both categorical and continuous measurements of attachment. In the categorical section, respondents identify one of four possible vignettes.
(one for each adult attachment style—secure, fearful, preoccupied, and dismissing) that best describes their close relationships. Respondents are then asked to indicate on a 7-point Likert-type scale (1 = disagree strongly, 4 = neutral/mixed, and 7 = agree strongly) how accurately each vignette describes them. The RQ attachment ratings show convergent validity with adult attachment ratings (Bartholomew & Horowitz, 1991). In addition, it has shown moderately high stability during an 8-month period (Scharfe & Bartholomew, 1998) and has moderate test–retest reliability (Griffin & Bartholomew, 1994). This instrument has been utilized to measure attachment among individuals with alcohol abuse problems (McNally, Palfai, Levine, & Moore, 2003) and has been used in clinical populations (Dutton, Saunders, Starzomski, & Bartholomew, 1994; Haaga et al., 2002; Pistole & Tarrant, 1993).

The Center for Epidemiologic Studies Depression Scale

The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) was utilized to measure the current level of depressive symptomatology. The CES-D is a 20-item self-report scale that has been used in multiple recent research studies with individuals who abused substances (Diaz, Horton, Green, et al., 2011; Diaz, Horton, McIlrleen, et al., 2011; Larson et al., 2007; Sofuoglu, Poling, Gonzalez, Gonsai, & Kosten, 2006; Strathdee et al., 2006). Respondents are asked how often they experienced each symptom during the previous week using a 4-point Likert-type scale. Response categories are as follows: 0 = rarely or none of the time (less than 1 day), 1 = some or little of the time (1–2 days), 2 = occasionally or a moderate amount of time (3–4 days), and 3 = most or all of the time (5–7 days). The total score is the sum of these 20 items and provides a continuous measure from 0 to 60. A cutoff score of 16 or more categorizes the respondent as clinically depressed (Myers & Weissman, 1980; Schulberg et al., 1985). The CES-D has demonstrated high reliability in a variety of clinical and community samples (Orme, Reis, & Herz, 1986; Radloff, 1977, 1987). In a substance abuse sample, the internal consistency reliability was reported to be .81 for the total scale (Diaz, Horton, Green, et al., 2011). In this sample, the Cronbach’s alpha was .92.

Other Variables

Demographic information was collected by self-report and included age and gender (female or male). Respondents also self-identified their race/ethnicity as White Non-Hispanic, Hispanic, African American, or Other. Response categories for marital status included single, never married, legally married, cohabitating with partner (but not married), separated but still married, divorced, widowed, and other (specify). Respondents were asked to identify their religious affiliation: Catholic, Adventist, Jehovah’s Witness, Mormon, Jewish, Muslim, Buddhist, Protestant, other, and none. In addition, respondents were asked to identify their employment status as either: work 40 hr per week, work fewer than 40 hr per week, homemaker, retired, or unemployed.

Data Analyses

An alpha level of .05 was used to assess statistical significance. Frequencies were examined to determine the numbers of participants in each of the four adult attachment styles (secure, preoccupied, dismissing, and fearful). Because there were only four participants in the dismissing group, the variable was transformed into a dichotomous variable containing a secure group (0) and an insecure group (1). The depression variable was also dichotomized so that comparisons between those who had clinical levels of depression (0) and those who scored below the clinical-level cutoff (1) could be made. Relationships between these categorical variables were then analyzed using two-way contingency analysis of depression (clinical and nonclinical) and attachment style (secure and insecure). Pearson’s r correlations were conducted to assess for the relationship and strength between the spirituality variables, attachment styles, and depressive symptoms. In all of these analyses, the number of respondents in some analyses varied due to missing data.

Hierarchical multiple regression analyses were used to determine the relative effect of each independent variable on depressive symptoms.
For these analyses, the continuous values of the depression variable were utilized. Three models were built entering: a) the attachment style variable (RQ); b) the RWB variable and RQ; and c) the RWB, the RQ, and the EWB. R-square changes were calculated with each new equation. The order of variables entered into the model was based on theoretical understanding that attachment style is established very early in life and before a spiritual understanding can be developed.

RESULTS

Univariate Analyses

Of the 77 participants in the study, 91% \( (n = 70) \) completed the RQ. Frequency analyses indicated that there were 26 participants (37.1%) who reported a secure style, 27 (38.6%) who reported a fearful attachment style, 13 (18.6%) who reported a preoccupied style, and 4 (5.6%) who reported a dismissing style. Because of the low number of participants reporting a dismissing style, this variable was collapsed into a dichotomous variable containing 44 participants (62.6%) reporting an insecure style and 26 (37.1%) reporting a secure style.

