Attachment Type and Cognitive Status of People in Treatment For Substance Use and Abuse

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Abstract

This study demonstrates the importance of examining attachment issues, and the cognitive status of people in treatment for substance abuse. The participants were seven clients aged between 20 and 45 years of age, in treatment for substance abuse, and six of their counsellors. The Adult Attachment Interview (AAI: George, Kaplan & Main, 1996) was used as a therapeutic tool to uncover forgotten trauma and unresolved grief. Each of these participants was interviewed and portions of the transcripts are used to demonstrate the effectiveness of the instrument in use. These findings give examples of the richness of the client AAI transcripts which are then used in the counselling process. The second measure used was Loevinger's Sentence Completion Test (1976,1998) which was thought to show promise for indicating where people are 'stuck' in their thinking. In this study rather than being 'stuck' in an immature way of thinking participants show evidence of mature thinking. Classification of the AAI gave support to findings in attachment research that reflect a substantial and enduring connection between attachment organisation and psychopathology, and was linked to a wide array of indices of psychosocial functioning. Intergenerational transmission of severe insecure attachment behaviours was evident with all clients, as expected, which suggests that further investigation of the use of the AAI in therapy is important.

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Chapter 1

Introduction

This research has come about because of personal issues that demanded attention. The underlying rationale is to draw attention to attachment, the interpersonal emotional interaction factors that present during the lifetime of persons caught in the cycle of addiction, with particular interest being given to those with substance abuse issues.

For most of my life, until 1994, I had experienced unhealthy addiction, whether it be sugar binging as a child, or alcohol and drug abuse later in adolescence and adulthood. In 1994 I went into detoxification and rehabilitation and since then have been on a journey to discover from where the dysfunctional behaviours originated. I needed to understand the process, to look for the possible origins, and then find some way of showing others that some aspects of our early development play important roles in our future development and subsequent behaviours. This research relates to my experience and that of many of my fellow addicts who have journeyed this road with me. Our stories are very similar and are illumined by attachment theory.

Attachment theory seems to offer explanations about the causes of substance abuse and gives reasons for different responses to therapy. I would like to explore why some of us have had some success in recovery while many others do not. My idea is that some are unable to use the tools given to us during rehabilitation and early recovery. In addition, Loevinger's ideas about ego development seemed to me to offer a theoretical framework or way of understanding if someone is 'stuck' in their way of thinking and is unable to move on. I also felt that this conceptual framework could possibly give indicators of attachment types as well. Nevertheless, these two areas require further attention and research.

I think it pertinent that I acknowledge that there are many other factors involved in substance abuse/addiction, with biological models of genetic predisposition and brain chemistry being important areas of study. These aspects that underlie, precede or are concurrent with attachment are not part of this study. I wish to draw attention to attachment issues and ego development as a way for practitioners to understand their

clients, and to tailor therapies more appropriate to the individual's needs.

I know what has worked for me and for those individuals who have sought my assistance in their recovery from addiction and their pervasive feelings of disconnectedness. This study is an attempt to demonstrate this personal knowledge through an academic medium so that others working with those in addiction can benefit from our experience, and share the joy of a strong recovery with the people they work with.

The study of substance use and abuse in the past has primarily focussed on quantitative studies, gathering large amounts of correlational data, examining multiple risk factors for substance abuse, with the conclusion drawn that one risk factor does not inevitably lead to major problems, but several risk factors present implies that they do. Since none of the variables in any combination can be shown to be directly causal, it seems that this line of research should be seen to have reached its limits, needing only to be repeated because environmental-social conditions may change over time.

Working in the reverse direction, people who are substance abusers, almost invariably can be shown to have a variety of risk factors applicable, however, not all of them and not in the same amount. There is a need to find a way to group these multiple risk factors and protective factors to find a pattern or typology that can be used to prevent or intervene in these problem behaviours. A new approach is needed, hence the attention being paid to attachment and ego development in this study.

Attachment theory is based on three tenets: 1) human infants are born with a repertoire of behaviours aimed at maintaining proximity to others, who help them survive and provide a secure base for exploring their environment; 2) proximity maintenance also depends on the responsivity of other persons to one's attachment needs; and 3) experiences with significant others are internalised into mental models of the world and the self and generalised to new relationships. These are the building blocks of people's attachment styles, stable patterns of relational cognitions and behaviours. Research suggests that these models are the main source of continuity between attachment experiences and subsequent feeling and behaviours throughout the life span. These models or mental schema organise internal understanding and shape the individual's social experience. Researchers now know that dysfunctional behaviour results from separation anxiety and trauma, with substance abuse issues being a part of the pychopathology of individuals for whom these experiences

have become part of their working model or schema (van der Kolk, McFarlane & Weisaeth, 1996a).

The relationship between attachment orientation, health, and social support needs to be investigated further, and from as many different perspectives as possible.

Ego development (Loevinger, 1987) on the other hand, provides a frame of reference that the individual uses to organise and give meaning to experience. "The sequence of ego-development steps, defined independently of age, has much relevance to psychosocial issues encountered during adolescence and adult years. Each of the stages differs from the others along intrapsychic and interpersonal dimensions" (Hauser, Powers, Noam, Jacobson, Weiss & Follansbee, 1984, p.196). As examples, among the characteristics of lower stages of ego development are found numerous indicators of psychopathology or maladaptation in adults, and at higher levels more internalisation, greater reflection, and depressive symptoms (Evans, Brody & Noam, 2001).

Hauser, Gerber and Allen (1998) review the relationship between attachment classifications and ego development stages as being stable over time,

> and share an optimism about human potential for change and flexible adaption in the face of normative stressors, like the transition to parenthood or traumatic events, like the sudden loss of a child or spouse. As a response to environmental changes, revised attachment representation may become more coherent, and transitions from lower to higher stages of ego development may occur, revealing varied developmental paths that may be traced over time. New work reexamining emotion processes and development should enhance our understanding of the intersection of ego development, internal representations, and interpersonal relationships, thereby deepening our knowledge of the evolution of developmental pathways through adolescence and adult years (p.215).

In the review of literature following, the evolution of theories relating to attachment, ego development, and the causes of substance abuse will be described. Research based on these ideas will be reviewed.

Chapter 2

Literature Review

A developmental perspective considers the continuous change and maturation of the individual during the life span, tracing the possible pathways of development. The discipline of human development is interested in not only the study of infants in families, but also the influences on developing individuals by different events and contexts as they grow and mature. The origins of addictions and substance abuse may be in genetics, or in psychosocial experiences in infancy, childhood, and adolescence. The adolescent research that is reviewed in this chapter, gives detailed examples of developmental pathways pertinent to people in the addiction cycle of substance abuse. During this time in an individuals development many changes are taking place and for many caught in the addiction cycle, this is when maladaptive behavioural and substance abuse patterns begin to make their presence felt. To incorporate research on adolescence is to keep perspective of the developmental process which is not often replicated in adult studies.

Substance use and abuse

During the literature search the prime focus was on finding articles that examined multi-risk factors relating to substance abuse and exploring the individual within an environmental context using a developmental model, a difficult task. An important question was whether there had been any research done using attachment theory and in particular looking at the interfamilial relationships and interactions. It was discovered that there is very little available and, as yet, none published in New Zealand. The research to date has been primarily epidemiological, with large samples, and quantitative sources of data. There seems to be no qualitative, narrative type studies that give us the real human experience. Studies in the last decade have focussed on associations between behaviour and substance use, to identify predictors (Derzon & Lipsey, 1999), frequency of use (Lewinsohn, Rohde & Seeley, 1996), quantity consumed (Rogers, Speraw & Ozbek, 1995), access to alcohol (Casswell & Zhang, 1997), types of substances used, and the consequences of that use (Fergusson, Lynskey & Horwood, 1996). Family and peer

influences (Duncan, Tildesley, Duncan & Hops, 1995; Fergusson, Lynskey & Horwood, 1995; Hoffmann & Su, 1998) are acknowledged as being significant in adolescent behaviour, as are comorbidity of substance abuse and depression or depressive symptoms and other mental disorders (Escobedo, Reddy & Giovino, 1998; Fergusson & Horwood, 1997; Fergusson, Woodward & Horwood, 1998; Henry, Feehan, McGee, Stanton, Moffitt & Silva, 1993; Krueger, Caspi, Moffitt, Silva & McGee, 1996; Miller-Johnson, Lochman, Coie, Terry & Hyman, 1998).

The prevalence and risk factors associated with consumption of substances has also been explored in the longitudinal study in Christchurch, New Zealand (Fergusson, Horwood & Lynskey, 1995). One of the aims of this study is to develop a tentative developmental model to suggest the major processes and pathways by which a series of family, individual and related factors combine to influence risks of substance abuse. Fergusson and Lynskey (1998) acknowledge that issues relating to the relationships between early behavioural adjustment and long-term outcomes requires further research and clarification, and that there was evidence of strong continuity in behaviour between childhood and adulthood. Lynskey and Fergusson (1995) suggest that early externalising behaviours have highly specific associations with later developmental outcomes, and that prevention programmes need to be embedded in a developmental approach. Krueger et al. (1996) suggest that comorbidity with other psychopathology needs further examination, while Henry et al. (1993) propose assessment of co-occurrence of conduct problems, for example, depressive symptoms and substance abuse should be incorporated as an integral part in developing programmes and for understanding causality. Also further research is required to examine how reciprocal relationships unfold over time (Hoffmann & Su, 1998; Han, McGue & Iacono, 1999), which brings us to attachment theory.

Antecedents identified in the emerging literature on substance abuse are what one would expect to find when identifying insecure attachment types, therefore inviting research exploring attachment issues. Some of the antecedents often mentioned previously in the literature have been associated with insecure attachment: lack of competence in peer relationships, presence of internalising behaviour problems such as depression and anxiety, and the presence of externalising and delinquent behaviours (Allen, Moore, Kuperminc & Bell, 1998; Cooper, Shaver & Collins, 1998; Leadbeater, Kuperminc, Blatt & Hertzog,

1999), emotional availability of parents (Biringen, 2000), parent/adolescent conflict (Caffery, 2000), parental separation (Woodward, Fergusson, & Belsky, 2000), affect regulation (Kobak & Sceery, 1988), family coping strategies (Harvey & Byrd, 2000), conduct disorders and teenage pregnancy (Zoccolillo, Meyers & Assiter, 1997), suicidal ideation, exposure to physical and sexual abuse and family dysfunction (Fergusson, Woodward & Horwood, 2000) and stressful life events (Hoffmann, Cerbone & Su, 2000). Bearing in mind that substance abuse/addiction and insecure attachment share many of the same antecedents leads us to the integrative approach.

Hofler and Kooyman (1996) advocate an integrative approach based on attachment theory for therapeutic intervention and subsequent programmes on addiction. This is based on their view that in light of attachment theory and research outlines, the concept that addiction is a delayed maladaptive attachment transition in young adults. They ask four questions:

1) Does attachment also play a role in adult life?
2) What role does it play for those whose attachment needs have still been unmet?
3) Can addiction be understood as a dysfunctional attachment transition?
4) Does this theoretical framework have implications for addiction therapy?

> Addiction can be understood, on the background of the concepts of attachment theory and research, as a shift of the painful urge for physical closeness toward a 'neutral object', the drug, which is cast to serve as a 'secure base'. The addicted person thus becomes able to withdraw from close relationships and intimacy. Pharmacological action of the drug enhances the shift toward a compulsive behaviour, both serving as relief from long-known discomfort or painful experience. (Hofler & Kooyman, 1996, p.518).

Why is attachment important at this stage of our developing theory on substance abuse? How do we 'get to the bottom of it'? By using attachment theory we can identify in what way people relate to others, and whether or not they have likely sustained some form of trauma early in life. There is the question of whether some are genetically predisposed to alcoholism and other drug addiction, and that an early trauma is part of the process of developing this, along with transgenerational transmission of dysfunctional type behaviours (Han et al., 1999). The findings of Han et al. (1999) add to the growing

behavioural-genetic literature that substance abuse is influenced primarily by environmental rather than genetic factors. This includes the experiences of neglect, abuse and loss which have been key concepts in attachment theory (Bowlby,1995) and found in research carried out by others (Wekerle & Wolfe, 1998). This leads us closer to the work being done on the biological model where Schore (2000) suggests that we need to return to the integration of the psychological and biological underpinnings of attachment theory. By understanding how neurobiology mediates affect regulation, more effective treatment and prevention will be possible. One could postulate that most, if not all, people in substance use and abuse are clinically depressed, or suffering from chronic posttraumatic stress disorder (Deykin & Buka, 1997) as most will present with comorbidity in varying combinations (Giaconia, Reinherz, Hauf, Paradis, Wasserman & Langhammer, 2000). Attachment research and the understanding of attachment issues is useful to bring us closer to the understanding of the biological as well as the psychosocial factors in substance abuse. The whole area of dysfunctional behaviour may not be learned, but may be due to either insufficient, or an over-abundance of certain neurotransmitters. By examining attachment behaviours, and moving away from the external blaming explanations, we will gain deeper insights into the Internal Working Model, proposed by attachment theory (Bowlby, 1982), and how we relate to one another, especially close family relationships and issues of intimacy.

Attachment

Attachment theory, developed by Bowlby (1982), holds the ethological view that early human behaviour is a set of innate responses to ensure survival, responses designed to elicit reciprocal responses from caregivers. It is also an ecological theory holding that development occurs through the interaction of innate and experiential factors. Based on the early relationships with parents, children develop an Internal Working Model (IWM) of relationships and this IWM tends to persist and to effect later relationships. Bowlby (1988) and Ainsworth, Blehar, Waters and Wall (1978) in their studies on attachment/separation believed that children's attachment to their parents is another way of conceptualising the condition of trust in their parent's reliability.

Ainsworth et al. (1978) went on to develop the Strange Situation as a measure of attachment relationships of a child and caregiver. The Strange Situation is a series of

several episodes used by Ainsworth and others in studies of attachment. In a laboratory setting the child, between the age of 12 and 18 months, is observed with the mother, then with the mother and a stranger, alone with the stranger, and then completely alone for a few minutes, reunited with mother, then left alone again, reunited with the stranger and then the mother. Ainsworth showed how children's reactions can be classified into three types, with the fourth classification coming later (Main & Solomon, 1990). The four types are Securely Attached, Insecure/Avoidant, Insecure/Ambivalent, and Insecure/Disorganised/Disoriented.

Much of the attachment literature is focussed on infants and young children, and their interactions with their mothers. To take the research to older age groups, Main and others (George, Kaplan & Main, 1996) went on to develop the Adult Attachment Interview (AAI). The interviews, once classified, fall into one of five categories:

1) Autonomous/Secure - talk coherently about their memories and assess them accurately.

2) Insecure/ Dismissing - unable to remember attachment related experiences or contradict themselves, but can remember other childhood experiences.

3) Insecure/Preoccupied - seem to be obsessed with attachment memories, can be confused, angry or passive.

4) Unresolved/Disorganised - suffered childhood loss, abuse or other trauma that was not emotionally resolved.

5) Cannot Classify - either fails to fit other categories or shifts unpredictably during interview.

Because the AAI provides rich detail of life experiences especially of early relationships and displays the person's state of mind with regard to relationships, research using the AAI was perceived as being particularly pertinent to the investigation of attachment issues that may be involved in substance abuse. The focus for the literature search was therefore on studies using the AAI.

The AAI is a structured, semi-clinical interview focussing upon childhood experiences and their effects. It collects information about life events that are meaningful to the speaker in a form that can be recorded and transcribed so that the nature of the discourse can be examined and interpretations made. In recent years, the use of the AAI in research could be demonstrating a shift by some researchers to examining developmental models that encompass the life-time of an individual. Benoit and Parker

(1994) studied the stability and transmission of attachment across three generations in a longitudinal study of infants, mothers, and maternal grandmothers, with the findings suggesting that states of mind with respect to attachment are very stable during adulthood, and that internal working models of attachment tend to be perpetuated across generations as suggested by Bowlby (1982). Ward and Carlson (1995) demonstrated that pregnant adolescents' discourse about attachment predicts later care-giving as well as the later organisation of their infants' attachment behaviour. In a meta-analysis of 33 studies using the AAI, the clinical component of this large sample was found to have a strong overrepresentation of insecure attachment representations (van IJzendoorn & Bakermans-Kranenburg, 1996), with instability strongly related to major negative life events such as parental loss, abuse, or serious illness (Waters, Merrick, Albershiem & Treboux, 1995). Kobak and Sceery (1988) used the AAI to examine the coherence of attachment organisation during late adolescence and showed attachment organisation to be associated in theoretically coherent ways with peer ratings of affect regulation and representations of self and others.

> [Many who] adopt attachment theory believe that both its structure and its relation to empirical data are now such that its usefulness can be tested systematically... In the field of psychopathology it can be used to frame specific hypotheses which relate different forms of psychotic disorder...attachment theory may prove useful as one component within the larger corpus of psychiatric science. (Bowlby, 1995, p.159).

