Journal of Healthcare Management and Administration (JHMA)
Volume 13, Number 4; April-2022;
ISSN: 2837-3677 | Impact Factor: 6.40
https://zapjournals.com/Journals/index.php/jhma
Published By: Zendo Academic Publishing

THE INTERPLAY OF ATTACHMENT, REJECTION SENSITIVITY, AND PSYCHOLOGICAL CAPITAL IN ALCOHOL DEPENDENCY AMONG STUDENTS

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Article Info

Keywords: rejection sensitivity, attachment, alcohol use, mental health, social support, psychological capital.

Abstract

This review explores the relationship between rejection sensitivity, attachment, and alcohol use, with a focus on understanding the potential links and implications for mental health and well-being. The literature review reveals that various factors, such as genetic predisposition, adverse life circumstances, and social influences, contribute to problem drinking among young people. In particular, insecure attachment has been consistently associated with alcohol abuse and addictive behaviors. Moreover, rejection sensitivity, characterized by a fear of social rejection and corresponding behavioral responses, has been identified as a risk factor for depression, interpersonal aggression, and borderline personality disorder. Rejection sensitivity is also longitudinally and stably related to anxiety, depression, loneliness, and susceptibility to infectious diseases. Evidence suggests that rejection sensitivity is learned through experiences of social rejection, including harsh parenting, family conflict, early childhood trauma, and experiences of prejudice and exclusion.

This review further highlights the interconnections between attachment, rejection sensitivity, and relationship difficulties. Insecure attachment and rejection sensitivity are associated with both alcohol abuse and problematic relationships. Moreover, social support, which is influenced by attachment style, mediates the impact of child abuse and plays a crucial role in mitigating stress and trauma in adults. Social support is also implicated as a causal factor in alcohol abuse and is considered a key element in interventions targeting problem drinking behavior.

Additionally, the concept of psychological capital, encompassing hope, efficacy, resilience, and optimism, has been applied to various domains, including personal relationships and health. Psychological capital has shown promising results in predicting better mental health outcomes and lower alcohol consumption. This construct serves as psychological resources that contribute to stress reduction, improved health, and overall well-being.

Overall, the findings suggest that rejection sensitivity, attachment, and social support are important factors to consider in understanding alcohol use and mental health outcomes. Future research should explore the complex

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interactions between these variables and their implications for intervention and prevention strategies.