Of the 77 participants, 68 (88.3%) completed the CES-D. Out of the 68, more than half (63.2%, \( n = 43 \)) reported CES-D scores of 16 or higher indicating high levels of depressive symptoms.

Bivariate Analyses

Correlation analyses indicated that all variables (SWB, EWB, RWB, and RQ) were statistically significantly related to depressive symptoms (see Table 1). All three of the spirituality scales were negatively related to depressive symptoms; the EWB had the strongest relationship with depressive symptoms.

The chi-square tests indicated that depressive symptoms were significantly associated with attachment style, \( X^2(1, 70) = 10.06, p = .002 \) (see Table 2). Approximately 80% \( (n = 35) \) of respondents who reported an insecure style reported clinical levels of depressive symptoms compared with only 42% \( (n = 11) \) of the secure attached individuals.

Multivariate Analyses

Table 3 presents the results of the hierarchical multiple linear regression models that examined potential factors associated with continuous depressive symptomatology. The model included the two attachment styles (secure vs. insecure) and the two subscales of the SWB. In the first equation, the attachment variable (RQ) was a statistically significant predictor of depressive symptoms \( (p < .01) \), with the insecure attachment style being associated with higher levels of depressive symptoms. This model accounted for 14.1% of the variance in depression scores. When the relational spirituality subscale (RWB) was added in the second equation, it was not significantly related to depressive symptoms. In this equation, the attachment variable remained highly significant \( (p < .01) \). In the final equation when the existential spirituality subscale (EWB) was entered, neither the RQ (attachment style) nor the RWB remained significant. However, the EWB was a highly significant predictor of depressive symptoms \( (p < .001) \), with higher scores on the EWB associated with lower levels of depressive symptoms. In addition, this variable accounted for an additional 24.2% of the variance in depressive symptom level for a total of 41.6%.

DISCUSSION

The purpose of this study was to examine how two factors—attachment styles and two dimensions of spirituality—were related to depressive symptoms in a sample of individuals in residential treatment for substance abuse issues. The high comorbidity rates between depressive symptoms and substance abuse disorders have been extensively documented in the literature (Brienza et al., 2000; Grant et al., 2004; Klein et al., 2000; Regier et al., 1990), and the findings of this study are generally consistent with that literature in that approximately 63% of the substance abuse treatment sample reported clinical levels of depressive symptoms. Interestingly, 63% of the respondents also reported an insecure attachment style. This finding is not surprising because substance abuse disorders are
more likely among individuals with anxious attachment styles (Riggs et al., 2007). In addition, results in the current study are congruent with the literature showing that the fearful attachment style predominates among individuals with drug dependence (Schindler et al., 2005). Also consistent with previous research showing that individuals with a dismissing attachment style are the least likely to enter treatment (Caspers, Yucuis, Troutman, & Spinks, 2006), only a very small proportion of participants in this study (5.6%) reported a dismissing style.

Our first hypothesis that participants reporting a secure adult attachment style would have lower levels of depressive symptoms compared with those reporting insecure styles was supported. Almost 80% of participants who reported an insecure attachment style also reported clinical levels of depressive symptoms. In comparison, only 42% of those reporting secure attachment scored above the clinical cutoff point for depressive symptoms. This finding is consistent with the literature that indicates associations between insecure attachment and psychopathology, particularly depression (Bifulco, Moran, Ball, & Bernazzani, 2002; Gerlsma & Luteijn, 2000).

Based on previous studies (Daaleman & Kaufman, 2006; Diaz, Horton, McIlveen, et al., 2011; Kendler et al., 2003), it was expected that spirituality would be related to depression scores such that higher levels of existential purpose and meaning in life would be related to lower levels of depression and higher religious well-being, or perceptions of closeness to God would be related to higher levels of depressive

### TABLE 1. Pearson’s Product–Moment Correlations for Depression Scores (CES) With Overall (SWB), Existential (EWB), and Relational (RWB) Spirituality Scores and Attachment Style (RQ)