When considering psychopathology, Rosenstein and Horowitz (1996) found support for the model of development of psychopathology based partially on relational experiences with parents. "What is salient about attachment in this process is the very early onset of deviation from the normal developmental pathway, making for sensitivity to the imposition of other risk factors"(p. 250). Carlson (1998) in her prospective longitudinal study of attachment disorganisation/disorientation highlights the complex nature of relations among factors and processes interacting over time. In a more recent study Allanson and Astbury (2001) suggest that links between insecure attachment, maternal ambivalence, and trauma/violence may be pursued via a collaboration of attachment and posttraumatic stress frameworks. This takes us into the area of comorbidity mentioned later in this writing.

On examination of the instruments that are available to measure attachment types, the AAI seems the most appropriate to use with those in treatment for substance abuse. This interview probes for general descriptions of childhood relationships with parents and other significant care givers, specific incidences or memories to support these, perceptions of current relationships with parents, and projections for future relationships regarding the next generation. Participants have the opportunity to talk about emotions, separation, traumatic events, loss by death of important people in their lives, as well as their perceptions of the effect these happenings have had on their lives. They are also asked for their perceptions of why their parents behaved the way they did, and, how the relationship with their parents changed over time (George et al., 1996). Coding is done from the transcript of the interview. Although the content is important, the coding and classification depend on the coherence of the discourse, whether subjects contradict themselves or not, whether their discourse is succinct, and yet complete, whether they keep to the point, and whether they present the information in a clear and orderly way (Main & Goldwyn, 1994).

Adolescence is often when the first behaviours appear that can indicate an individual is prone to substance abuse. Adolescence can be a turbulent time especially for those with attachment issues, with adjustment and externalising behaviours demonstrating a clear pathway of dysfunctional behaviours (Fergusson & Horwood, 1998; Fergusson & Lynskey, 1998). The degree of family dysfunction is more predictive of adult adjustment than whether the dysfunction involves alcohol abuse (Hadley, Holloway & Mallinckrodt, 1993).

Active research programmes over recent years have made strong links between attachment organisation and adolescent psychopathology. The findings in attachment research reflect a substantial and enduring connection between attachment organisation and severe adolescent psychopathology (Bowlby, 1988). The studies by Allen, Hauser and Borman-Spurrell (1996), Rosenstein and Horowitz (1996), and Allen et al. (1998), were linked to a wide array of indices of psychosocial functioning. The findings are consistent with developmental pathways perspective of processes that unfold over time, a complex mix of social and psychological factors that impinge on the individual. There are multiple pathways that any individual can take, similar to that of a city road map, with deviations from the main path. Therefore an individual may pursue the deviation or deflect back

towards more normal adaptation or more typical pathway. The longer the deviation is maintained the less likely a return to centrality and positive functioning (Fergusson & Horwood, 1998; Fergusson & Lynskey, 1998; Sroufe, Carlson, Levy & Egeland, 1999).

International research to date on attachment and substance abuse is minimal, however graduate dissertations on the subject are growing in number. At present there is no accessible attachment literature, in particular attachment research, available on New Zealand studies into attachment theory and issues. It has been assumed that the attachment research in New Zealand will produce similar results to that in other English speaking countries. This however needs to be tested empirically. One could argue that attachment theory is in its infancy in New Zealand and as yet has not attracted a large enough following to generate the required research. Whether this lack of support for attachment theory is due to cultural differences or geographical isolation, research into attachment issues and their relevance to substance abuse would give an understanding of possible early pathways leading to substance abuse issues later in life.

Ego Development

Ego development as perceived by Loevinger (1987) involves cognitive, character, self, moral and interpersonal development. It is how people perceive themselves, their frames of reference. Primarily, the ego as described in Loevinger's ego development theory, is about how the self relates to social reality and this incorporates characteristics of personality, individuality, methods of facing problems, opinions about oneself and the problems of life, and the whole attitude towards life. Loevinger developed a sentence completion test, the Washington University Sentence Completion Test (SCT), a set of 36 sentence stems, which would, after coding, demonstrate the different levels of cognitive functioning in ego development. By using the SCT it is possible to ascertain the level of thinking of the participant. There are eight to ten stages, with three typical manifestations in each stage (Hy & Loevinger, 1996). The eight stages that relate to the majority of the population, in order are, Impulsive, Self-Protective, Conformist, Self Aware, Conscientious, Individualistic, Autonomous, and Integrated. Within each of these stages are defined three typical manifestations: impulse control, interpersonal mode, and conscious preoccupations. A more comprehensive description of these eight stages can be found in Appendix Six.

In theory a person progresses through successive stages during their ego development. Ninety nine percent of the population are rated on a continuum between the impulsive and autonomous stages. Impulsive people are usually children who understand their world in terms of physical needs, and are dependent on others for controls. On the other hand, towards the other end of the continuum, an Autonomous person has an understanding of the inevitable interdependence of human beings, and is seeking self-fulfilment. A large proportion of the adult population has been rated at the Self-Aware stage, previously labelled Conscientious-Conformist, where one is "beginning to differentiate one's real self and ideal self. Interpersonal relations are seen not only as actions but also in terms of feelings"...,the Conscientious-conformist sees 'problems', implying that there are reasons....., [and one's] inner life is described in more varied terms, but still with emphasis on self-consciousness, loneliness, and similar feelings of being apart from the group" (Loevinger, 1987, p.228).

The SCT is a way of understanding where a person is in their understanding of self, and of how they relate to and understand others. Loevinger (1987) reported that the SCT has been applied to

> clinical studies, educational intervention studies, and cross-cultural studies. The kinds of questions to which the method is pertinent include: Are some ego levels prone to particular kinds of pathology? Are some ego levels particularly appropriate for certain kinds of psychotherapy? Do chronic childhood diseases retard normal ego growth? What kinds of high school or college courses or curricula promote ego growth? What is the normal course of development for men and for women? Do some cultures promote or retard ego growth for some elements of the population? (Loevinger,1987, p.232).

Research shows that Loevinger's Ego Development Model is useful for understanding psychopathology (Noam, Hauser, Santostefano, Garrison, Jacobson, Powers & Mead, 1984), with a study by Frank and Quinlan (1976) on ego development and delinquent girls supporting the validity of the SCT at the lower stages. More recently, a study of ego development, self-perception, and self-complexity in adolescent female psychiatric inpatients revealed that developmental theory and research may contribute to clinical intervention strategies (Evans, Brody & Noam, 2001). It may be that a particular

ego level may predispose a person to develop a particular disorder but it is more likely to be a combinations of factors so that therapists need to be responsive to the client's developmental level in the selection and application in the therapeutic procedure (Westenberg, Siebelink, Warmenhoven & Treffers, 1999). Correlations have been demonstrated with conformity, delinquency, and antisocial behaviour (Westenberg, Blasi & Cohn, 1998), which would lead one to surmise that the SCT could be used with effect in the area of substance abuse and specifically as a therapeutic tool.

Ego development level remains stable in adulthood unless challenged. "When there are substantial changes in experience, the individual's frame of reference needs to change; accommodative effort is desirable" (Helson & Roberts, 1994, p. 918). Therefore ego level can change if there is receptivity, commitment, and life experiences great enough to require adaptation. How life experiences are perceived and responded to is influenced by psychological factors which include verbal aptitude, psychological mindedness, defence mechanisms, and cognitive development (Manners & Durkin, 2000). Newman, Tellegen and Bouchard (1998) in their study of twins reared apart were interested in whether adults' ego development level differed because of heredity or because of variations in experience. They found that heredity contributes around fifty percent with the remaining half due to life experience.

Research being conducted at present is becoming interdisciplinary, drawing the threads of different theories together, realising that many are closely related and interact with one another. There is often an overlap in closely related areas of study where assumptions are made about causes where, for example, substance abuse is present in addition to other disorders. Comorbidity of differing disorders is becoming more obvious to researchers as results from the different disciplines are publicised.

Comorbidity

Research into substance abuse is complicated by its frequently being associated with other disorders. The term comorbidity is used for two or more psychiatric disorders that exist at the same time within the individual. Comorbidity has been noted in substance abuse, attachment, and ego development literature but also in areas of closely related study, for example, Personality Disorders, Post Traumatic Stress Disorder (PTSD) (Horowitz,

1999), Depression, Attachment, to mention but a few. Many studies done on PTSD for instance, concentrate on the trauma and the biological ramifications of that, while attachment studies concentrate primarily on how that trauma came to be. The trauma generally is a result of loss, abuse, and abandonment (Bowlby, 1995). Both attachment and psychoneurobiological theories have developed therapies that access the trauma. The work being done in neuroscience is now giving us the biological understanding of attachment (Schore, 2000; van der Kolk et al.,1996a). There are those theorists who explore survival strategies (Valent,1998), dissociation, affect dysregulation and somatization (Horowitz, 1999; van der Kolk et al.,1996a), and neurobiology of adaptation and how states become traits (Perry, Pollard, Blakley, Baker & Vigilante,1996), all being closely related to one another and studying the same sets of criteria to varying degrees. It can be argued that these disorders all have loss, abuse, and abandonment in their etiology.

If we look at dissociation, somatization and affect dysregulation, for example (van der Kolk, Pekovitz, Roth, Mandel, McFarlane & Herman, 1996b), it is evident that these three problems are an integral part of the disorders mentioned above. They are ways in which the individual adapts to their environment when having first experienced trauma to some degree or other. "Childhood trauma has a profound impact on the emotional, behavioural, cognitive, social and physical functioning of children. Developmental experiences determine the organizational and functional status of the mature brain" (Perry et al.,1996, p.2).

Comorbidity is apparent in the examples given of the different areas of study mentioned such as Personality Disorders, Post Traumatic Stress Disorder, Substance Abuse, and Reactive Attachment Disorder. The SCT could be another instrument in helping those who engage in the various areas of study to draw their data together to gain a more in-depth understanding of human development.

Summary

According to John Bowlby (1995), the father of attachment theory, substance use and abuse, along with other emotional disorders and behavioural problems, stems from an insecure attachment early in a person's life. Research findings (cited in Allen et al., 1996) suggest that insecure attachment can be linked to difficulties in childhood and adolescence

ranging from depression to severe behavioural problems. Several studies on attachment (cited in Cooper, Shaver & Collins, 1998) gives support to the hypothesis that attachment styles are related to drug and alcohol abuse, promiscuity, delinquency, educational underachievement, and risky or problematic behaviours including social involvement and adjustment. Also studies that focus on the developmental pathways to young adult drug behaviour (Brook, Whiteman & Finch, 1993; Brook, Whiteman, Finch & Cohen, 1998) demonstrate that childhood aggression may effect adolescent drug use through the stability of the parent-child mutual attachment relationship.

A further eight articles were reviewed that related to adolescence and attachment (Beckwith, Cohen & Hamilton, 1999; Carlson, 1998; Cooper, Shaver & Collins, 1998; del Carmen & Huffman, 1996; Larose & Boivin, 1997; Lieberman, Doyle & Markiewicz, 1999), with only two of these investigating adolescent attachment using the AAI (Allen et al., 1996; Allen et al., 1998). Much of the attachment research has only recently been reported, in the years since 1996. Participants in longitudinal studies of attachment have barely reached adulthood (Allen & Land, 1999). There is reference to the continuity of attachment since infancy to age 19 (Main,1997), and age 21 (Waters et al., 1995). Internationally attachment theory is gaining recognition with a surge in publications, especially dissertations, in 1999 and 2000. There were no articles found relating specifically to ego development and substance use/addictions.

To date there is no published New Zealand research using attachment theory or ego development theory with psychopathologies of any sort, let alone specifically in relation to substance use and abuse.

Implications for Treatment and Therapy

A developmental approach is necessary in the structuring of treatment programmes that will tend to the individual needs. There needs to be consideration for the interactions of a lifetime within the client's environment, whether it be cohort, family, culture, physical, spiritual or psychological. Therefore this holistic view in delivery of mental health and allied services requires interdisciplinary co-operation.

Already in New Zealand services cater to the many aspects of the individual when they are faced with mental health issues, although our service delivery could be taken

further. Farmer & Farmer (2001) identify three distinct approaches to care especially in relation to emotional and behavioural problems, such as those characteristic of people in treatment for substance abuse issues:

1) developmental science - holistic interdisciplinary study of individual development across the life span.
2) systems of care - service delivery structures.
3) preventative models.

Farmer and Farmer (2001) promote the idea of developmental science, an emerging discipline (Cairns, 2000; Magnusson, 2000), located at the interface of developmental psychology, developmental biology, molecular biology, physiology, neuropsychology, social psychology, sociology, anthropology, and neighbouring disciplines. "Individual functioning and adaptation can only be understood by considering how internal (e.g., cognitive, emotional, endocrine, morphological, neurobiological, perceptual, physiological) and external (e.g., family, peer group, neighbourhood, culture) subsystems work together to contribute to development" (Farmer & Farmer, 2001, p.172).

'Systems of care' is based on the United States model of a government assisted community system of care consisting of multi-agency service delivery structures that provide coordinated and comprehensive interventions to clients and their families. These systems should be responsive and individualised to the particular needs of the client, with full participation of the family, and include service coordination across participating agencies, with the emphasis on early identification and intervention. Farmer and Farmer (2001) point out that this is a mammoth undertaking but in time is possible, desirable and cost effective.

'Prevention models' emphasise the need "to reduce the incidence and recurrence of mental and behavioural problems by identifying specific antecedents of later mental problems or health, and targeting them to inhibit or enhance their influence on the life-course" (Farmer & Farmer, 2001, p.176). Risk factors contributing to the development of emotional and behavioural problems for the individual are identified as family processes, which include attachment relationship difficulties, psychobiological factors and problem peer relations, with a raft of others pertaining to the wider community and cultural contexts.

Therefore it can be argued that an integrated approach to prevention, intervention

where required, and the promotion of well-ness within the whole family, would eventually reduce the number of persons developing full blown mental disorders and maladaptive behaviours.

As has already been discussed substance abuse disorders and psychiatric comorbidity are prevalent with the individuals seeking treatment for substance use and abuse. Depression, posttraumatic stress disorder and anxiety for instance are acknowledged, but the impact of coexisting disorders on the course and outcome of addiction treatment still requires clarification, and in particular in relation to relapse of substance use (Charney, Paraherakis, Negrete & Gill, 1998; Oei & Loveday, 1997; Sharkansky, Pierce, Meehan, Brief & Mannix, 1999).

The use of the AAI may provide information about conditions in a person's life which may have occurred prior to the development of the psychopathologies. Therefore the use of attachment theory will generate a better understanding of how these comorbid conditions are laid down during development and tailor treatment and intervention programmes to suit. John Bowlby (cited in Pottharst, 1990) had this to say:

> Strong support is thus given to hypotheses that see a broad range of emotional and social disturbances of adult life as being due to personality during development having deviated from a healthy developmental pathway as a result of individuals having been exposed to certain specific aversive events and situations during childhood and adolescence, and having thence-forward taken one or another pathological direction. The pathogenic roles of long separation from, and loss of, parents without good substitute care, now widely recognised, are amply confirmed. It is of special interest, moreover, that amongst the variety of adverse childhood experiences that these studies show frequently to be associated with pathology, and almost certainly to be playing a causal role, are several that until very recently have been woefully neglected by psychiatrists and psychotherapists. These include both physical and sexual abuse as well as frequent threats to abandon a child as a means of exercising control. The conclusion emerging from these studies.....that particular types of disturbance are probably caused by specific combinations of adverse childhood experiences adds greatly to our knowledge. (John Bowlby, foreword).

Bowlby gives us many insights into the origin of psychopathology. It can be argued that pathologies are the symptoms of past episodes in early life, where the original trauma has halted the expected path of development, and has deviated onto another, presenting often in later years as a diagnosable pathological condition. In a recent study by Schore (2000), support is given to Bowlby's attachment theory from the field of neuroscience. Schore (2000) mounts a convincing array of evidence supporting Bowlby's assertions that attachment is instinctive behaviour with a biological function.

With regard to using attachment theory to structure therapies, evidence has accumulated that some individuals have been able to create a coherent working model of the self despite a history of negative attachment experiences (van IJzendoorn & Bakermans-Kranenburg, 1997; West,1997), with some having integrated very difficult experiences demonstrating that change can occur in the years of maturity (Sroufe et al., 1999).