1. Introduction

In their review of reviews (Newbury-Birch et al., 2014) identified a range of factors that may predispose young people to problem drinking including, genetic factors, physical or sexual abuse in childhood, family history of alcohol problems and exposure to problem drinking in siblings or parents, and peer pressure. Arguably the influence of family history may be confused with genetic factors. Common across all these factors are social relations and adverse life circumstances. There is a substantial literature evidencing a link between lack of secure attachment and alcohol abuse (Hocking, Simons, Simons, & Freeman, 2018) and indeed addictive behaviour in general (Nakhoul et al., 2020). Fairbairn et al. (2018) in a meta-analysis of 34 studies (total N=56,721) conclude that on the balance of evidence the direction of effect is that attachment insecurity precedes both alcohol problems and problems in adult relationships. Levitt and Leonard (2015) investigated relationship specific drinking in 470 couples over the first nine years of marriage and found that it was mediated by insecure (anxious) attachment. The link between anxious and avoidant attachment and alcohol consumption and relationships was further investigated in a study of young adults and concluded that attachment issues
should be viewed as potential precursors to alcohol problems (Goldstein, Haller, Mackinnon, & Stewart, 2019).
Rejection sensitivity describes individuals who fear social rejection and tend to react to social cues in manner consistent with their fear (Liu, Kraines, Massing-Schaffer, & Alloy, 2014). It is a risk factor for depression (Chango, McElhaney, Allen, Schad, & Marston, 2012; Liu et al., 2014) and has been associated with interpersonal aggression and borderline personality disorder (Chesin, Fertuck, Goodman, Lichenstein, & Stanley, 2015; Lawson & Brossart, 2013). Gao, Assink, Cipriani, and Lin (2017) in a meta-analytic review of 75 studies conclude that there is a longitudinal and stable relationship between rejection sensitivity and anxiety, depression and loneliness sufficient for them to recommend that it should be a focus in risk assessment and intervention for mental health problems. Marin and Miller (2013) in a review of 76 long term studies suggest that rejection sensitivity is linked to susceptibility to infectious diseases.
Evidence suggests that rejection sensitivity is learned as a consequence of previous experiences of social rejection (Romero Canyas, Downey, Berenson, Ayduk, & Kang, 2010) and is linked to harsh parenting, family conflict, and early childhood trauma (Downey, Khouri, & Feldman, 1997; Godleski, Eiden, Kachadourian, & Lucke, 2019). The latter authors tested an etiological model of rejection sensitivity in 227 families from infancy to adolescence and concluded that it is an outcome of diverse negative childhood experiences largely related to problematic attachment. Among the specific factors were father's alcohol problems and harsh mothering. Other research has linked rejection sensitivity to early interpersonal experiences of prejudice and exclusion because of ethnic group membership (Pachankis, Hatzenbuehler, & Starks, 2014). These authors also conclude that rejection sensitivity interacts with aspects of the social environment to predict important health-related behaviour in adolescents and is associated with social withdrawal and loneliness (Watson & Nesdale, 2012). In one rare study looking at rejection sensitivity and alcohol problems the authors express surprise that the link has not been more fully explored (Laws, Ellerbeck, Rodrigues, Simmons, & Ansell, 2017). They found that social rejection by others in a relationship was linked to daily alcohol consumption.
Thus far the evidence reviewed suggests that a) insecure / problematic attachment is linked to alcohol use, b) there is a link between problematic attachment and rejection sensitivity, and c) rejection sensitivity is linked to emotional problems and health-related behaviours. This would seem to allow the hypothesis that rejection sensitivity might also be related to alcohol use.
Research has also shown that both insecure and anxious attachment and rejection sensitivity are related to relationship difficulties (Downey, Feldman, & Ayduk, 2000; Downey & Feldman, 1996; Downey., Mougios, Ayduk, London, & Shoda, 2004). As of course is alcohol abuse (Fischer & Wiersma, 2012; Leonard & Eiden, 2007). The evidence is that alcohol abuse follows from attachment insecurity rather than vice versa (Fairbairn et al., 2018).

Attachment is related to social support in complex ways and has been shown to mediate the impact of child abuse (Struck et al., 2020). In adults social support is perhaps the key mediator of stress and trauma on mental health and wellbeing (Taylor, 2011). Insecure attachment interacts with ineffective support seeking in couples leading to problems in relationships (Khodarahimi, Hashim, & MohdZaharim, 2016; McLeod, Berry, Hodgson, & Wearden, 2020). Social support is a key element of any intervention to change problem drinking behaviour (McGaffin, Deane, Kelly, & Blackman, 2018) and is also implicated as a causal factor in alcohol abuse (Hamdan-Mansour, 2016).

Drawing on the well-established construct of psychological capital in the domain of work, Fred Luthans, Youssef, Sweetman, and Harms (2013) suggest that it might be usefully applied to other domains including personal relationships and health (Fred Luthans & Youssef-Morgan, 2017). Other research has applied the model to mental health and substance abuse (Krasikova, Lester, & Harms, 2015). These researchers found that psychological capital predicted better mental health and lower alcohol consumption in almost 2,000 army personnel following a tour of duty. Psychological capital is based on four constructs, hope, efficacy, resilience and optimism (acronym HERO), each with a substantial literature as psychological resources in the field of stress, health and wellbeing (Fred Luthans & Youssef-Morgan, 2017).

Given the literature reviewed above a possible model for predicting problematic alcohol consumption was proposed and is shown in Figure 1.