<table>
<thead>
<tr>
<th></th>
<th>CES</th>
<th>SWB</th>
<th>EWB</th>
<th>RWB</th>
<th>RQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>CES</td>
<td>1</td>
<td>−0.452***</td>
<td>−0.616***</td>
<td>−0.249*</td>
<td>0.299*</td>
</tr>
<tr>
<td>N</td>
<td>68</td>
<td>68</td>
<td>68</td>
<td>68</td>
<td>63</td>
</tr>
<tr>
<td>SWB</td>
<td>1</td>
<td>0.832***</td>
<td>0.917***</td>
<td>−0.279*</td>
<td>−0.352**</td>
</tr>
<tr>
<td>N</td>
<td>76</td>
<td>76</td>
<td>76</td>
<td>69</td>
<td></td>
</tr>
<tr>
<td>EWB</td>
<td>1</td>
<td>0.549***</td>
<td>−0.191</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>76</td>
<td>76</td>
<td>69</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>RWB</td>
<td>1</td>
<td>−0.191</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>70</td>
<td>10</td>
<td></td>
<td>70</td>
<td></td>
</tr>
</tbody>
</table>

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

CES = Center for Epidemiologic Studies Depression Scale; SWB = Spiritual Well-Being Scale; EWB = Existential Well-Being Scale; RWB = Religious Well-Being Scale; RQ = Relationship Questionnaire.

### TABLE 2. Crosstabulation of Level of Depression and Attachment Style

<table>
<thead>
<tr>
<th>Depression Level</th>
<th>Insecure % (n)</th>
<th>Secure % (n)</th>
<th>Total % (n)</th>
<th>X²(df)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonclinical</td>
<td>20.5 (9)</td>
<td>57.5 (15)</td>
<td>34.3 (24)</td>
<td>10.06 (1)**</td>
</tr>
<tr>
<td>Clinical</td>
<td>79.5 (35)</td>
<td>42.3 (11)</td>
<td>65.7 (46)</td>
<td></td>
</tr>
</tbody>
</table>

** p < .01.
TABLE 3. Summary of Hierarchical Multiple Regression Analysis Regressing Depressive Symptoms on Attachment Style and the Spirituality Subscales

<table>
<thead>
<tr>
<th>Variable</th>
<th>Unstandardized Regression Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eq. 1</td>
</tr>
<tr>
<td>Attachment style</td>
<td>9.58**</td>
</tr>
<tr>
<td>SWB Relational</td>
<td>-0.179</td>
</tr>
<tr>
<td>SWB Existential</td>
<td>-1.74</td>
</tr>
<tr>
<td>$R^2$</td>
<td>0.141</td>
</tr>
<tr>
<td>$R^2$ Change</td>
<td>0.032</td>
</tr>
<tr>
<td>$F$</td>
<td>10.05**</td>
</tr>
</tbody>
</table>

** $p < .01$, *** $p < .001$.

SWB = Spiritual Well-Being Scale.

Symptoms. Only the first hypothesis was supported. Participants who reported higher scores on the EWB were more likely to report lower levels of depressive symptoms. These findings are not surprising because the existential dimension of spirituality involves purpose and meaning in life (Diarmuid, 1994), possibly resulting in feelings of hope and optimism and thus buffering symptoms of depression.

Counter to our expectations, however, there was a nonsignificant relationship between the relational dimension of spirituality or perceived relationship with God (the RWB) and depressive symptoms. This finding is not consistent with results from two previous research studies conducted in a substance use population (Diaz, Horton, Green, et al., 2011; Diaz, Horton, McIlveen, et al., 2011) that indicated a positive relationship between these variables. A confounding factor and possible explanation for this contradictory finding could involve the recent implementation of a religious track at the treatment center while this research study was being conducted. Based on empirical evidence in the literature documenting the negative relationship between spirituality and depression, the treatment center implemented this track and clients attended sessions where topics related to their religious beliefs and practices and their addiction were the focus of clinical attention. Thus, it is possible that the religious track might have modified clients’ perceptions about their relationship with a transcendent being and the role that the relationship plays in their lives, resulting in a larger number of participants without clinical levels of depression reporting a stronger relationship with God, thus affecting the results of this study.

Results of the hierarchical multiple regression analyses indicated that when attachment style and the relational/religious well-being dimension of spirituality were examined together, attachment style was the only factor significantly related to level of depressive symptoms. This result is interesting because it suggests that attachment style is more important than their perceived closeness to God in predicting depressive symptoms in this sample.