Support for integrating a developmental perspective into the understanding of clinical disorders (del Carmen & Huffman, 1996), and therapies based on cognitive restructuring and therapeutic holding generate discussion on an intervention technique based on attachment theory with an example given by Howe and Fearnley (1999). This particular article is based on therapeutic practice used at the Keys Attachment Centre, Rossendale, Lancashire where treatment of children and their families is their specialty. Therapy within the holding environment, a safe, secure place where emotions can be explored, has to match relationship experiences, the intensity of the negative emotional conditions that the child experienced in the relationship with the abusive parent, if the person is to become 'unstuck'. This is a reworking of the attachment process, going back to where it was traumatically interrupted and then approximating a healthy attachment (Keck & Kupecky, 1995), tracing developmental pathways. This same process, in a similar environment that is culturally appropriate for the individual, can be created for adolescents and adults in order to rework their attachment process. There is also a need here to understand how these behaviours are passed from one generation to the next.

Intergenerational transmission of attachment behaviours (Benoit & Parker, 1994; van IJzendoorn & Bakermans-Kranenburg, 1997) is an integral part of the attachment process, with many articles, especially in relation to substance abuse, delving into this area of familial interaction. If attachment theory is used to understand these interactions, a much

clearer picture would be made available, and we would have a clearer understanding of the continuation of dysfunctional behaviours over time, and the forces that come into play within the family when an individual begins to make changes. Byng-Hall (2000) in his practice of family therapy finds Bowlby's concept of developmental pathways for attachment useful. "The pathway towards establishing a secure attachment may stray off course in emotionally deprived situations, but it can be brought back onto a more secure pathway by adding the missing components at a later date. This concept can be helpful as a frame of reference for thinking about the family development that has become very diverse....."(p. 265).

Caffery (2000) has developed a model for use in parent-adolescent conflict using attachment theory and argues the key to success is understanding family dynamics. There needs to be flexibility between the behavioural and the affective realms, with a thorough understanding of the entire context in which the problem behaviours are embedded. "Hence, the conflictual patterns that exist between individual family members, and throughout the entire family, can be addressed through behavioural as well as through affective interventions"(p. 22).

Attachment theory is also now being used in residential programmes for troubled youth (Moore, Moretti & Holland, 1998; Moses, 2000) making a shift from the traditional contain and control methods of treatment, to reinforcement schedules to reduce undesired behaviour, an approach that begins with an appreciation of the youth's IWM of self and other.

Only two articles were found that specifically studied addiction and attachment theory for treatment. Hofler and Kooyman (1996) advocate the safe holding environment, a supportive social setting, where the struggling individual can begin to feel secure, where transference is encouraged within that environment, and where the therapist or the group implicitly take the role of parental substitutes, bearing in mind the responsibilities of that role. In this way an adult can develop reliable attachment bonds and reconnect again with human relationships. Ball and Legow (1996) use a two stage therapeutic technique with their clients. Early recovery focuses on achieving abstinence and establishing a secure base, moving on to facilitating exploration in later recovery. "Working through these issues in the therapeutic transition provides an excellent opportunity to examine the interpersonal and

emotional difficulties of addicted [clients]"(p. 533).

There is a need to know whether counsellors use attachment theory in their practice, whether they understand it, and whether they are interested in becoming more aware of it. Do we have the necessary tools? This brings the writer to investigate the therapeutic use of the AAI and SCT.

It is believed that the AAI is an instrument that can help the therapist uncover and identify the many layers of experience of the individual, and in particular with the addiction process, identify where the frozen way of thinking may have originated. In addition, it is proposed that the SCT might identify frozen ways of thinking, identifying the individual's integrative processes and overall frame of reference (Noam et al., 1984), which for the therapist, will give an indication as to how best to tailor a programme that will suit the individual in question. Each person presenting for treatment of substance abuse issues has known a different pathway and therefore must be treated bearing that in mind. These two instruments can be used for that purpose in a one-to-one situation to begin with, and later in group work. Not only is the individual given the chance to tell their story, but the ensuing therapy provides an opportunity to get closer to the source of the dysfunctional behaviour in a very personal way, encouraging the healing process.

Since the AAI is time consuming, requires transcribing and coding, and as the AAI is not required for use in every case, I would like to test the idea that the SCT may give an opportunity to show main issues of a person that are relevant to their addiction and treatment.

Research Questions

The specific aims of the study are to investigate:

1. Are there experiences of loss, abuse and abandonment in the lives of substance abuse clients?
2. What is the state of mind regarding childhood attachment of these clients?
3. What is the attachment type of each client?
4. Does the client's attachment type relate to theoretical descriptions, and attachment explanations?
5. What is the ego development level of each client?

6. How does the content area of responses to the AAI and the SCT assist the counsellor to understand the issues and areas of concern underlying the substance abuse of each client?
7. Do counsellors perceive this information to be useful to the clients in their recovery process?
8. What are the implications of attachment for therapy with substance abuse?
9. How does attachment theory relate to existing practices?

Chapter 3

Methodology

Aims

The aim of the present study is to investigate the value of two specific instruments and their underlying theoretical concepts in therapeutic interventions.

The questions being asked are:

- How does attachment type and cognitive status relate to people in treatment for substance abuse?
- Does the Adult Attachment Interview (AAI) and the Washington University Sentence Completion Test (SCT) reveal to counsellors important issues to be addressed in therapy?
- What do attachment theory and ego development theory contribute to an understanding of the life events which may be implicated in addiction and substance abuse?

Instruments

The AAI is an instrument that can uncover and identify the many layers of experience of the individual, and in particular with the addiction process, identify where the frozen way of thinking may have originated.

The Adult Attachment Interview (AAI: George, Kaplan & Main,1996) is described by the authors as follows:

> The Adult Attachment Interview is a structured, semi-clinical interview focussing upon early attachment experiences and their effects. [Participants] are asked for five adjectives to describe their relationship to each parent during childhood, and then for memories which support the choice of each adjective. They are asked whether they felt closer to one parent, and why; whether they had ever felt rejected during childhood; whether parents had been threatening with them in any way; why

parents may have behaved as they did during childhood; and how these experiences may have affected the development of their personality. In addition, they are asked about other loss experiences.....

(p.3).

The hour long interview is transcribed verbatim, and judges work exclusively from the discourse record. The transcript is submitted to an independent coder for attachment type classification. The use of this instrument is restricted to trained interviewers and must be coded by a trained coder.

The AAI is an in-depth interview that is designed to surprise the participant into talking about otherwise difficult, hard to access memories, or if these are inaccessible, then to give a descriptive account of feelings. By using this type of descriptive narrative methodology and analysis, we can uncover deep-seated, otherwise hidden, information. Also, by looking for what a person is unable to talk about, we may gain valuable clues as to what may be being avoided, which may also be indicative of attachment type. Careful analysis of the discourse gives the necessary insight into what is, or is not, being said, allowing us to draw a much more detailed picture of past events, trauma, and the like, and exposing the pathways of transgenerational transmission of expectations about how we relate to others, and what may be triggering the addictive type behaviours.

Washington University Sentence Completion Test (SCT: Loevinger, 1987).

The SCT is a projective, or free response test, consisting of 36 sentence stems (see Appendix Five), that can be answered using an exclamation mark, a word, a phrase, a sentence, or a paragraph. The objective is to obtain a reliable picture of the person's personality, using a comprehensive scoring system (Hy & Loevinger, 1996). Each response is assigned a score, followed by the algorithm for assigning the final ego stages, the descriptions of which are given in Appendix Six.

The SCT has sharpened and clarified approaches to the study of personality development. Unlike trait theorists, who believe that everything exists in some amount and that amount can be measured, cognitive developmentalists would say that everything in adult personality must have developed, and that the developmental course can be traced

(Loevinger,1987). This is precisely what the SCT can demonstrate, it can indicate where a person is in their ego development. This information may prove valuable to counsellors and therapists, possibly indicating whether or not there are particular areas where a client is either 'stuck' or has 'progressed' to. The SCT may identify frozen ways of thinking, identifying the individual's integrative processes and overall frames of reference.

Ethical considerations.

The study was approved by the Massey University Human Ethics Committee and the Manawatu-Whanganui Ethics Committee as meeting their requirements regarding justification for the project, recruitment and sensitive consideration of participants, informed consent, research procedures, and the handling and storage of materials.

Procedure

In the presence of the counsellor the AAI was given to the client followed by the SCT. The interviews were audiotaped, then transcribed and the coding was done for both AAI and SCT. A copy of the transcript and the questionnaire were returned to the counsellor and client. Later, each of the counsellors were interviewed. These interviews were transcribed and returned to the counsellor with further feedback, both written and oral.

Methods of analysis

Each transcript was read through and content analysis began with a tentative set of headings, for example, experience of separation, violence, loss, moves of house, and abandonment. These headings were added to until the list was finalised at 20 items as shown in Table 1. The AAI transcripts were coded by Sue Watson who is an approved reliable AAI coder trained by Professor David Pederson at the University of Western Ontario.

The SCT was scored by two coders, the researcher and the supervisor, using the coding manual (Hy & Loevinger, 1996; Loevinger, 1998).

Recruiting participants

The original proposal was to work with adolescent males. The counsellors in the service agencies advised that young males rarely persisted with treatment long enough to be suitable participants and advised the researcher to consider changing the design to include males and females of any age who would be more likely to wish to participate.

Recruiting was to be undertaken in two parts. Firstly, a drug and alcohol services agency would be approached by the researcher and the request made to work with counsellors, and their clients. Then the counsellors who agreed to participate would approach clients who they thought would benefit from the experience and not be at any added risk. They would inform these clients of the research and invite them to participate in the study.

Sample

For inclusion in the study, participants needed to be in treatment for substance abuse, invited by their counsellors to consider taking part and who have consented to take part. In practice this meant the counsellor did not suggest participation if he/she felt this would not be safe for the client. Clients with dual or multiple diagnoses other than depression and substance abuse, would not be eligible. In the end the sample was drawn from seven counsellors and ten clients. In the final study the sample is six counsellors, one of whom is Maori, and seven of their clients, in a New Zealand provincial city. Of the clients, five are Maori and two are European. The counsellors were experienced in alcohol and drug dependency issues and were working for an agency. The seven clients, two male and five female, were aged between 20 and 45 years in treatment for substance use and abuse.

Informed consent

All participants were provided with an information sheet (Appendices One and Two) explaining the study and the measures used. Before consent forms (Appendices Three and Four) were signed, all questions relating to the study were answered to the satisfaction of the counsellor and clients.

Handling and storage of materials.

In compliance with the Massey University Human Ethics Committee requirements, all tapes, transcripts, and sentence completion tests were kept in a locked cabinet. The tapes were transcribed by the researcher, and the sentence completion tests were read and scored by the researcher and the second coder, the project supervisor.

Participants interviewed were identified on transcripts only by code numbers, and a list matching those numbers with names was kept in another locked cabinet in a different room. No participant was identified other than by his/her code number in any written or spoken communication during this project. In the results chapter, participants are given a pseudonym.

Chapter 4

Results

The intentions of the author of this research were to investigate the value of the Adult Attachment Interview and the Sentence Completion Test and their underlying theoretical concepts in therapeutic interventions for addictions and substance abuse. In this chapter, a brief description of each client derived from the interviews is given, using pseudonyms, followed by a condensed table of the content of the AAI and the content analysis. Further results are organised under the research questions. Excerpts from the clients' transcripts demonstrate the richness of their content. Later, excerpts from the counsellors responses are presented, along with a summary of the results. The chapter concludes with a brief postscript of each client. The findings are organised in the order of the questions for the specific aims of the study, as set out at the end of the Literature Review, in Chapter 2.

Introducing the seven clients:

Jenny is a 44 year old Maori woman, articulate and intelligent with an engaging smile and soft voice. She was brought up in poverty, the second eldest of nine children. She lived her childhood in her place of birth before marrying and leaving home at 16. Jenny has been married twice and also has had another long term relationship. There are three children from her marriages, her two elder children living with their father and the youngest with her. When the two elder children were taken from her she never really recovered from the separation. In her mid adult years she had a nervous breakdown and has since self-medicated with drugs.

Throughout her entire life she has struggled to seek love, or feel loved by her mother, always trying to seek her approval. Her main preoccupation in life has been to seek approval, and the one night stands were a way of desperately seeking love which always seemed to escape her.

In further consultation with Jenny and her counsellor a deeper understanding of her healing process was gained. When Jenny began her recovery she had the determination and

the commitment to go back and explore her past hurts. Although she had done much work before she took part in this study, the AAI helped her come to the realisation that there were issues there that still needed her attention, especially unresolved grief. She has been as open and as honest as she is able in the therapy process and is now more stable emotionally than she has ever experienced in her life. She is dealing with issues of physical and sexual abuse that began when she was still in diapers, and is in the process of revisiting family members, going through the process of forgiveness, and the rebuilding of those relationships where possible. The most important relationship is the one she is now learning to have with herself. Her ability to share her emotions in a deep and uninhibited way has been inspirational for those in recovery with her.

Alison is a 37 year old Maori woman, with the body, appearance, and sometimes the behaviour of an adolescent. She will engage during sessions and then at the next meeting will avoid contact, appears tense and troubled, while apologising for being tired.

She is the eldest of five children. Although her mother had ten children in total, the other five were adopted out. The first eight years of her life were often spent in the care of other people while her mother went off. She has some vague memories of her father being around in those early days. When she was eight her mother settled with her stepfather. Her whole life has been a continuous series of physical and sexual abuse, abandonment and neglect, which she grew up to think of as normal.

Alison has never settled long in any relationship and has had five children, three of whom have been taken by the authorities, the remaining two were adopted. She has done several prison terms for burglary and assault. Alcohol and drugs for her were a way of dealing with the emotional pain she felt, especially after raging, violent outbursts.

Her recovery process has been difficult and chances of relapse are high. She has difficulty in understanding what her reflections of the past mean to her and is therefore unable to process them at a deep enough level to reach closure. Impulse control is poor although much improved, she is aware of it and is working on these issues. She now has access to her second youngest son, the only child that she ever felt a real bond with. She is also rebuilding a relationship with her mother, and for the first time in their lives they have been able to say to one another "I love you".

Alison's counsellor commented that Alison has had counselling on and off since she began her childbearing years, and also whilst in prison and that in this study, the AAI gave her the first chance to put the whole thing together, and it all tumbled out as fast as she could speak it. Evidently because this was a piece of research and not someone trying to 'fix' her, she allowed the process to flow, and allowed herself to feel the depth of some of that pain.

Rebecca is a 24 year old woman, very lively, who talked often without pauses and often forgot what she was talking about. She constantly rolled and smoked cigarettes which appeared to be a nervous response to the interview process. During the interview she cried a lot and it became apparent during the proceedings that she had a great deal of unresolved grief.

She had had what could be considered a stable home-life except for the fact that her parents worked their own business and spent very little time with Rebecca and her younger sibling. She had all the material things that a child could wish for, however she was constantly tense and worried, had trouble sleeping, and often threw tantrums, trashing her room, slamming doors, and the like. She mentioned sexual abuse at age 14 but this wasn't probed in the interview. She said that her parents were unapproachable if she had a problem that needed their attention. Her memory of childhood events was minimal. She left home at 15 and was pregnant at 16. She has had three children, each with a different father, and one of her children died a cot death. She has been in counselling to resolve grief, and she acknowledges that there is much more to do.

Rebecca has responded well to counselling and is continuing the process and realises it will be a long haul. She is more aware now of how her behaviour effects her children and is making an effort to 'break the cycle' of affectional neglect. She is now beginning to understand her parents and is having a much better relationship with them.

Jane is a softly spoken, friendly 27 year old Maori woman, shy and yet curious. She giggled a lot especially when she felt embarrassed or was trying to think about unpleasant situations regarding other family members. She had difficulty remembering things when she felt she was under pressure, and this happened when she couldn't remember a specific

incident when she knew there must have been one. At times it was like a 'freeze' response.

Jane, the oldest of five children, had a close relationship with her mother and admits to being scared of her father. She had ongoing sexual abuse for most of her childhood by a family member and at 14 ran away from home, then was sent to a foster home. At present she has two children and is pregnant with the third. When her mother died in recent years she began drinking and drugging to cope with the emotional pain, reached rock bottom and sought help when her children were taken from her by the authorities.

In her recovery process she has done much to understand family dynamics, and has done a lot of grief work. She now has her children back with her permanently and she is learning more appropriate parenting skills. She has found that she can express her deep emotions by sketching and painting. She is a member of a women's support group in her neighbourhood, where they can support and understand one another as they work their recovery process.

Michael is a very lively, very sociable 43 year old Maori man, with bright, keen eyes and a dry sense of humour. Humour is one of his coping mechanisms. He is intelligent but has never had the opportunity to realise it. It comes across in his quick wit and his ability to accept and work new ideas and concepts once they have been explained in language that he understands. He has in effect halted in his emotional development at age 15 when his granny died. Although he lived much of his time with his family, his grandparents adopted him, took care of his schooling, gave him the special attention he required and craved, and reprimanded the parents when they felt the need. His grandparents were the only people he felt connected to.