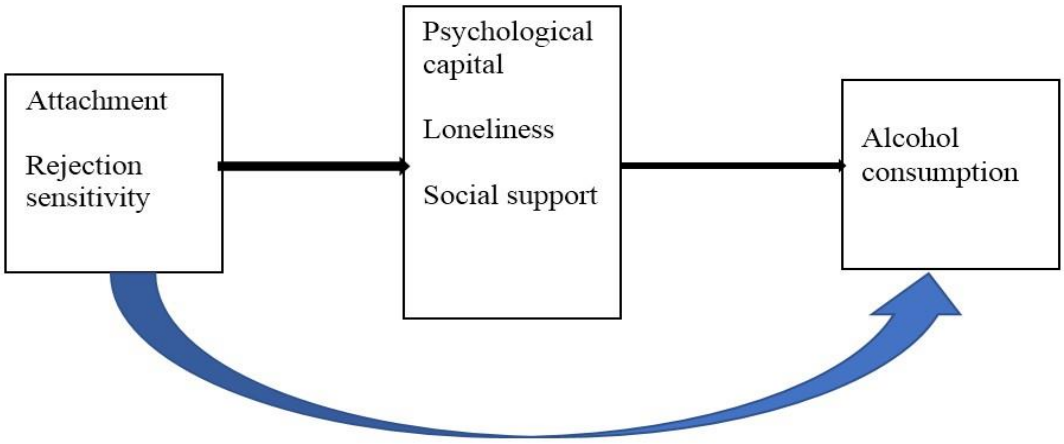

Figure-1.

Path model of the predictors of alcohol consumption.

2. Methodology

Design: An online survey using questionnaire data collection was used to explore the variables identified in the model at Figure 1.

Participants: The sample consisted of 762 participants (532 female and 230 females) representing a convenience sample of emerging adults. The participants ranged in age from 18 to 26 years (M =22.32, SD =2.20).

Measures: Participants were asked for their age and sex before completing the following measures.

*Attachmen*t: The Revised Hazan and Shaver (1987) three-item questionnaire designed to measure adult attachment was employed. The three attachment styles are secure, anxious, and avoidant (Hazan & Shaver, 1987). Secure: typically describe romantic relationships as amicable, trusting, and happy (Hazan & Shaver, 1987). Such individuals are accepting of their partners and tend to have long satisfying relationships (Hazan & Shaver, 1987). Anxious: typically view lovers in a neurotic way, with a constant need for reciprocation and support (Hazan & Shaver, 1987). Avoidant individuals are typically apprehensive of intimacy, experiencing emotional highs and lows during relationships (Hazan & Shaver, 1987). This measure demonstrates good internal consistency across the three categories (secure: $\alpha = 0.82$; anxious: $\alpha = 0.76$; avoidant: $\alpha =0.82$) (Fraley, Waller, & Brennan, 2000).

Alcohol use: The Alcohol Use Disorders Identification Test (AUDIT) (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001) was developed by the World Health Organization (WHO) as a self-report screening test to identify alcohol disorders. The 10-item scale covers 3 symptom areas: hazardous use, dependence symptoms, and

harmful use. All item scores range from 0 to 4 and are commonly summarized to provide an overall measure of hazardous drinking. Scores range from 0-40 and it has been established that scores of 0-7 indicate low risk, 8-15 indicates increasing risk, 16-19 indicates higher risk, and scores of over 20 indicate potential dependency.

Psychological Capital: Psychological Capital, defined by Luthans, Youssef-Morgan, and Avolio (2015) is an individual's positive psychological state of development that is made up of four constructs; Resilience, Hope, Optimism and Self- Efficacy. A total score on Psychological Capital obtained by summing these four constructs is used in analysis. The Compound PsyCap (CPC-12) Scale is a composite measure of hope, resilience, self-efficacy, and optimism, encompassing 12 items. Each of the four components is reported on a 6-point Likert scale from *Strongly Disagree (=1) to Strongly Agree* (=6). It measures psychological capital in a universal manner. The CPC-12 has been demonstrated to have good reliability and external validity (Lorenz, Beer, Pütz, & Heinitz, 2016). In this study, the Cronbach's alpha for the CPC-12 scale was 0.93.

Perceived social support: Perceived levels of social support from family and peers were assessed by employing the Perceived Social Support Scale (PSSS) (Procidano & Heller, 1983). This measure consists of two 20-item subscales focusing on perceived social support from both family members and friends. Identical wording is used on both subscales, apart from modifying the referent of the statement (e.g. "Members of my family are good at helping me solve problems" vs. "My friends are good at helping me solve problems"). The measure assesses a range of instances of support including emotional, information, feedback and reciprocity (i.e. provision of support by the individual). In the present study the Cronbach Alpha values were family support ($\alpha = 0.81$), and support from friends ($\alpha = 0.83$).