Interestingly, neither religious well-being nor attachment style was associated with depressive symptoms after the existential dimension was added to the model. This finding suggests that although individuals’ current relationships may not be ideal because of attachment issues, if they have adequate levels of existential purpose and meaning in life, they may be protected against clinical levels of depressive symptoms. Very little research has been conducted concerning relationships between purpose and meaning in life and substance abuse. However, these findings are consonant with early research that showed that drug users scored significantly lower on measures of purpose and meaning of life than did individuals who did not use drugs (Shean & Fetchman, 1971) and that individuals in residential treatment for drug abuse had significantly lower levels of meaning in life compared with non-drug-using controls (Nicholson et al., 1994). More current research concerning relationships with meaning in life among
adolescents revealed that lower levels of meaning in life were correlated to illegal drug use and sedative use among male adolescents and binge drinking among female adolescents (Brassai, Piko, & Steger, 2011). In addition, Mascaro and Rosen (2008) showed that low levels of meaning in life are related to increases in depression during a 2-month period among college students.

There are various limitations in the present study. First, generalizability is limited because the sample used for this study came from a single residential treatment agency located in Southeastern Florida. The racial and ethnic composition of the sample also compromises generalizability as the vast majority of clients were White Non-Hispanics. In addition, it is important to mention a measurement concern in that the categorical nature of the RQ (Bartholomew & Horowitz, 1991) did not allow for a thorough examination of the continuous dimensions of attachment styles. It would be valuable for future investigations to utilize a more comprehensive instrument such as the Experiences of Close Relationship Scale (Fraley, Waller, & Brennen, 2000), which could expand on the relationship of the examined variables. Moreover, this study did not include a control group of a different clinical sample or nonclinical participants, and thus, it is not possible to make comparisons with higher-functioning groups. Lastly, this study involved a very small number of respondents reporting a dismissing attachment style, which limited the confidence in the findings concerning this particular attachment category. Dismissing clients are the least likely to seek treatment among all the insecure attached individuals; therefore, future investigations will need to recruit a larger sample that would allow a sufficient number of respondents per category.

Despite these limitations, this study is the first to examine depressive symptomatology, attachment style, and spirituality among individuals with substance abuse problems in a residential treatment facility. Therefore, this study fills an important gap in the knowledge base concerning risk and protective factors that influence this population.

**Conclusion and Implications for Practice and Future Directions**

Previous studies examining attachment styles and spirituality have not been conducted among individuals struggling with substance abuse issues and have been limited to exploring how attachment styles and spirituality separately influence depression. Our study expanded the existing literature by examining the relative influence of these two factors simultaneously on depressive symptoms in this population. In addition, previous investigations have focused on a single dimension of spirituality, religiosity, while our study explored two dimensions—existential purpose and meaning in life and religious well-being or the perceived relationship with God. The inclusion of two dimensions may enhance our understanding of the potential protective role that purpose and meaning in life may bring to dually diagnosed individuals.

Based on our findings, having an insecure attachment style seems to be a risk factor for the development of depressive symptoms. Another significant finding of this study shows that the existential-purpose and meaning-in-life dimension of spirituality seems to be the most important factor related to depressive symptoms among this sample of individuals in treatment for substance abuse issues. Although our results suggest that practitioners could consider focusing on promoting improved interpersonal relationships for individuals with insecure attachment styles, they may want to place the fostering of purpose and meaning in life as a higher priority for treatment planning. These results may also have implications for program development. First, many substance abuse treatment programs are based on the 12-step model that stresses the spiritual component of addiction. Therefore, these programs might take into consideration the relative importance of the two spiritual dimensions and put into place programmatic support for the development of purpose and meaning in life rather than stressing the perceived closeness to God.

Future research may expand our results by exploring the insecure attachment styles in greater depth. This exploration could include a larger
sample that would allow analyses of the dismissing style, which was not possible in our study due to the low number of individuals in this category. Likewise, future investigations may consider having a more diverse sample to examine the impact of demographic factors (e.g., race/ethnicity, culture, religious affiliation, and practices) on the results. In addition, it would be interesting to use an instrument that assesses for levels of attachment anxiety and avoidance rather than categorical attachment styles.

Lastly, considering the relative importance of the purpose and meaning in life, future research may focus on ways that practitioners can help their clients to increase purpose and meaning within a therapeutic environment. It would be interesting to understand clinical techniques, methods, and/or activities that would foster this dimension of spirituality. For example, therapeutic activities that involve creativity (i.e., painting, drawing, writing, dancing, gardening, etc.), solitude (i.e., praying, meditation, walking a labyrinth, etc.), and service to others (i.e., service and chores within a residential program, service to the larger community where the facilities are located) could be explored in future research.

REFERENCES