Michael is the eldest child of six and spent much of his childhood taking responsibility for the younger siblings and taking bashings from his parents. Both parents were heavy drinkers and gambled. He was given special attention by the elders as he was the first grandchild. The constant conflict with his father may have been in part because his father was jealous of this. The family moved around a lot, either being near the mother's family, and at other times near the father's family. From age 15 when his granny died Michael has spent more time in prison than out. He went into shock at the time of her death and has never resolved the grief he felt. During this study the AAI helped him realise this

grief and he acknowledges the need to go back and grieve and process these issues when he feels strong enough to do so. Until he can feel secure in his environment, and have the necessary support people available, he is not likely to begin that grieving process.

Michael has had one long term relationship and has three children and at present does not know where they are. He loves them deeply and understands why their mother wants to separate them from him, but until he can understand himself better he knows he can never be the father he believes he ultimately can be. At present he is concentrating on his abstinence and learning how to live life outside prison. In the past, institutions were the only places where he felt secure, where everything was taken care of. Interactions with people in the outside world were often difficult because of his anger problems.

Josie is a 38 year old Maori woman, attractive, friendly, articulate, and educated. She can be aggressive when challenged. She has been in recovery for nine years and has used the cognitive behavioural methodology to help restructure her life. She acknowledges that many emotions confuse her and positive emotions often scare or overwhelm her.

Her family situation is very complex. Josie is an identical twin born to a teenage mother. Her grandparents brought them up, along with their mother's younger siblings and their illegitimate offspring, therefore many people were always living in the house. The younger children took the brunt of these living conditions and were often subject to physical violence from the angry grandmother, and her own children who were still living at home. Resources were scarce. Both grandparents worked. The grandfather would get drunk and the grandmother would beat him on a regular basis. Violence was the norm.

Josie has two children and lives in a lesbian relationship. She has difficulty relating to her children especially when things occur that she has no personal experience of, for example, when her children are sick she becomes overwhelmed and does not know how to respond in an appropriate manner. Her counsellor has prepared her twice to go into a residential programme where emotions are explored. Each time she has been unable to make that final step. Her emotions frighten her.

In further discussion, Josie commented that in this study the AAI revealed to her once again, her need to become an emotionally whole person, and ultimately this is what she strives for. She also came to realise that she has unresolved grief from her childhood.

Her counsellor commented that this is probably the first time she has been able hear herself talk about many of her issues, all at the same time, and to see how they link together and how they are related to what goes on in her life today. Although she knew much of this 'stuff', it was the first time it had been put together in this way. As has been the case in the past she has taken a break from therapy and the counsellor feels the AAI could have disturbed a few deep-seated issues and that when she is ready she will come back to the therapy process to work them through.

John is a 34 year old male, small in stature with an infectious smile, a very helpful and thoughtful person, empathising readily with others and by doing so was seen as supportive by others in recovery with him. He acknowledges being an angry person and desperately wants to change. He said he has come to the time in his life where he is prepared to do whatever is necessary to make the changes required for a strong recovery.

John is the third child of four, and has always felt that he was not wanted, especially by his father. At a young age his family moved around a lot and he felt that he was unable to settle, having to leave his pets and being unable to grieve openly for them. His maternal grandfather died when he was four and from that day on his mother 'lost the plot'. She was overwhelmed by grief and had difficulty relating to others. At six John's parents divorced and his mother left. From that point onwards his emotions were all taken inward and only expressed outwardly as anger. He has memories of always being hungry and of constant beatings from his stepmother and father. His older brother of four years often coerced him into activities that frightened and traumatised him. In the early years his mother kept coming back into his life, and after a short period leaving again. Therefore, today, he has feelings of ambivalence towards her and now sees her as emotionally unstable. He describes his father as emotionally dead.

Due to past trauma he has no desire to ever go back home or to see his parents. In the last eight years he has done a residential programme, became involved in the church for awhile and been in prison. His anger was becoming less and less manageable. He married and divorced, and has three children whom he adores. His ultimate aim is to be the best father he can, to be able to give to his children what he never received from his parents. On other occasions when John has been observed with his children, his love for them is obvious and he shares his emotions with them openly and freely.

John has made huge gains in his understanding of himself and of how past events have helped shape the way things are for him. His counsellor has been able to walk him slowly back into his pain from whence he gained the insight necessary to let go and move forward without anger as a constant companion.

Content Analysis of AAI Transcripts

The outcome of the analytic procedure outlined in Chapter 2, is summarised in Table 1. The items in Table 1 (p. 35-38) have been taken from the AAI and the answers from the clients' transcripts. The answers in the AAI provide rich detail of life experiences especially of early relationships, and displays the person's state of mind with regard to relationships. These answers have been condensed using the clients' own words where possible to illustrate the answers given.

1. **Relationship with parents:** Only one person reported having a mother who 'was there'. Another lost his mother at age six. Two were adopted by grandparents. In all cases there was no available father figure.

1a. **Perceived attachment**: All had difficult attachments. The attachment literature cautions against using the word 'unattached' since infants become insecurely attached to even abusive and neglectful parents. 'Unattached' is a term that has been used for children reared in orphanages where there has been no regular and continuous caregiver with whom the child could form a relationship. However, in the case of Alison, although her mother was in her life, there was no one constantly in a relationship with her until she was eight years of age, hence her feeling of not being attached to anyone.

2. **Separations, earliest memories:** Separation is an event that all participants remember vividly. Four have early memories while three do not. These three, plus Alison, experienced very early trauma, prior to three years of age, and had difficulty in recalling early events.

3. **Ever held when hurt or ill:** Being held is an important human need. Failure to be held as an infant is now seen to be an abnormal condition for infant development. Four cannot remember ever being held, two remember being held by their mother but never by their father, and only one person remembers being held by both parents.

4. **Felt rejection as a child:** All seven felt rejected with one also feeling ignored.
5. **Frightened or worried as a child:** All were worried or frightened.
6. **Parents threatening:** Only one did not have threatening parent(s).
7. **Threats from others:** All had memories of threats from people other than parents.
8. **Silent treatment:** Four experienced silent treatment, one did not, and one felt ignored.
9. **Overall experiences affected adult personality:** Six felt their overall experiences had affected their adult personalities while one could not relate because he hadn't grown up.
10. **Unresolved grief:** Six are experiencing unresolved grief.
11. **Other traumatic experiences:** All have experienced traumatic events.
12. **Parents' behaviour (why they did it?):** All had some understanding of why their parents behaved the way they did.
13. **Close to any other adults:** All had another adult with whom they say they felt close. Four said they were close to their mother's sister. The word "close" in this context refers to their feeling some sense of comfort.
14. **How often the family moved house:** Two lived in their birthplace during their childhood, two had two moves at a young age and three moved around a lot.
15. **Sent to live with relatives or into foster care:** Six were sent to live with relatives or into foster care for varying lengths of time; only one did not.
16. **Who raised you?:** Two said their mother raised them, two their grandparents, one everybody and two with no one in particular.
17. **Father's occupation:** All fathers had full-time employment in trades
18. **Father's availability:** In all cases father was unavailable
19. **Emotional responses during childhood:** Emotional responses for all persons were inhibited in some way.
20. **Changes in relationships with parents over time:** Five have had positive changes in relationship with parents in adulthood and two have not.
21. **Current relationship with parents:** Two have no current relationship with parents. Five were aware of the satisfaction and dissatisfaction they experience in the relationship.

Table 1. Content analysis of AAI transcripts

	Item	Jenny	Alison	Rebecca	Jane	Michael	Josie	John
1	**relationship with parents**	father away, mother strict	mother unavailable	parents always working	mother there, father working	adopted by grandparents	grandmother domineering, grandfather quiet	father unavailable, mother for first six years only
1a	**percieved attachment**	wanting approval	not attached to anyone	unable to relate	scared of father	couldn't get close to parents	scared of grandmother	wanting of recognition
2	**seperations, earliest memory**	10-12 yrs	4 yrs	4 yrs	15 yrs	2-3 yrs	7 yrs	2 yrs
3	**ever held when hurt or ill**	once by mother, not by father	can't ever remember being held	don't remember ever being held	remembers being held	don't remember being held, tried but always pushed away	never held, cuddled or told I love you	mother when I was young, never by father
4	**felt rejection as a child**	yes, a constant	yes, all the time	yes, a constant, all the time	yes, but not all the time, felt ignored	yes, most of the time	yes, my biggest issue	yes, always
5	**frightened or worried as a child**	yes, of being abandoned & not being loved	yes, of being left alone or moved somhere else	yes, adolescence, stressed out, very nervous	yes, worried about sexual abuse being discovered	yes bedwetter till 9 yrs, of father's violent abuse	yes, too detached to remember what about	yes, fear of heights from an incident as a toddler
6	**parents threatening**	mother	both parents	no	both parents	both parents	grandmother on a daily basis & other older family members	father & stepmother

	Item	Jenny	Alison	Rebecca	Jane	Michael	Josie	John
7	**Threats from others**	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8	**silent treatment**	yes	?	ignored	no	yes	yes	yes
9	**overall experiences affected adult personality**	yes	yes	yes	yes	(yes) can't relate to it, never grew up	yes	yes
10	**unresolved grief**	yes	yes	yes	no	yes	yes	yes
11	**other traumatic experiences**	2 children taken away by husband, nervous breakdown	sexual abuse ongoing	possessive psychotic partner	sexual abuse, put into foster care, children taken away	watched someone die	family violence, where loaded firearms presented	being beaten constantly
12	**parents behaviour (why they did it)**	mother had horrific unstable childhood, resentful father, violent drinker	no idea, mother raised same way	parents didn't know any better, they did thier best	because of thier upbringing, they did their best at the time	dependent on each other, drunk all the time, didn't know what they were into	did the best they could, were wounded themselves, not being able to be themselves	father didn't have a father, mother lost the plot when her father died
13	**close to any other adults**	school teacher	auntie (mother's sister)	auntie	auntie, uncle (mother's) siblings)	grandparents	auntie (mother's sister)	grandmother, school teacher, friends' mothers during teens

	Item	Jenny	Alison	Rebecca	Jane	Michael	Josie	John
14	**how often the family moved house**	stayed in birthplace	moved around a lot	1-2 moves at young age	1-2 moves at young age	moved around a lot	stayed in birthplace	moved around a lot
15	**sent to live with relatives or into foster care**	yes	yes	no	yes	yes	yes	yes
16	**who raised you?**	mother	everybody	parents working	mother	grandmother	grandparents	myself
17	**father's occupation**	hunter & diver	farmer	mechanic	diesel mechanic	fisherman	freezing worker	fitter & turner
18	**father's availability**	away a lot	always working	always working	always working	went away a lot	unavailable	always working
19	**emotional responces during childhood**	find a place to hide & cry, not show emotions in front of anybody, accused of daydreaming a lot, go into head, go off on my own when older	pick on siblings, run away on horses, lots of missing memories, cried a lot, called a sook	get angry, throw tantrums, slam doors, throw things, yell, scream, no one ever came, always on my own	cover myself with blankets, push face into pillow, bash the animals and siblings	hide, then get a hiding when found, go to grandparents when feeling brave	not allowed to be upset, detached, wished a lot especially to be living with not so many people	when very young cry to mum until she left then got angry, parents stopped me from crying or grieving
20	**changes in relationship with parents over time**	put-downs not so frequent	can talk to stepfather now	left home at 15, pregnant at 16, father didn't speak for 3 years	not talking to dad for 3 years, ran away in teens	no	yes, began accepting grandmother	no

	Item	Jenny	Alison	Rebecca	Jane	Michael	Josie	John
21	**current relationship with with parents**	still scared of being rejected, difficult communicating	can't stand mother, no contact, learnt hard attitude from mother	close to father now he has more understanding, get on OK with mother	good relationship with father now, can understand him, have forgiven him, understand the trans generational behaviours	non-existant, doesn't know where his mother is or even if she's alive. No contact for 6 years	gratitude to grandparents, empathy & admiration, not as hurtful now. Mutual relationship with biological mother, no sharing of emotion, resentment, judgemental of mother	don't have one, not spoken to mother in 4 years, father emotionally dead, wished he hadn't been born
21a	**dissatisfaction in current relationship**	irritated by mother, mother seen as not helpful	supportive of others, but not of her or her sister, still no good communication	controlling mother	father a black & white thinker	*	remorse from grandmother's funeral, did not give her an apropriate farewell	*
21b	**satisfaction with relationship**	*	*	good financial support, can rely on father when needed	the relationship I have today	none	*	none

In the next section, data will be summarised under each of the research questions.

1. Are there experiences of loss, abuse, and abandonment in the lives of substance abuse clients?

All cases give specific incidences in the transcripts of loss, abuse and abandonment. **Jenny,** the second eldest of nine children experienced a strict upbringing with little physical contact with her mother apart from beatings. She felt she was constantly pushed away when trying to gain proximity to her mother. Sexual abuse began when she was a toddler. In later years her three children were taken from her by her husband, with only one returning to her care. She has experienced the death of her older sister and her father. Jenny has experiences of loss, abandonment, physical and sexual abuse.

Alison as the eldest of five children who remained initially with her mother, had the experience of other children being adopted out, and of the mother disappearing for a time. Under such circumstances there would have been multiple experiences of loss and abandonment. She experienced sexual abuse by her biological father when young, and later by cousins throughout her childhood. Physical abuse was frequent from both her mother and her stepfather. In adult years she has experienced the suicide of a brother, adopting out two of her own children, and having the remaining three taken from her and placed into care. She has also spent time in prison. In her life to date Alison has experienced loss, abandonment, physical and sexual abuse.

Rebecca is the eldest child of two. Both parents worked throughout her childhood and although she never wanted for material things, her parents were never available to her. She experienced sexual abuse at 14 years. In later years she had experienced the death of her infant son, the miscarriage of twins, and a partner with psychotic type behaviour. Rebecca has experienced loss, abandonment and sexual abuse.

Jane is the eldest child of five. She experienced threats from her mother to send her away and was beaten by her father. When young, she experienced sexual abuse from an uncle which continued through her childhood. Her relationship with her parental

grandparents consisted of sarcasm and derogation. In adolescence she ran away from home, and was put into foster care. In her young adult years her mother died and she had her children taken from her and placed into care. Jane experienced loss, abandonment, physical and sexual abuse.

Michael is the eldest child of seven, one of whom was stillborn. Although he lived with his parents his grandparents were also guardians offering some protection from the family violence. Beatings from both parents were frequent and he felt he was constantly pushed away by his mother when trying to gain proximity to her. In his adolescence he experienced the death of his grandmother, and as an adult, separation from his three children. He also witnessed another person dying, and has spent much of his adult life in prison. Michael has multiple experiences of loss, abandonment and physical abuse.

Josie is an illegitimate child brought up by her maternal grandparents. From an early age she experienced rejection by her biological mother and biological father, sexual abuse, and physical abuse from her grandmother and the older children. She was beaten for expressing emotions and was unable to get close to anyone in her very large family. When she was nine her grandfather died. In her adult years she has an ambivalent relationship with her biological mother and her grandmother has died. During her life Josie has experienced multiple abandonment, loss, sexual and physical abuse.

John, the fourth child of five, endured bullying by his older brothers. At age two his paternal grandfather died, at age four his maternal grandfather died, and at age six his parents divorced and his mother left. His stepmother beat him frequently, as did his father. Over the years his mother on several occasions has come back with promises to stay and then left again. In adult years he has divorced and has been separated from his children. John has multiple experiences of loss, abandonment and physical abuse.

2. What is the state of mind regarding childhood attachment of these clients?

Item 1a, Table 1 gives the perceived attachment of these clients. Jenny wanted approval from her mother, Alison did not feel attached to anyone, Rebecca felt she and her

parents were unable to relate, Jane was scared of her father, Michael felt he couldn't get close to his parents, Josie was scared of her grandmother, and John wanted recognition especially from his father. Overall they all have an unsatisfied yearning and an inability to relate to others.

3. What is the attachment type of each client?

Present state of mind regarding attachment is measured by the coding system of the AAI. The transcripts were coded according to the coding manual (George, Kaplan & Main, 1996) by a certified reliable coder. No certified second coder was available in New Zealand.

Jenny	U/CC
Alison	U/CC/Ds2/E2
Rebecca	U/Ds2
Jane	U/E3/F4b
Michael	CC/Ds2/E2/U
Josie	F4
John	U/E2

A classification of U (Unresolved) indicates that in a description of loss or abuse there was enough incoherence in the discourse to justify a score that signifies that this incident continues to disturb the person. A CC (Can't Code) classification means that there was a mixture of attachment strategies, indicating that the person had no coherent state of mind regarding attachment.

The interview transcripts have provided examples of particular states of mind regarding attachment, in particular where attachment style is given, such as Ds2: Dismissing, actively devaluing attachment, and E2: Preoccupied, angry, resentful, conflicted about caregiver's behaviour and own attempts to gain care. If both a clear Dismissing and a clear Preoccupied state of mind is present in the same person, it is considered that the person has a very disturbed attachment orientation, and most significantly, one which will make satisfactory interpersonal relations extremely unlikely.