Rejection Sensitivity Questionnaire (Downey & Feldman, 1996)*:* The rejection sensitivity questionnaire assesses "generalized expectations and anxiety about whether significant others will meet one's needs for acceptance or will be rejecting" (Downey & Feldman, 1996). The 18-item scale presents hypothetical requests of people close to an individual (e. g. "You ask your boyfriend/girlfriend if they really love you", "You ask your parents for extra money to cover living expenses"). Participants are required to state how anxious they would feel about making the request and how they think the person will respond to the request on a six-point Likert scale. When answering the first part of each question, 1 represents "Very Unconcerned" and 6 represents "Very Concerned" on the Likert scale. For the second part of each question 1 represents "Very Unlikely" and 6 represents "Very Likely". It is scored by reversing the likelihood estimates for all items, summing these products and dividing the total by 18 (Brookings, Zembar, & Hochstetler, 2003). Internal reliability was satisfactory with a Cronbach's alpha value of 0.92. Downey and Feldman (1996) reported a mean (std. deviation) of 9.69(3.07), an internal consistency reliability of 0.81 and test-retest reliability of 0.83.

Loneliness: This was measured by a short 3-item scale developed by Hughes, Waite, Hawkley, and Cacioppo (2004) for use in surveys. It was developed from the R-UCLA Loneliness Scale (Russell, Peplau, & Cutrona, 1980). The scale had an Alpha of 0.72.

3. Results

In terms of AUDIT scores 154 (20.2%) were in the low-risk category, 275 (36.1%) were in the increasing risk category and 184 (24.1%) were in the higher risk category. A total of 149 (19.6%) scored over 20 hence were deemed to be potentially alcohol dependent. Mean scores for males (M=8.87, Sd=4.65) and females (M=8.37, Sd=4.50) did not differ significantly nor was there any significant relationship between sex and AUDIT category based on chi-square analysis.

Hierarchical Multiple Regression Analysis (HMRA) was used with alcohol consumption as the dependent variable. On step one age and sex were entered as predictor variables and accounted for 1% of the variance in alcohol consumption (β=0.105, $p<0.01$). The three dimensions of attachment were entered on step 2 and added 18% to the variance explained. Avoidant (β=0.131, $p<0.01$) and ambivalent (β=0.214, $p<0.001$) attachment were direct predictor while secure (β=-0.211, $p<0.01$) attachment was an inverse predictor. On the next step, rejection sensitivity was entered and added a further 16% to the variance explained (β=0.427, $p<0.01$). On step 4 social support was added and produced a further 2% of explained variance (β=-0.160, $p<0.01$). We added psychological capital on the next step, and this gave an additional 8% explained

variance (□=-0.295, p<0.01). On the final step loneliness was added and provided a further 2% of variance explained (□=0.153, p<0.01). See Table 1.

Table-1.

HMRA to identify the predictors of alcohol consumption.

	B	**SE.B**	□
Step 1: R^2= 0.01, F(2,759) = 4.45, *p* <0.01			
Age	-0.065	0.023	-0.106**
Sex	0.079	0.553	0.005
Step 2: R^2 Δ= 0.18, F(3,756) = 55.94, *p* <0.001			
Age	-0.065	0.021	-0.106**
Sex	-0.200	0.502	-0.013
Secure Attachment	-1.094	0.218	-0.211***
Avoidant Attachment	0.633	0.204	0.131**
Ambivalent Attachment	1.123	0.180	0.214***
Step 3: R^2 Δ= 0.16, F(1,755) = 187.55, *p* <0.001			
Age	-0.061	0.019	-0.099***
Sex	-0.101	0.450	-0.007
Secure Attachment	-0.727	0.197	-0.140***
Avoidant Attachment	0.331	0.184	0.068
Ambivalent Attachment	0.830	0.163	0.158***
Rejection sensitivity	1.898	0.139	0.427***
Step 4: R^2 Δ= 0.02, F(1,754) = 23.99, *p* <0.01			
Age	-0.020	0.020	-0.033
Sex	-0.263	0.444	-0.018
Secure Attachment	-0.742	0.194	-0.143***
Avoidant Attachment	0.316	0.182	0.065
Ambivalent Attachment	0.792	0.161	0.151***
Rejection sensitivity	1.798	0.138	0.405***
Support	-0.406	0.083	-0.160***
Step 5: R^2 Δ= 0.08, F(1,753) = 107.25, *p* <0.01			
Age	-0.022	0.019	-0.037
Sex	-0.885	0.420	-0.059*
Secure Attachment	-0.733	0.181	-0.142***
Avoidant Attachment	0.321	0.170	0.066
Ambivalent Attachment	0.674	0.151	0.128***
Rejection sensitivity	1.493	0.133	0.336***