One participant, Josie, is coded as F4. This means there is a strong valuing of relationships with some preoccupation about attachment figures probably connected to past

trauma, yet on the whole talking about it in a mature, reflective manner. Often a person coded F4 who has had a traumatic attachment history is called "earned secure" but in this case, it is unlikely that Josie can be called "secure" in any sense. Intellectually she has the potential to understand her problems but that does not mean she has yet achieved the impulse control and inner confidence necessary for her to be secure in herself as an adult should be.

Therefore, the discourse of all the participants in this study shows that they have difficulties with intimate relationships and that early problems with parents are still felt painfully today. See Appendix Six for further coding details.

4. Does the client's attachment type relate to theoretical descriptions, and attachment explanations?

Attachment theory suggests that an Internal Working Model (IWM) of relationships is formed in the first year of life, and is shaped by the experiences of being cared for.

Secure attachment in infancy is seen as a protective factor against disturbances in later life. Some disturbances caused by neglect or abuse in infancy are expected to predispose a person to later difficulties with relationships and further psychopathological problems. Support was given to the hypothesis that by using attachment theory we can identify in what way people relate to others, and whether or not they have sustained some form of trauma in early life. All these participants have had early experiences that attachment theory would associate with later relationship problems and with psychopathology. From these case studies came all of the antecedents and associated conditions mentioned in the literature review for both substance abuse and insecure attachment. An example from each transcript demonstrates how the clients responded to the question asked. For the purpose of illustration, a succinct and coherent example is chosen, not necessarily the most traumatic.

Jenny gave the adjective 'vicious' to describe her mother. She was then asked if she could give a particular incident to illustrate the use of that word. She was nine years old at the time. What follows is part of the answer.

I got a terrible, terrible beating off her, she just wouldn't stop hitting me, and she just kept going and going, and she belted me that bad I had, I remember I had, my legs were just covered in welts, some of them were bleeding, I remember that, and it was a plastic shoe and you could see the marks of the whole shoe on me, and she had to keep me home. I don't know how long I was kept away from school because those marks were really bad... [later in the same answer] *I remember being locked outside, pushed out the door and it was locked, being really, really scared because there was no path or anything, there was no light there, all long grass....and you're banging on the door because you want to go back inside and you're so scared....and today I have a fear of the dark, it seems so stupid.*

Alison was asked to try and describe her relationship with her parents as a young child.

I longed for my mother, at that age she kept going off all the time and we were left with different people but I really wanted mum but she wasn't there, um so I basically clung to my sister and brother, but there was, I never got attached to anybody at that age um just a lot of ugly...and [father] um he um he I, I, I sort of remember him but there's a lot of other stuff in there as well. [sexual abuse that came up later in the transcript]

Rebecca was asked to try and describe her relationship with her parents as a young child.

I just remember them being at work all the time, that's sort of I know mum was home for the first five or six years but I don't really remember, I sort of only remember from when she went back to work and then it was sort of we didn't very often see them...unavailable, I s'pose unavailable....both me and, my brother had whatever we wanted with money but we just didn't get any time.

Jane was asked to give a particular incident or a memory relating to her father, and the word 'anxious' that she had chosen to describe her relationship with him.

I think as far back as I can remember I've always been anxious around him, I always have been...not really anxiousness, it's just how I felt the majority of the time, I s'pose anxious when I knew that he was in a bad mood or something, yeah whatever, there

were heaps of times...um this is when I got older though, I think I was fourteen and mum and dad had a fight, and I hadn't eaten my breakfast, and then he came in, he said have you had any breakfast and I said, and I was anxious then, and I was like no, cause I knew what was gonna happen, then I got a hiding and then I wee'd my pants.

Michael was asked if he could remember any abusive behaviour that was immediately terrifying or traumatic, anything that he hadn't already mentioned. What follows are excerpts from his answer.

The old man give me a hiding one time with a poker, give me a bloody hiding with a poker...I went down to the, I had to go to the shop [he stopped to talk to his girlfriend on the way back]...and next minute the car came down the and it's the old man, we'd only been five minutes, actually it was longer, and the old man goes, get in the car, and as soon as I got in the car he gave me a bang, right in the mouth, I thought I told you there and get straight back, like the old lady was at housie or something, so he turns around and goes back up, we get back to the house, and we're walking in the front door and um...cause I cut my lip and is was bleeding but not dripping out, it was just bleeding, so ah we got out of the car, walked in the front door, he pushed the door open, and goes, go and put that stuff on the bench and get back here, so I walked down to put the shopping on the bench, turned around, when I looked around and stood back the old man was holding the poker, come here, I sort of stood there in the doorway I was freaking out man, I was just freaking out, come here, so I, you get used to getting a hiding, I just sort of walked up and ah whatever, and he turned me around and wack, he give me one across just the top half of my, not, just below the um my tail-bone and then I just felt my legs go down and I fell on the ground and he give me another one across the back of my legs, and one across my back, and by then I was crying so hard I couldn't breathe, and then he just picked me up, threw me on the bed, shut up and go to sleep, or shut up or ah, it's the thing if you don't shut up if you don't shut up I'll give you more of it...something like that anyway, but yeah, on the bed, slammed the door shut, and walked away, and I couldn't roll over or anything, I just sort of lay, I was laying sort of um, crouched but like in the foetal thing but couldn't lay like that either because it hurt so then I tried to stretch out it even hurt even worse, I was like a half crouch, half foetal thing and then I fell asleep crying, and woke up in the morning and had

these great big welts across my back and arse, and the back of my legs were all, yeah I couldn't go to school cause I couldn't walk, but that was just the old man being the old man...

Josie was asked to give a particular incident to do with her grandfather that would explain the adjective 'angry' that she had given.

I was really angry when he came home drunk, drunk cause I knew he was getting a hiding and I always wondered why he did that, why he would drink himself into oblivion and knowing damn well he's gonna get a hiding, like vicious hidings, yeah so I was always angry, how the hell he managed to why he kept doing that like that was quite confusing really... and I was angry when he died...yeah I was angry when he died, cause he just died.

John was asked what he did when he was upset as a child.

Up until mum left, go to mum...and I'd cry if something upset me off hand but when she left I didn't cry, after she left I would get angry, I didn't, I didn't like feeling any hurt or anything so I just got angry, I was angry all my life.

These questions produced answers describing severe physical violence, abandonment, neglect, loss, and the emotional reactions as anxiety, anger, and repressed emotion. The use of the AAI to elicit memories of early relationships that can be seen to be significant in shaping the person who has become a substance abuser will be discussed further in the next chapter.

5. What is the ego development level of each client?

The SCT responses were coded by two experienced coders using the manual (Hy & Loevinger, 1996). There was a high degree of agreement between coders. Where there was disagreement on an item, coding was agreed by discussion. The Ego levels assigned to each participant are as follows:

Jenny	E6	Conscientious
Alison	E5	Self-Aware
Rebecca	E7	Individualistic
Jane	E7	Individualistic

Michael	E5	Self-Aware
Josie	E7	Individualistic
John	E6	Conscientious

It was expected that the level of each might relate to the way of thinking that contributed to and maintained their addiction and behaviour. In particular, if people were classified as Impulsive, Self-protective or Conformist, it might be possible to describe how they were 'stuck' in the addictive behaviour. As it turned out, all the participants were well into the adult range of ego development, with two at E5 Self-aware, two at E6 Conscientious, and three at E7 Individualistic. Since median score for American adults was E5 (Hy & Leovinger, 1996), the high ego levels of this sample provide new potential explanations relevant to therapy with these adults. See Appendix Six for further explanations of levels of ego development.

The interpretation of the coding did not reveal the clients to be 'stuck', but on examining the individual answers, it became apparent there were signs of the areas in their lives where they had become 'stuck', with the most obvious ones issues of a sexual nature, and those relating to parenting roles. To demonstrate this an excerpt, in Table 2, has been extracted from the SCT coding form, complete with coding scores, for items 11 to 20, to illustrate how an issue can be identified.

Table 2. Example of SCT scores and answers

sex	age	ID	item	code1	code2	response
f	44	1	12	8a	8a	is someone who can understand their children & love them for what they are
f	44	1	13	6i	6i	say NO & be respected for that
f	44	1	14	6f	6f	can laugh & joke about it too but inside my stomach is churning
f	44	1	15	6j	6j	to be able to have time away from home, to be selfish to her wants once in a
f	44	1	16	5b	5b	for starving children & children who's parents don't give a damn
f	44	1	17	2a	2a	he has had sex
f	44	1	18	5e	5e	put in place for a reason
f	44	1	19	5d	5d	parents cared about their children
f	44	1	20	6b	6d	they don't have periods or have to carry a child for 9 months & are not as
f	44	1	21	5j	5j	are blatantly abnoxious

This example is from Jenny's questionnaire. Her response to question 17: A man feels good when.....is of a sexual nature, and when compared with her past tendency for one night stands with men, the coding suggests that she may be 'stuck' with that particular issue. The coding system assigns that sentence completion to the lowest ego level for adults - 2. That is a marked contrast to her items which score at 7 and 8 which are unusually high. So far the efficacy of the SCT to detect where a person is 'stuck' is suggestive but needs more calculated investigation.

6. How does the content area of responses to the AAI and the SCT assist the counsellor understand the issues and areas of concern, underlying the substance abuse of each client?

Attachment and ways of relating were familiar areas to the counsellors; therefore, the AAI was readily accepted as another tool for delving into past issues. What we needed to find out was whether the AAI revealed anything that would not or had not come up via their usual counselling methods. After the counsellors had received copies of their client's interview transcript and sentence completion forms, they were asked what they thought of the instruments in the therapeutic process. The responses from the counsellors were positive, relating in particular to the AAI's effectiveness in the process:

I felt it was very effective, it was definitely good for taking the client back to childhood and bringing up memories that had been forgotten, which triggered off issues that needed to be dealt with. (Counsellor 2)

The AAI got underneath the barriers put up by the client...breaking down the walls and actually allowing the emotions and the reality of what they were, become visible for him, the reality and the depth of them. (Counsellor 3)

Brought them [issues of concern] up in a succinct, ordered manner, discussing parenthood, childhood and related issues. (Counsellor 4)

They were asked whether the use of the AAI added to their understanding of the issues underlying the substance abuse of each client. The counsellors felt that it did uncover some issues but these might already have been apparent to the counsellors.

It gave me a better understanding as to how the client is feeling, the information

that was fed back, and if you really listen, you know I had a good read of the questions and how these questions come back, and I've also worked with them around that, and it's not clear for them, it's not spontaneous, it's something that is really, really searched for...this attachment theory process, it's part of them and they don't realise it, really realise what the intensity is until they were given the opportunity to be able to fully grasp hold of it. (Counsellor 6)

One counsellor was cautious about whether these revelations were necessarily desirable:

It stirred her emotions and it brought to the fore again her lack of memory and her frustration over her lack of memory for the past ..it was effective in revealing areas of concern but it left her very frustrated. (Counsellor 5)

One counsellor commented on how it demonstrated in a very clear way the types of issues she is dealing with:

A lot of the therapy I do is the inter-generational stuff, so a lot of the concerns [for her client] are there [in the responses], it's very clear. (Counsellor 1)

The responses of the counsellors indicated that they had little understanding of attachment theory concepts, or could not articulate them. However, they could make use of the emotional stories of childhood abuse to aid their own understanding of the circumstances that had contributed to the substance abuse. At the same time they could see that the clients themselves gained new perspectives on themselves and their relationships which they might not have achieved by the usual methods.

The SCT was used in this study to find out firstly, if Loevinger's formation of ego development levels related to the client's being 'stuck', and secondly, whether the counsellor would gain from knowing the ego level that their client was functioning from in relation to the type of therapy that could then be used. Counsellors received information on the formation of ego and the different ego levels, but did not have the chance to discuss it and become more familiar with the purpose of it for this particular study. Following so closely after the AAI its usefulness was not fully appreciated, as the focus remained primarily on the AAI and the consequences of that process. They did however perceive it as being another useful instrument when working with clients:

Recovering is a process and I think anything that makes people look at their

feelings, and their reactions, and their belief system, and makes them understand themselves a little bit more about why they do things, why they react the way that they do, why they say the things they do, why they believe the things they do, is another step in the healing process...yes I did think it was useful, it's another tool, another tool that you can use to open people up and to get them to think about what it is that makes them react, what the trigger is. (Counsellor 5)

I think it was very, very useful, they're very much off the cuff questions aren't they?...at this point in time when these questions were actually put them, they'd done a lot of work by then, I could also say that they possibly wouldn't have answered those questions in the same manner as they would further back in the piece. (Counsellor 6)

Only one counsellor indicated that she understood that the SCT gave an indication of the level of thinking:

I felt E5 was emerging at that stage and it still is to a certain extent, but there were bits of the other [stages] in there too. (Counsellor 4)

One counsellor suggested that the SCT could have perhaps been delivered at another time, so that the SCT could be given the necessary attention by the counsellor and client alike, instead of being perceived as a fun thing to do to ground the client after completing the AAI:

I don't know really what she got out of that if anything ....I was wondering if it could have been done at another time [not with the interview]....I think that if it was in a therapeutic group setting, get them to do it and then have a discussion around it, it would certainly help to build trust, it would definitely help the process. (Counsellor 1)

This counsellor perceived this instrument as being useful in a group setting as a device to get them talking due to the ease of implementation, its non-threatening nature, and how readily clients were prepared to share their responses.

Only two counsellors were curious about the coding and were interested in knowing more. One didn't have an opinion:

I think it would be, I would have liked to have had the results, looked at them, and then worked through them with the client, seeing what their reaction was, looking to see whether it would be necessary to do that. (Counsellor 2)

I'd certainly be intrigued with the [coding], what the criteria for coding them is,

and then I might have a better understanding of this. (Counsellor 3)

I'm not sure about this because [the client] never brought it up in counselling sessions. (Counsellor 4)

7. Do counsellors perceive the information to be useful to their clients in their recovery process?

Each counsellor perceived the information from the AAI as valuable to their client. Copies of the transcript were given to the counsellor and client so that client and counsellor were able to continue the process outside of therapy sessions. The counsellors commented that for these clients to have validation of what they shared was an empowering process in itself.

Two counsellors identified the effectiveness of the interview as a way of getting to the underlying issues and helping the client identify and focus on the issues. The interview also highlighted the depth the counsellor needed to go to explore the issues:

Definitely yes, my client's biggest problem was attachment issues, the biggest one was lack of bonding with her mum, and that lack of bonding was transferred to every authority that she came into contact with and they all reminded her of her mother and how she used to treat her, whether it was an institution, or an individual person, so the AAI brought up these things so we could actually deal with underlying issues...(Counsellor 4)

Oh yeah, that's an understatement, I guess with this particular issue [attachment issues] you know that it has happened...help them refocus and truly identify exactly what their [attachment] process should be and whether it was needed [talking about a particular client now] he was trying to make attachment to somebody and there were no bridges there right from the word go and he couldn't understand why it wasn't received in the way it should have been done and that was really ticking him off, and he's now come to understand that he was actually trying to mend something or trying to bridge the gap where the person just kept walking away from the other end, so he is never ever going to reach his goal. Now that he understands that, he's able to understand who the support people are, and they were always there under his nose, and he's now making attachments as an adult...yeah it's a big process to understand where they are at. (Counsellor 6)

Two counsellors suggested that the AAI could be given at the beginning of the

counselling process, one saying it would assist in the opening up of the client. This counsellor, in discussion, had made a comparison between her clients that came from all walks of life, and the addicts she worked with. The first group took some time to break through the 'niceties', and to build the necessary trust to begin working with their issues. On the other hand, she found addicts to be more open and honest with the attitude 'this is me, like it or lump it', and were more willing to explore new possibilities once a safe counselling environment had been established. The second counsellor would use it to refer back to give validation and perspective to the client as issues were worked through:

I think it gave [my client] a real shock that the depth of pain and emotion under there was still there because he had been pretty good at getting through life without letting that affect him...this kind of thing [the AAI] earlier would be better, because it opens up quicker, it paves the way to dealing with the real issues of attachment and the stuff underneath at an earlier stage of the healing process, I think it's an incredible tool.
(Counsellor 3)

The following counsellor works with the attachment processes frequently using a Maori based philosophy and he suggests that the AAI could be given earlier in the counselling process, where the understanding of whanau connections are initially made. The information gleaned from the AAI is often given in the first two sessions of counselling before therapy begins:

*It would be very interesting to take down the information right at the onset, right at the beginning of the sessions and to be able to identify where they sit with the [attachment] process initially when they're first interviewed, without any counselling, without any therapy, and just see where they sit with that process, and then do it again at a later date...because what I'm thinking of, and in situations where I've understood and we've actually worked it [the attachment issue] through, I've held onto a lot of the information that has initially been picked up in the first or second session, and they probably wouldn't have understood that, there were a lot of attachment processes that would have been identified right back in our earlier sessions....*He also explains the perceived value to the clients...*it's been amazing for them... to be able to have it in writing.... when you're doing that you're giving them the empowerment of their own stuff.*
(Counsellor 6)

One counsellor thought the AAI could have been dealt with in sections. Her client had difficulty in remembering therefore was particularly frustrated with the process and needed time, and several counselling sessions to recover memories.

It's definitely relevant but my feeling was that it was too much at once, I don't know about others, yes I'd have gone off and probably dealt with the child first, whatever she could remember and how she felt, and getting her to think about as far back as she could, and work with that before going onto the next stage. (Counsellor 5)

One client, Josie, did not return for the following sessions, something she has done on several occasions in the past, therefore the counsellor was unable to comment other than to say:

I think it will be, would be, can be and could be but as I said what sometimes happens [my client] takes breaks, but this would be good to bring her back and refocus, it might be scarey, it might have given her a bit of a shake up. (Counsellor 1)

The counsellor said that Josie often takes breaks from the counselling process, especially when she needs time to think about the issues that are coming to the surface, and when Josie is ready to deal with them, she comes back to counselling.

It was unlikely that doing the SCT would be seen to provide information that would not already be apparent to the client. Comments from each of the counsellors about the SCT indicated that they were confused by the question or did not understand the concept of ego development enough to comment:

I don't know, I'm not sure it really was, but it could be if I took it and focussed on it. (Counsellor 1)

Because I didn't read the results it's hard for me to say but I think it would be....(Counsellor 2)

Don't know cause I wasn't there when it [the coding] was done. (Counsellor 3)

And as has been mentioned before only one counsellor understood the level of development:

I felt E5 was emerging at that stage and it still is to a certain extent, but there were bits of the other [stages] in there too. (Counsellor 4)

Two counsellors thought the information was useful:

I think so, again because [her client] had to look at, think about things... (Counsellor 5)

Because this whole thing has been about themselves at an early age, or the biggest majority of the attachment processes develops at an early stage, and it's given them a better insight as to where they sit today and a big focus on identifying what the requirements are for themselves, it's something they did themselves....yes I think it certainly showed that. (Counsellor 6)

8. What are the implications of attachment for therapy with substance abuse?

Comments from each of the counsellors provide a window to their theoretical positions. Understanding of attachment theory was very vague in some cases, but the issue of attachment, especially the need for attachment and the impact of childhood experiences of adult behaviours were considered important by all.

Counsellor 1 works primarily with children and adolescents and uses attachment theory to understand the transgenerational cycles of behaviour

The attachment stuff is very clear and when I'm working with [my client] and her children, then I need to look at it...it's on her mind how her anger comes out on her children, and her lack of attachment with her family, parents, and significant people....certainly [the AAI] makes it very clear the problems she has with her children, which is replicated in all kinds of areas....I'm a strong believer in attachment issues and how they impact on life-style, across the life cycle really, so there is much to be gained from using the AAI.....

Counsellor 2 views addiction as a means of meeting unmet attachment needs, and that substance abuse is an effort to fill the void created by impaired attachment

I believe that when a child is growing up and there are certain issues and events that happen in their lives often with significant parent.... they become quite stuck and there's definitely a void that seems to be created, it can sometimes cause dissociation, a fragmentation, therefore the attachment between parent and child has been impaired or broken in some way....from there on in, many clients tend to start behavioural patterns and ways of relating that are all based around gaining what they needed from that parent that they didn't get earlier...using drugs and alcohol is definitely a part of that behaviour, is one

of the strategies that they use in order to gain the significance or love or self worth or security that they were needing which didn't happen at that time.

Counsellor 3 believes that emotional addiction is the key issue to understand for therapy in substance abuse

There was obviously the chemical and physiological addiction, but the emotional was stronger, emotional attachment is what made the 'make or break' of these people [addicts]...emotional attachment as far as environment, relationships, familiarity of life-style, the whole thing, was one hundred per cent stronger than in the chemical attachment area.... If you are aware of these areas and the client becomes aware of those areas as well, cause quite often they're not aware, it's just a pull or overwhelming desire that takes them back, it's the lack of understanding about these desires that takes them back [into substance abuse]....

Counsellor 4 places emphasis on attachment issues in therapy to overcome substance abuse

Of the clients I've worked with that have really dealt with and overcome their substance abuse, there seems to be quite a real honesty as far as their attachment issues are concerned, parent/attachment, adult/attachment, to parents, stepparents, people of significance when they are growing up, and working with them and helping them to work through issues they've never really faced and got over before in areas of attachment, has actually been one of the keys to their moving on and although I've never looked at it as far as doing the AAI, I've been aware of the human development part of it. Those clients that do not delve into the underlying issues of attachment, are the ones that are most likely to relapse.

Counsellor 5 views the understanding of relationships with others as the key to successful therapy, and the need to explore emotional pain

The implications are quite important in any relationship, if the person hasn't looked at why they do certain things and why they put that in place in their lives or why they feel the need [to do what they do]...so it's a very important part of it, and the ones on substance abuse are the ones who find the pain too much, they just want to stop the pain and you've got to walk through it... and when you walk through it you grow, you mature, and you can usually deal with whatever is in that process but it's painful.

Counsellor 6 gives examples of secure attachment with positive reinforcement and carries on to say

in the addiction process where the other [secure attachment] is the exception, where it is turned around and gone the other way, where the addiction process [begins], and without the [secure] attachment process, is spinning like an unorganised top, that's how I see it, and of course being able to understand that at a later date, and to be able to steady it up and give it some direction...

This counsellor is aware of the need to understand the attachment processes and what happens when that process becomes maladaptive:

You can't do that unless you fully understand how that process has been initially, to be able to bring it back, and that's what I understand and take from the whole attachment process....I refocus the client to be able to see that, and get them to understand that process in their own way, and by understanding it...they're able to take some control or let the issues they have from the past, and their belief patterns, they are able to let go a hell of a lot easier...for me it's a really, really good pivoting point, a starting point, for their wellness....

He also explained that by identifying early maladaptive attachment behaviours, so too can the origins of the addictive type behaviours be identified

...attachment theory is for me a basic nurturing process which sets up a lot of good starts and a lot of gains for adolescence, for young people, for little people, and good attachment processes will set them up with some good directions initially. If they don't have that, then they're going to pick up with other behaviours and take that through....I really need to understand where it [the behaviour] has come from [and in turn] be able to explain [to the client] those same processes that have come through.

9. How does attachment theory relate to existing practices?

Although the counsellors have a poor understanding of attachment theory per se, they do give their understanding of it, that is, the need to go back to early childhood experiences to establish the underlying causes of substance abuse, and that interfamilial interactions and affect dysregulation is a part of the client's profile. These counsellors are eclectic in their approach, with attachment type practices only a part of their whole practice.

Counsellors 1, 2, and 6 use attachment related methods frequently in their practice

I'm a strong believer in attachment therapy so for me it fits very well, areas and issues of attachment are big with me and this fits well with my existing practices. (Counsellor 1)

It certainly relates to the theory that I understand about detachment, but there are a lot of counselling styles that wouldn't actually go into all of this, it's more pyschoanalytic...in cognitive behavioural therapy I don't think there would be much, if it is recognised at all, so there are not too many practices, or theories I should say, that would bring it [attachment] up specifically...a lot of counsellors are eclectic anyway so they tend to want a client to go back to childhood to work those kind of issues.
(Counsellor 2)

It's part and parcel of the whole process... it can be a very intricate part of the whole process, when you need to go back that far... then it needs to be done quietly, it needs to be done supportively, as I said before, it needs to be part and parcel and generally is in most cases. I certainly work it through and see if the attachment processes need to be implemented in the work I am doing with a particular client, and if it is, I normally slow the whole process down, because I know what it means to be able to [examine] that long lost stuff and take our time with it. .. Sometimes it's not about sitting in your office and working it out and saying "this is the thing to do blah, blah, blah", it's understanding how it is, the best process for it to be enlightening, because it's a very, very close process if it's done properly. It's very meaningful, sad in a lot of cases, terribly sad in a lot of cases, so one has to be aware of that, and to able to work it through safely, and understand the process to be good. (Counsellor 6)

Counsellors 3 and 4 have a basic understanding of attachment and are just beginning their counselling practice on completion of their diploma

I have a basic understanding of attachment theory, and in the practice and with my clients I have been seeing, in reality it was just a background awareness for me, it didn't impact my practice because I was working towards my diploma and needing to learn different things, and it was more a thought in the back of my head, an awareness that 'oh this is what's happening', rather than me doing anything with it at the time.
(Counsellor 3)

Some counselling models don't actually mention attachment or human development at all, they have different focuses, personally I'm very aware of unfinished stages, problems with attachments for clients...[and with clients] you'll nearly always go back to childhood experiences and then you get stories of struggles with attachments with parents or stepparents, those sorts of situations, so I'm personally very aware of childhood situations that these clients have never worked through even when they're adults. (Counsellor 4)

One counsellor has had many years of experience and concentrates on relationships and ways of relating within those relationships

Our whole living is to do with relationships with other people and how we get on with other people isn't it? and being able to accept other people as they are.... I would hope that each of the various ways of counselling, the ultimate aim would be to set the people free from the bondages that are there from the past and enable them to have good relationships where they can just accept people as they are...they will grow out of it if they are allowed to develop what needs to be developed in them to help them change. (Counsellor 5)

Further comments from the counsellors on the use of, the effectiveness of, or the significance of the interview or the questionnaire in therapeutic practice are given.

One counsellor felt that the AAI would not be useful with adolescents because they lack insight. Presumably she thinks the value of the AAI is in allowing the client to see from the interview how events of the past have affected him or her. She then goes on to liken substance abusers to those with bipolar disorders, already mentioned before, to illustrate how unpredictable they can be, and also mentions the inter-generational transmission of these dysfunctional behaviours:

it is more for adults, very few younger people would have the insight, although some of the older ones [late teens] may, you could adapt it for younger people if you were using it in a therapeutic way...the inconsistency of alcoholic and drug families really is that they are wonderful at times, and at other times they are not, the alcohol and drug in my own work is a bit like working with somebody who is bipolar or even I guess going through depression at times, unpredictable...[now she is talking about her client and her anger] that intergenerational stuff, that it went back to the great grandparents, to the

grandparents, to the parent, to this mum, and then through to her children, how many generations, that's five generations, that's looking at it in this family and is likely to repeat itself at least in one of the children, but not all of them.... (Counsellor 1)

Another counsellor recognised how the interview brought up issues she had long believed to be important in the lives of addicts, unconscious memories, unresolved grief, traumatic events in childhood that need to be examined, events that have caused 'blockages':

I believe that you've got to really get to the unconscious mind, to me the interview brought up lots of feelings, unconscious stuff is what counts, what I've noticed in mine and my client's progression is that unresolved grief is a lot of the problem, they get stuck...[with]issues that happened earlier on in their childhood ... so bringing them back to that place, getting them to revisit it, and many counsellors won't agree with this, and actually feel the feelings that they have blocked off, cause that's where dissociation comes from... I believe that it is very necessary to allow them to actually grieve those times in their lives, and that can take a day, or two days, or five minutes, and then they seem to move from that and the behaviour starts changing. It's so powerful for addictive natures cause most of them... are in their heads, they're analytical. Everything that happens gets pushed down, the attachment stuff, and until they allow themselves to feel it, and to re-experience emotions around where they got stuck, they don't grow up, they stay stuck in childish areas, so that's where the attachment stuff is so important...there are many therapists that wouldn't agree at all, especially behaviouristic therapists looking at changing the way you think but they're not getting to the unconscious mind which is where the client is stuck...[addicts] have a gap between their feelings and their thoughts and they're living from here up [in their head] they don't want to feel because they've had too much pain. [As counsellors]we've got to obviously allow them their time but they've got to re-experience, in my opinion, to feel what they've blocked off before they can move forward. (Counsellor 2)

The third counsellor is concerned that counsellors need to experience the therapeutic tools for themselves before using them with their clients. She therefore feels she needs to experience the "instrument" if she were to ethically use it with a client and to have the necessary empathy to establish a lasting connection, especially with addicts.

Apart from the fact that I would be really interested to know more about it, I do think it's important for my own experience to do it myself first, [and] I don't think that anybody should be using tools [in this therapeutic environment] *that they haven't first experienced. It gives an awareness of what it is like for the client which I think is vital... cause you really have no idea of what is happening for them. There's a real sense within your spirit the power of something if you've done it yourself...only people who have experienced the healing could really go out there and know what they were talking about, it becomes a passion if you have known the effectiveness for yourself.* (Counsellor 3)

The fourth counsellor explains how the AAI reveals areas of concern quicker and that there is a common 'thread' with clients and violence, that violence from caregivers inevitably leads back to attachment issues:

There is a common thread often with clients that I've seen with physical violence, so naturally if a person has been through what they call 'hell bashings' by [parents and step parents], it leads back to the fact that there are attachment problems there and I found the AAI made it quicker in revealing areas of concern with clients, and if it's not hell bashings, it's comments like mum was controlling, and it's their perception of it. (Counsellor 4)

Counsellor 6 is concerned that many counsellors have no understanding or knowledge of attachment, or that it is generalised as something of no great significance. Also that when clients present with obvious attachment issues they are often not picked up by the counsellor:

I don't know how you'd actually get on with that [educating counsellors to 'listen'] you'd really have to understand what the attachment process is all about and have some working models within your own... cause there's no one way, attachment could be on numerous things and to be able to hear it and not pick it up, I don't know how you'd go about doing that....there has been some awareness about the subject [attachment].... I don't think in all the training that I know of, and the experiences that I had, is a lot of time given to that process of attachment, it's rather been generalised, but for me it's so important. (Counsellor 6)

Summary

The purpose of this study was to find out if the AAI and the SCT would shed light on the conditions that led people towards substance abuse, and if attachment theory and Loevinger's ego development theory would provide new explanations for the conditions experienced by clients presenting with a problem of substance abuse.

The AAI classification process demonstrated the complexity of the attachment issues these clients have, and that loss, abandonment and abuse are an integral part of their early life experiences which have influenced later psychopathology. All clients had stories of loss, abuse, and abandonment. There was ample evidence for each client that trauma had been experienced during early childhood, and that negative contexts remained throughout their lives to inhibit change. All of the clients, except one, were given insecure attachment classifications, with all unable to respond appropriately in relationships. Support was given to the hypothesis that by using attachment theory we can identify in what way people relate to others, and whether or not they have sustained some form of trauma in early life.

The SCT provided the surprising insight that these people are not 'stuck' at some immature ego stage according to Loevinger"s theory, but have achieved ego development levels considered well within the normal range for most adults. What was revealed with the SCT were issues, or areas of concern, where the client might have become 'stuck.'

The value of the AAI and the SCT as therapeutic tools, helping to identify areas of concern for clients in treatment for substance abuse, was verified as most useful by the counsellors and the clients alike. The AAI was most useful as a tool for breaking down the barriers, and for bringing issues up to be addressed in counselling sessions.

Although the counsellors had little understanding of attachment theory per se, they were aware of the importance of attachment issues in the lives of addicts and the need to resolve these issues for a chance at recovery.

Postscript

What follows is a brief progress report from the counsellors on each client five months after the AAI and SCT were given:

Jenny is strong in her recovery and is now working with other addicts in a residential programme. She has begun addressing her issues with her mother and has

allowed herself to begin the grieving process for her father. She and her mother now have better communication. Jenny is learning who she is and how to nurture herself.

Alison has made the first steps toward recovery. She and her mother are now communicating and forging a new relationship. She is becoming more aware of her issues. She has regular access to her second youngest son now.

Rebecca is steadily making progress with her interfamilial relationships and has recognised her need to continue her grieving process for her infant son. She understands how her behaviours affect her children now, and also the issues of control she has with her mother. She also recognises family dynamics and is beginning to make sense of the different behaviours.

Jane is developing her relationship with her children. She continues to express herself artistically and participants in a women's self-help group within her neighbourhood. She now has a better and more realistic understanding of her father.

Michael has remained chemical free. He has a full time job and has just ventured into a new relationship. He now understands more fully where his areas of conflict are, and acknowledges that these issues will need to be resolved when he feels he's strong enough to do so.

Josie has not returned to the counselling process since the interview. This behaviour is usual for Josie and the counsellor still has contact with her.

John has been able to begin to address his issues of childhood abuse with some real understanding, particularly with regard to his anger. Today he is strong in his recovery process, and has a good relationship with his children.

Chapter 5

Discussion

The present study set out to investigate the value of the Adult Attachment Interview and the Sentence Completion Test and their underlying theoretical concepts, in therapeutic interventions for addictions, in particular substance abuse.