Support	-0.346	0.078	-0.136***
Psychological Capital	-0.324	0.031	-0.295***
Step 6: R^2 Δ= 0.02, F(1,752) = 31.81, p <0.001			
Age	-0.024	0.018	-0.039
Sex	-0.715	0.413	-0.048
Secure Attachment	-0.756	0.178	-0.146***
Avoidant Attachment	0.419	0.167	0.087**
Ambivalent Attachment	0.729	0.148	0.139***
Rejection sensitivity	1.435	0.130	0.323***
Support	-0.328	0.076	-0.129***
Psychological Capital	-0.310	0.031	-0.283***
Loneliness	0.602	0.107	0.153***
Total R^2 = 0.47			

Note: * $p < 0.05$. ** $p < 0.01$ *** $p < 0.001$

This provides some preliminary support for the model proposed in Figure 1 and suggests that individuals with insecure, avoidant, or ambivalent attachment, who are sensitive to social rejection, who have less support and lower psychological capital, and exhibit more loneliness are likely to drink more alcohol.

To test the model, we used the Structural Equation Program on AMOS 25 to build and test the fit of a path model. This can be seen in Figure 2 and supports the proposed model in Figure 1. The data were a good fit (chi-square (5) = 6.97, p=0.222, CMIN/DF = 1.395, GFI = 0.99, NFI = 0.99, IFI = 0.99, CFI = 0.99, RMSEA = 0.023, PCLOSE = 0.876). See Figure 2.

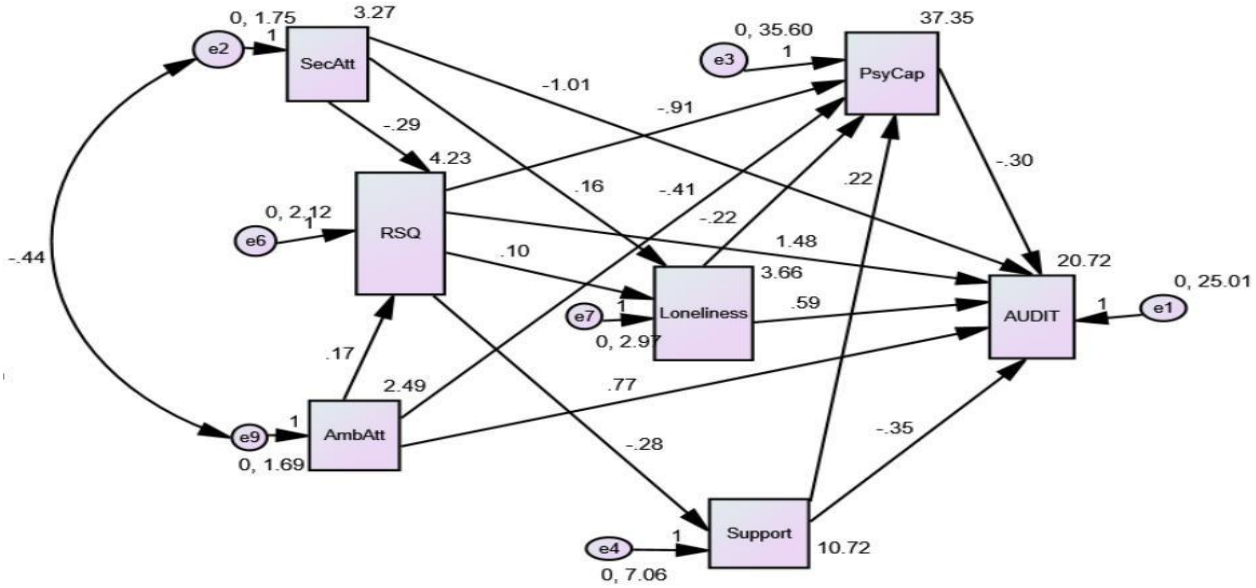

Figure-2.