It was expected that this study would show that attachment issues underlie substance abuse. Relevant attachment issues are neglect, separation, loss, abuse in infancy, and the continuation of negative contexts that prevent correction of negative pathways established in infancy. Other attachment issues are poor experiences at school, lack of self esteem and friends, the notion that one is not deserving of support, and often the inability to respond appropriately when support is given. All these were evident. Lack of security, be it of physical safety, familiarity of place, or of expectation that somebody cares, are also attachment issues relevant in this study. It was thought that the SCT might indicate where there were problems in thinking.

In this chapter each of the research questions will be discussed in order. Following discussion of the answers to these questions, other emerging themes will be discussed, the limitations and strengths of this study are outlined, along with suggestions for future research.

1. Experiences of loss, abuse and abandonment

Whilst studying the research on substance abuse it became obvious that the antecedents commonly referred to in the literature were parallel to those of attachment theory. This study is an effort to draw attention to the underlying attachment issues that are a part of the lives of addicts, and to suggest further development of therapies congruent with symptoms presenting in conjunction with substance abuse. In this sample of seven, all had stories of loss. Loss was understood in many forms from the death of a close person, to the loss of childhood experiences and innocence by sexual abuse, or the loss of children being taken into care. Abuse was evident in its many forms with all participants experiencing emotional abuse, with all except one experiencing physical and sexual abuse. Neglect was

also prevalent in its many guises such as lack of emotional and physical support, inadequate schooling and medical care, and inadequate nourishment. Abandonment was not only experienced as the physical disappearance or unavailability of a parent but also as threats of abandonment. Loss, abuse and abandonment were the rule rather than the exception and the AAI was particularly effective in exposing these issues.

2. Childhood attachment

The participants in this study were preoccupied with their childhood attachment as are many clients in treatment for substance abuse. It was clear that all had puzzled about the treatment they received as children, although they could describe defences they had constructed against the pain and confusion that they had suffered. The AAI gave them the opportunity to put their life story together for the first time. Many aspects of their narrative had been dealt with during counselling but had never been put together in such a succinct manner. The AAI illustrated the developmental pathways of attachment, made them visible to the participants and the counsellors alike, emphasising the importance of therapy directed at healing interfamilial relationships, understanding the interactions and the consequences of those interactions. Understanding the early childhood attachment processes and related issues of substance abusers assists in identifying the triggers to self medicating behaviour in later life.

3. Attachment type

As was expected all participants except one, Josie, were given insecure attachment classifications, and Josie was recognised as being a border-line 'earned' secure attachment. The literature suggests that an individual who acquires an 'earned' secure classification may have had a positive initial foundation, with a secure attachment relationship in infancy (Sroufe et al.,1999). Another explanation might be that they have found an alternative figure outside the family, someone who has allowed them to experience a sense of mattering to a person whom they care about. In general a person who is called 'earned' secure reports a childhood bereft of warm attachments and often with abuse and loss, yet somehow as adults they can speak about it with understanding for themselves as children and for their parents in the situations they were in. However, they have clearly come to

terms with it as it might affect their own behaviour. They accept responsibility for their own actions and are determined not to treat their own children in the same way. In the case of Josie, however, it is clear that although she can speak about the negative events in childhood without disorientation, and can reflect in a mature way on her own and other's behaviour, it is also clear that her addictions complicate the concept of mature 'autonomy' and internalised 'security', which is what is meant by 'earned' secure and the category of F4. This woman has developed cognitively to be able to reflect, but she is still gripped by past events.

4. Attachment type, theoretical descriptions, and attachment explanations.

In this non-normative sample we would expect to get 'Can't Code' and 'Unresolved' transcripts. Josie's F4 transcript is an apparent anomaly and does not fit the theory. A possible reason is that because she is an identical twin, she was able to construct an attachment that was secure with her twin sister. Perhaps the twins were able to support one another, and anecdotal evidence suggests that monozygotic twins often role share, therefore becoming two parts to the whole. In this way the burden of the abusive upbringing could be shared, with neither twin having to experience in full the complete cognitive awareness of the negativity in their childhood. This is something that needs to be explored further. In adult years, and in recovery for substance abuse for some time, both twins have undertaken tertiary study. This indicates that the neglect and abuse they experienced as infants may have had a damaging effect, but they appear to have overcome at least some of the cognitive damage that recent studies of neurobiological development has shown to be the result of early neglect and abuse. Josie also received the highest coding, E7, for the SCT score which provides evidence of intellectualising in addiction that is cut off from the emotional damage, and the ability to express emotions in healthy ways.

5. Ego development level

Findings from research (Manners & Durkin, 2000) into ego development in adulthood found that ego development stabilises by early adulthood for the majority of adults. Transition to higher levels in adulthood is due to an accommodative response to life experiences. It was hypothesised that substance users might have become users because of

maladaptive constraints on their development of competencies, identity, and social skills. They may have become 'stuck' at an immature level. However, participants in this sample had ego levels above the median score.

One counsellor suggested that if the SCT had been given before therapy began the ego level would have been lower, the answers less complex. People come to substance abuse with some rigidity of thinking which supports their addiction. The SCT may help sort out what that thinking may be. Rather than support the idea that their thinking is underdeveloped, if we look at the levels 5, 6 and 7 of Ego Development, we can see that there is a systematic unfolding of ability to reflect on self. At level 5, Self-Aware, a person has become aware that everyone does not need to conform to stereotypes. They are beginning to emerge from the 'ought to be' to the 'what I am', in other words beginning the exploration of self. They are also beginning to use words to describe feelings. At level E6, Conscientious, a person is aware of how they personally feel about given situations and has a sense of individual difference, with motives and consequences being more important than rules. This person is reflective and priorities and appropriateness are considered, with an ability to think beyond the self to others. At level E7, Individualistic, a person has a sense of individuality, and a greater tolerance for individual differences. There is a tendency to explore psychological causation and development. Each level involves greater conceptual complexity. The results of the SCT show that these participants are relatively advanced in ego level. This indicates that a great deal of mental effort has gone into trying to understand themselves and others. In conjunction with the AAI, it can be seen that these participants can be described as people who ruminate about themselves. Rumination can increase the ability to be reflective, but it can also mean that the person is engaged in circular reasoning, oscillating between positive and negative evaluations and not being able to come to any firm, satisfactory understanding of self or others. This is seen as a characteristic of substance abuse clients. One counsellor said 'it's a bit like working with somebody who is bipolar or even I guess going into depression at times, you don't know,' referring to the unpredictability of substance abusing clients.

6. Counsellors' understanding of the AAI and SCT

Although the counsellors had only a basic or superficial understanding of the theory behind the AAI and the SCT, their responses indicated that they did understand the concept of their use. They were more interested in using them as tools within the therapeutic environment rather than for their theoretical value at this point. This is not due to lack of interest, rather a lack of time in a busy schedule, and time constraints within the study. All counsellors expressed the desire to know more about both theories as in the past attachment had only been covered briefly in their training, and Loevinger's Ego Development was a new concept to them. As has been mentioned these counsellors understood the importance of delving into childhood interfamilial relationships to assist their clients in establishing a strong recovery from substance abuse, inappropriate behaviours within relationships, and difficulties with intimacy. There were varying amounts of importance assigned by these therapists about uncovering the early history of their clients.

7. Counsellors' perceptions

Counsellors' perceived the information gained from the AAI as very useful to their client in their recovery process in several ways. Firstly, for the client, the process of talking about their issues, having them recorded and given back in written form, was an empowering process for the client. It seemed to give them validation of their story, of themselves in their story, and the women in particular each expressed the desire to show it to their children at a later date. Their desire to break the cycle of abusive behaviour was paramount and the AAI transcript was seen by them as valuable in that process. This capturing of their story in a written form fits in with newer 'narrative' methods of psychotherapy which have been developing over recent years (Holmes, 1997; Monk, Winslade, Crocket & Epston, 1997; Roberts & Holmes, 1999) and in psychological research (Kirkman, 2002).

Secondly, the counsellors expressed that they gained a different insight into their client by playing a passive role as a listener during the interviewing process of this study. They expressed they were able to see many aspects of previous therapy drawn together in a succinct way, which highlighted the areas of concern and issues to be dealt with in future sessions. The AAI has given them relevant common ground to explore together, and has

strengthened the relationship between the client and the counsellor.

Thirdly, three counsellors said the AAI had advanced them in the counselling process with their client by three to six weeks, going straight to the core of the clients' issues. Two counsellors expressed that they thought the AAI could be given at the onset of therapy, and suggest the transcript be used throughout the counselling process as a point of reference. Steele and Steele (in press) also suggest that to determine the treatment approach most likely to prove successful, the AAI could be administered early in the treatment process. These two counsellors also suggested that the AAI could be given again at 12 or 24 months to give a clearer understanding of the effectiveness of the counselling process on early childhood attachment issues. These are valuable comments which would be desirable to explore further. Counsellors were aware of the time taken to transcribe the interviews and pointed out that realistically this was something that may not be affordable in practice, but perhaps possible in future research.

Because the SCT provides a written record of the client's opinions and first thoughts stimulated by the sentence stems, the SCT is a valuable device to start reflective discussions. The SCT was seen primarily by counsellors as another tool for the continuation of client self expression rather than a tool they could use themselves for understanding at what level the client was functioning and responding to external stimuli, in particular their frame of reference. The counsellors did express interest in knowing more and saw how the SCT could be used in several settings as a therapeutic tool for their clients. One counsellor thought that this questionnaire could be used in group discussion and would be valuable for breaking down barriers of resistance, and for building trust within the counselling relationship and within the group. General consensus from the counsellors was that the SCT could have been given at another time and not straight after the AAI as was the case in this study. Their focus was on the revelations just received from the AAI, therefore they were unable at the time to give the SCT the attention they felt perhaps they could have. If the counsellors could recognise that some clients are just becoming able to reflect on themselves in context, and others are expert at it, they will be able to describe better what type of approaches are more suitable for those of different levels of ability.

8. Implications of attachment for therapy

This research provides strong evidence that attachment issues need to be addressed in therapy. Although the counsellors showed an awareness of the need to deal with early childhood issues and emotional turmoil with their clients, there was little understanding of attachment issues.

The most pressing of the implications for therapy is the misunderstanding or lack of understanding of the importance of the original trauma(s) of the addicted person. This is an underlying cause and needs a great deal more training to explore and to facilitate the healing process. Three counsellors understood the process. One understood based on a traditional Maori perspective, and two gained their understanding from a Christian based philosophy. These counsellors practice the gentle process of taking clients back to their childhood in whatever manner is appropriate for the client. By giving them the opportunity to process childhood hurts at that deeper level, they helped bring that understanding into the present to initiate closure. This process requires an expert practitioner who can handle the feelings elicited by the process and who can support the subsequent effects of the events of the counselling session.

Academic training of counsellors in the field of addiction needs a sound grounding in the understanding of trauma and the neurobiological underpinnings of the behaviours that present. Malicoat (2002) in his work on trauma and grief has found that there are differences between traumatic and non-traumatic memory and the related differences in emotional, cognitive and physical processing. Therefore traumatised people experience a vastly different reaction to their experience of loss compared to non traumatic processing.

Malicoat (2002) contends that considering the neurobiology of trauma and grief, the field must re-evaluate how we do work with people living with all types of loss, and to do good trauma intervention, specific training designated to address a myriad of potential clinical circumstances is required.

Not only do we need to address trauma intervention but also affect regulation. Research has shown emotional experiencing can and does occur prior to or independently of higher level cognitive processing and highlights the need for therapeutic interventions to encompass strategies that facilitate affective processing (Paulson & Worth, 2002).

9. Attachment theory in practice

Whilst preparing to undertake this study it became apparent that few counsellors have an understanding of attachment or use it in their therapeutic practices. Several counsellors were approached to take part in this study but declined due to lack of knowledge on attachment theory or lack of confidence in that particular area. Conversations with many clients in treatment for substance abuse issues substantiated this, and it appears that many therapies are still based on cognitive behavioural theory. The counsellors in this study are family-based in their approach, therefore, family relationships and interfamilial interactions are an integral part of their therapy. The need for clients to experience a 'secure base' relationship themselves was understood and practised by all of the counsellors. The process of counselling substance abusers into a strong recovery is time consuming, therefore, there is ample time to develop a close relationship with the counsellor. From this point the client can then begin the process of learning to parent themselves, the process of going back and healing childhood hurts from the adult. In due course other healthy relationships are established and the client is able to move on from the counsellor.

Emerging themes

The themes that emerged were not prompted by specific questions but were pervasive throughout the research process. The most prominent was that of transgenerational behaviours. This was perceived by participants as repeating the cycle, of being in a cycle, and that without professional help they were unable to understand or to make the necessary changes that they could see were warranted for a healthier relationship with their own children. These parents experienced confusion when identifying patterns of behaviour that they had experienced as children and in turn were passing on to their children. At times, they felt overwhelming guilt, and sometimes feelings of helplessness. Sroufe and Fleeson (1986) discuss attachment and the construction of relationships and in particular how children learn not only the role of the victim but also the role of perpetrator, therefore the 'whole' relationship is learned, and these roles are carried forward to ensuing relationships.

There appeared to be a strong feeling of incongruence and confusion, of not being

able to understand, from a child's perspective, how parents could behave in such a negative way toward a small child, whether it be beatings, some other form of abuse, or the expectation of adults that children perform adult tasks. On the other hand, these participants, as parents, found themselves behaving in the same manner with their own children. From this small sample there was strong evidence to support the transgenerational transmission of relationship patterns.

Another theme, as expected, related to lack of memory and dissociative type behaviours. Research has shown that those who have experienced attachment disruptions were more likely to show dissociative symptomology (Kobak, Little, Race & Acosta, 2001) and that there are elevated levels of dissociative symptoms in people who have experienced sexual abuse (Putman, Helmers & Trickett, 1993) and trauma (Ogawa, Sroufe, Wienfield, Carlson & Egeland, 1997). In this study participants spoke of 'flashbacks', 'blanking out', and 'going into [their] head' when referring to memory or the lack of it. This aligns with symptoms of Posttraumatic Stress Disorder (PTSD) as well as attachment theory. Unresolved trauma may be identified from these types of comments giving clear indication to counsellors and therapists that exploration of the trauma is required if the aim of the therapy is for recovery from substance abuse. These unresolved traumas relate to the triggers that lead to relapse and continued substance abuse. Attachment-related traumas leave a person vulnerable to lapses in organised coping (Kobak et al., 2001). The clients are generally not consciously aware of these old traumas and are therefore not in a position to understand them; professional help is required. The comments elicited by the AAI are valuable to this process of narrative discourse analysis. The following comments are examples extracted from the discourse: "I feel the threats from my mother but have no memory of them", "I know someone has done something [to me]", "I can give an incident but cannot remember the content or the feelings that go with it", and "I'm getting a mind blank, trying to think about it but can't put memories into a time space, just know things without specific memories". These types of comments are common among substance abusers and require more attention than has previously been given. If the emphasis in counselling and therapy was shifted from predominantly cognitive/behavioural therapy to incorporate work on trauma and affect disregulation, the chances of helping substance abusers abstain and develop to their fullest potential is more likely, and in the long term,

more cost effective. Further development of treatment and therapies congruent with the symptoms presenting in conjunction with substance abuse are required. For some time, grief counsellors have been working with trauma counselling models. They recognise the need for a new paradigm for healing, integrating psychology with physiology, supported by ongoing neurobiological research. Counsellors must learn to recognise when unresolved trauma/grief may be blocking the healing process, and make referrals if trauma healing is not part of their counselling model (Smith, 2001). This study gave strong evidence that unresolved grief was present in all participants and one could argue that trauma counselling would have been beneficial to these substance abuse clients.

Limitations of this study

From the beginning it was recognised that generalisations from this study should not be made. This type of qualitative research is time consuming and so sample size is necessarily small.

Originally it was proposed that the interviews be limited to one sex, or one age group, but access to suitable volunteers proved to be difficult. In the end the people who were willing to participate provided valuable information.

The most obvious limitation to this study was the lack of time given to counsellors to explain and discuss the theoretical background of attachment and Loevinger's Ego Development theories. The counsellors were given information to read but that was not enough. Time should have been allocated early in the study to familiarise the counsellors with these theories and opportunity given for discussion.

The timing of the giving of the AAI and the SCT was brought into question by the counsellors. All thought that they could have been given at separate times so that the significance of both could have been more fully understood. As it was, the SCT followed immediately after the AAI, with both client and counsellor alike still feeling the full effects of the AAI. They may not have been in the right frame of mind to pay attention to the SCT. It is recommended that in future research, another time be found if instruments in addition to the AAI are to be administered.