Path model of the predicators of alcohol consumption, as measured by the AUDIT. (SecAtt=secure attachment; AmbAtt=Ambivalent attachment; RSQ=Rejection Sensitivity; PsyCap=Psychological Capital; AUDIT=measure of alcohol consumption.

4. Discussion

The aim of the current study was to test the model proposed in Figure 1, which in essence suggests that higher levels of alcohol consumption are related to several different aspects of social and intimate relations. These include insecure, ambivalent, and anxious attachment, sensitivity to social rejection, levels of perceived social support, and loneliness. In addition, these factors are mediated by psychological capital which is an indication of the psychological resilience or resourcefulness of the individual. The data do support the model. From the regression analysis we can see that attachment, rejection sensitivity, loneliness, social support, and psychological capital all contribute to the variance in alcohol consumption at a statistical level. The way in which these variable inter-relate is explicated more clearly in the path model. While the data is cross sectional the order of causality cannot be firmly established. However, based on the evidence reviewed in the introduction it is reasonable to suggest that attachment disruption and rejection sensitivity are predictive of alcohol consumption and are variables with an aetiology that links back to childhood experiences (Fairbairn et al., 2018; Godleski et al., 2019). We also know that both problem attachment style and rejection sensitivity make it difficult to form social relations (Chesin et al., 2015; Fairbairn et al., 2018) or to maintain them once formed (Downey et al., 2000; Levitt & Leonard, 2015). The consequence of this is social withdrawal and loneliness (Watson & Nesdale, 2012) and reduced social support since that support depends on forming and maintaining social relations. Of course, not every individual who has difficulty in social attachment and is sensitive to rejection, or who is lonely and feels unsupported, will abuse alcohol. To some extent that will depend on their psychological resources (Krasikova et al., 2015; Luthans & Youssef-Morgan, 2017).

What we are proposing is that individuals who have developed insecure attachment styles and who are sensitive to social rejection will find relationships difficult to establish and will experience loneliness and low levels of social support. Consequently, they may use alcohol as a crutch leading to dependency and a vicious circle. Those who find some optimism and hope and have a stronger sense of autonomy and ultimately are more resilient may be less likely to succumb to the temptation of alcohol. This is supported to some extent by the data and the path model. Again, this needs further testing in longitudinal data.

The importance of this, and our model is not new but builds on existing evidence, is the potential for prevention. The process follows on from attachment problems and fear of social rejection, both of which can be targets for intervention. There are a number of social problem-solving programmes which could be applied where an individual has already developed attachment and rejection issues (Malouff, Thorsteinsson, & Schutte, 2007; Merrill, Smith, Cumming, & Daunic, 2017). However, the implications are more far reaching as there is strong evidence that attachment and rejection issues originate in childhood (Fairbairn et al., 2018; Godleski et al., 2019). There are some very efficacious social problemsolving interventions for children, for example the I Can Problem Solve (ICPS) programme – formerly called the Interpersonal Cognitive Problem-Solving programme (Shure, 1992; Shure & Spivack, 1982). A recent meta-analytic review provides evidence of the efficacy of social problem-solving interventions in increasing social competence in children even at pre-school (Barnes, Wang, & O'Brien, 2018).

Given the cross-sectional design of the present study, issues concerning causal direction are left open, and need to be explored further in longitudinal research.

5. Conclusion

The current study provides a model building on previous which places attachment, rejection and relationships at the core of the development of alcohol dependence. As such it provides a potential focus not only for intervention, but also for prevention starting in childhood. Initially the authors suggest it should be used to guide longitudinal research to provide stronger evidence.

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