Strengths of this study

One of the main strengths in this study is the contribution it makes to the growing body of knowledge on attachment theory. In addition, and perhaps more importantly, this study draws attention to some of the underlying issues of substance abusers. For too long the emphasis in many alcohol and drug treatments has been cognitive/behavioural, concentrating on abstinence from drugs and/or alcohol, changing the ways of thinking in order to alter behaviours. This approach is more often than not, only effective for a short period of time with the client inevitably relapsing into substance abuse. These people have at some stage in their lives been traumatised and the substance use is a way of self medicating against the emotional pain they feel. This study, using the AAI, gave an opportunity to examine the types of trauma that substance abusers endure, and accentuated the loss, abandonment, and the abuse that is a major part of their lives. Just how this information is best used in therapy is not part of this research. More investigations are being conducted which will contribute to improvements in therapeutic approaches. Research on the implications for attachment theory and practice of individual psychotherapy with adults (Slade, 1999) has contributed to our understanding of metacognitive monitoring, reflective functioning, and relevance of coherence. It has become apparent that countertransference is required for successful outcomes within therapeutic relationships when dealing with disturbed attachment organisations. In view of the recent developments in understanding the link between neurobiology and attachment, it should be noted that the differences inherent in working with dismissing and preoccupied clients may involve differential involvement of left-right brain functioning (Slade, 1999) There is a long way to go, but there are psychotherapists working in this area trying to apply the theory (Fonagy, Leigh, Steele, Steele, Kennedy & Mattoon, 1996; Holmes, 1997; Horowitz, Rosenberg & Bartholomew, 1993; Mallinckrodt, Coble & Gantt, 1995).

Suggestion for future research

New Zealand needs a large scale normative sample to find out how Pakeha and Maori culture may be different, for example, and what difference there may be in the distribution of attachment types in comparison to that shown in studies done in differing cultures elsewhere (van IJzendoorn, M.H. & Sagi, A., 1999). In this study the identification

of Maori participants was done out of respect for those people who wished to be identified as being Maori, and not for the purposes of drawing conclusions about cultures. As has been mentioned, a large scale study for that specific purpose would be required.

More studies are needed to explore developmental pathways in the area of substance abuse. Future studies would need to be longitudinal, examining the different treatments and therapies currently used and their success and failure rate. Only by examining the present state of treatments and their outcomes will it become obvious that change is required. If we bear in mind that a more holistic approach is necessary for the treatment of substance abusers, and that a paradigm shift may be required, we will be in a better position to develop therapies that support long term, as opposed to short term, recovery.

Attachment disruptions play a critical role in the emergence of psychopathology in children, adolescents, and adults. Research aimed at understanding these events and assessing the disruptions will help in the development of appropriate treatment.

A longitudinal study using the SCT was suggested by the counsellors. The client would be given the SCT at the beginning of treatment and then again when treatment is no longer a priority for the client, that is, the client is stable in recovery. This could ascertain whether or not the ego level increases and by how much. Receptivity, commitment and life experiences are essential elements for a change in ego level to take place. Movement brought about by the challenge to change first requires accommodation before subsequent movement to the next ego level. By using the test-retest methodology these changes could be examined further.

An interesting aspect of this study was the anomalous classification of the participant who is an identical twin. There is anecdotal evidence to suggest that monozygotic twins role share and whether or not these twins become a secure attachment figure for one another is worth investigating. There was no research found to date to suggest that this type of research has been attempted.

Another aspect made obvious in this study was that of transgenerational behaviours. Perhaps it is time to begin exploring how we in our culture perpetuate these behaviours which would invite investigation from an anthropological perspective. We could also investigate on a smaller scale events in history beginning from the present and working backwards, with the emphasis on peoples' behaviours and reactions to specific events. The

majority of citizens in New Zealand probably have issues to do with disconnectedness, whether it be past or recent history, immigration or colonisation, and by using attachment theory as a basis for investigation into this whole area of disconnectedness, we may well find an effective way of healing past hurts. It could be argued that substance abuse and unhealthy addictions are the end of a long chain of events, and the sooner we understand the many links in that chain, the closer we will come to understand how to heal effectively.

Conclusion

This small sample has provided evidence of the significance of understanding developmental pathways and of how maladaptive pathways are created. This study has given theoretic explanations for these processes. Attachment theory and the AAI were used to measure ways of thinking about relationships, to gain information about affect regulation, and to see whether or not substance abusers had sustained a trauma in early childhood. This was coupled with Loevinger's Ego Development and the SCT to measure cognitive functioning.

Many alcohol and drug agencies favour cognitive behavioural therapies, aiming to help clients achieve abstinence, without addressing the underlying issues behind addiction or affect regulation. Many counsellors have no training or grounding and very little understanding of attachment issues and their related trauma(s), often thinking of it as something quite general and not a theory that is specific and measurable. Some therapists do have a good understanding of the need to explore emotions, and have a basic knowledge of attachment, but the success rate of these therapies in helping the client maintain a strong recovery, has yet to be explored and substantiated.

The time has come for a paradigm shift, where a more holistic approach to mental health per se, and substance abuse in particular, is required.

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Appendix One

Client's information sheet

How Do Clients in Treatment for Substance Use and Abuse Relate to Others? How are they thinking and feeling?

Information Sheet

* Hi, my name is Lesley Murch and this research that you are being invited to take part in, is part of my Masters degree. I spent many years in substance use and abuse, and after detoxification (drying out) and rehabilitation(doing a residential programme), I have been clean and dry for 7 years. It can be a difficult process in early recovery and I guess you could say I'm on a mission, to help the helpers to better understand those in need of help, that is people like us. I learned much from my own journey which I would like to be able to share with others. My aim is to in some small way be able to help you understand your present journey like so many others have done for me.
I am especially interested in Attachment and ways of thinking.

What is Attachment?

In our first year as babies, in our minds we develop a way of understanding of how to relate to others and in turn how others relate to us. This is our attachment style which for some people can last for the rest of their lives.

The Attachment Interview helps us identify whether a person has any difficulties in attachment, and in turn provides the opportunity to begin the healing process. Counsellors working in the area of addiction have long been aware of family dynamics and the influences on various family members. Attachment theory can give us a deeper understanding as to the origin of some of these observable behaviours.

What is our cognitive ability or status? (How do we think?)

People can develop ways of thinking which makes it difficult for them to make changes in their lives. Sometimes, for any number of reasons, we can become *frozen* or *stuck* in our way of thinking. The Sentence Completion Test gives us a reliable picture of a person's personality and can identify the *frozen* ways of thinking that are part of the addiction process.

* You will be given two questionnaires.
The first questionnaire is the ***Adult Attachment Interview*** which has twenty

questions that will be audio taped and will take approximately one hour.
The second questionnaire is the ***Sentence Completion Test*** which asks you to complete 36 sentences with your ideas. This will take approximately twenty to thirty minutes.
Your counsellor will be present when you answer both of these questionnaires. Some of the questions may stir unpleasant or uncomfortable memories and that is why I require your counsellor to be present, so that when this session is finished your counsellor can continue the process of healing with you.

* I will discuss the results of the interview and the questionnaire with your counsellor to evaluate their usefulness in helping in future client treatment programmes.

If you accept my invitation to take part, at any time you can

* refuse to continue to take part
* refuse to answer any questions
* pull out from the study
* to ask any questions about the study at any time

also

* your safety and wellbeing are of the utmost importance.
* every effort will be made to ensure anonymity and confidentiality
* your name will never be used. The only people who will know your name will be the counsellor and the researcher
* I will be audio-taping the ***Adult Attachment Interview*** (both questions and answers), and at the end of the study this tape will be given back to you along with a summary of my findings if you want them.
* The audio tape will be transcribed, or typed up, by my secretary who will sign a Confidentiality Agreement, then the transcript will be coded by my Supervisor.
* My Supervisor is Sue Watson

  Lecturer in Human Development
  Department of Educational Studies and Community Support
  Room: Awanui 405, Hokowhitu Campus
  Telephone: (06) 356 9099, ext 8882

Any enquiries you may have speak to me personally or communicate with my Supervisor.

* My contact details

  Lesley B Murch
  Telephone: (06) 356 5779

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Appendix Two

Counsellor's information sheet

How Do Clients in Treatment for Substance Use and Abuse Relate to Others? How are they thinking and feeling?

Information Sheet (For the Counsellor)

* Hi, my name is Lesley Murch and this research that you are being invited to take part in, is part of my Masters degree. I spent many years in substance use and abuse, and after detoxification (drying out) and rehabilitation(doing a residential programme), I have been clean and dry for 7 years. It can be a difficult process in early recovery and I guess you could say I'm on a mission, to help the helpers to better understand those in need of help, that is people like us. I learned much from my own journey which I would like to be able to share with others. My aim is to in some small way be able to help you understand your present journey like so many others have done for me.

I am especially interested in Attachment and ways of thinking.

What is Attachment?

In our first year as babies, in our minds we develop a way of understanding of how to relate to others and in turn how others relate to us. This is our attachment style which for some people can last for the rest of their lives.

The Attachment Interview helps us identify whether a person has any difficulties in attachment, and in turn provides the opportunity to begin the healing process. Counsellors working in the area of addiction have long been aware of family dynamics and the influences on various family members. Attachment theory can give us a deeper understanding as to the origin of some of these observable behaviours.

What is our cognitive ability or status? (How do we think?)

People can develop ways of thinking which makes it difficult for them to make changes in their lives. Sometimes, for any number of reasons, we can become *frozen* or *stuck* in our way of thinking. The Sentence Completion Test gives us a reliable picture of a person's personality and can identify the *frozen* ways of thinking that are part of the addiction process.

* I ask you to participate with me in this study, to be present throughout the entire procedings, so that you can be available for the client if need be.

* and to discuss the relevance of the interview and questionnaire in relation to their future use in therapy.

* I will be using two questionnaires.

The first questionnaire is the ***Adult Attachment Interview*** which has twenty questions that will be audio taped and will take approximately one hour.

The second questionnaire is the ***Sentence Completion Test*** which asks the client to complete 36 sentences with their ideas. This will take approximately twenty to thirty minutes.

I require you to be present when the client answers both of these questionnaires. Some of the questions may stir unpleasant or uncomfortable memories and that is why I require you to be present. When these sessions are completed, the information and understanding gained may be of further assistance to you and the client in the ongoing counselling process.

* I will discuss the results of the interview and the questionnaire with you to evaluate their usefulness in helping in future client treatment programmes.

* At the completion of all the interviews and questionnaires you and I will have a debriefing session where we can discuss the results, how relevant the theory and measurements are, implications for future therapy and the like.

If you accept my invitation to take part, at any time you can

* refuse to continue to take part

* refuse to answer any questions

* pull out from the study

* to ask any questions about the study at any time, also

* your safety and wellbeing are of the utmost importance.

* every effort will be made to ensure anonymity and confidentiality

* your name will never be used. The only people who will know your name will be the researcher and my Supervisor.

* I will be audio-taping the ***Adult Attachment Interview*** (both questions and answers), and at the end of the study this tape will be given back to the client if they wish, along with a summary of my findings if they want them. A more in-depth report will be available to you.

* The audio tape will be transcribed, or typed up, by my secretary who will sign a Confidentiality Agreement, then the transcript will be coded by my Supervisor.

* My Supervisor is Sue Watson

  Lecturer in Human Development

  Department of Educational Studies and Community Support

  Room: Awanui 405, Hokowhitu Campus

  Telephone: (06) 356 9099, ext 8882

Dr Robert Gregory is my second supervisor

  School of Psychology

  Massey University

  Telephone: (06) 350 5799, ext 2053

Any enquiries you may have speak to me personally or communicate with my Supervisor.

* My contact details

  Lesley B Murch

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Appendix Three

Client's consent form

How Do Clients in Treatment for Substance Use and Abuse Relate to Others?

How are they thinking and feeling?

Consent Form

- I have read and understand the information sheet for volunteers taking part in the study on adolescents. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my continuing health care.
- I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.
- I have had time to consider whether to take part.
- I know whom to contact if I have any side effects of the study.
- I know whom to contact if I have any questions about the study.
- I consent to my interview being audio-taped Yes / No
- I would like the researcher to discuss the outcomes of the study with me Yes / No
- I wish to receive a summary of the results Yes / No
- I wish to have the tape and questionnaire returned to me Yes / No

I..... hereby consent to take part in this study.

(Full name)

Date .....

Signature .....

Signature of Witness .....

Name of Witness .....

Signature of Researcher .....

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Appendix Four

Counsellor's consent form

How Do Clients in Treatment for Substance Use and Abuse Relate to Others?

How are they thinking and feeling?

Consent Form (For the Counsellor)

- I have read and understand the information sheet for volunteers taking part in the study on adolescents. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time.
- I understand my responsibility for selecting clients who will benefit from participating in this study.
- I understand that my responsibility in this study is to protect the well-being of my client.
- I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.
- I have had time to consider whether to take part.
- I know whom to contact if I have any side effects of the study.
- I know whom to contact if I have any questions about the study.
- I consent to the interviews being audio-taped Yes / No
- I would like the researcher to discuss the outcomes of the study with me Yes / No
- I wish to receive a summary of the results Yes / No

I..... hereby consent to take part in this study.
(Full name)

Date .....

Signature .....

Signature of Witness .....

Name of Witness .....

Signature of Researcher .....

Name of Researcher .....

Appendix Five

Sentence completion test

Sentence Completion Test for Men (Form 81) Date.....
Name/ID..... Age ..... Marital Status.....:

Directions: Complete the following sentences:

1. When a child will not join in group activities

2. Raising a family

3. When I am criticised

4. A man's job

5. Being with other people

6. The thing I like about myself is

7. My mother and I

8. What gets me into trouble is

9. Education

10. When people are helpless

11. Women are lucky because

12. A good father

13. A girl has the right to

14. When they talked about sex, I

15. A wife should

16. I feel sorry

17. A man feels good when

18. Rules are

19. Crime and delinquency could be halted if

20. Men are lucky because

21. I just can't stand people who

22. At times he worried about

23. I am

24. A woman feels good when

25. My main problem is

26. A husband has a right to

27. The worst thing about being a man

28. A good mother

29. When I am with a woman

30. Sometimes he wished

31. My father

32. If I can't get what I want

33. Usually he felt that sex

34. For a woman a career is

35. My conscience bothers me if

36. A man should always

Appendix Six

Material handed to the counsellors

Measuring Ego Development

&

Adult attachment scoring and classification systems.

Measuring Ego Development

Second Edition

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1996 Mahwah, New Jersey

CHAPTER ONE

The Concept of Ego Development

The concept of *ego development* has roots in ancient Greek, Hebrew, and Hindu cultures.[1] Contrary to common belief, it did not originate with Freud or with later psychoanalysts. Psychoanalysis, in fact, originated in part as a rebellion against 19th-century ego psychology. Freud (1926/1959) consciously avoided using the term *ego*; he preferred words chosen from common speech to those of Latin origin, a preference that was ignored by his translators.

Once granted that the original sources were not written in English, it follows that one must look under other terms, the I (*das Ich*), the me (*le moi*), the self, and so on, to trace the relevant literature. There have been many similar or related conceptions, variously termed *moral development* (Kohlberg, 1964), *character development* (Peck & Havighurst, 1960), *interpersonal relatability* (Isaacs, 1956), *cognitive complexity* (Harvey, Hunt, & Schroder, 1961), and *interpersonal integration* (C. Sullivan et al., 1957). Many of the foregoing authors acknowledged as sources H. S. Sullivan's (1953) *Interpersonal Theory of Psychiatry* and Piaget's (1932) *Moral Judgment of the Child.* Although the definitions of the various stages and their sequence are not identical from author to author, there are many similarities, too many to be considered independent phenomena (Loevinger, 1976).

Interest in all aspects of development was stimulated at the end of the 19th century by the impact of Darwin's theory of evolution. For this and other reasons, in the early 20th century a child study movement in the United States led to the founding of child welfare institutes and incorporation of the topic of child development in texts and college curricula. The standard approaches to child development, at least in the past, tended to blur the topic of ego development. Children's growth was studied in terms of chronology, taking in order the behaviors characteristic of average and not-so-average children of each successive age.

Such atheoretical approaches have the weakness that all kinds of development are occurring together. Observation by itself will never yield a concept such as ego development nor distinguish signs of ego development from signs of intellectual development, of psychosexual development, or even of adjustment. Ego development is an abstraction, and the essence of science is that abstract ideas guide observations, and observations in turn alter abstract ideas.

A long-standing issue in the study of ego development is whether the ego is derived from and more or less explained in terms of instinctual drives, as Freud and many of his followers believed in the early years of psychoanalysis. That issue separated Freud and Adler in 1911. Adler maintained that the drives were largely subordinate to the ego and the ego strove spontaneously to develop. Freud countered that to adopt Adler's view would be to give up the hard-won gains of psychoanalytic insights, but many of his followers believed that the two views could be reconciled. Some years later, Freud returned to the topic of ego development and made major theoretical contributions whose importance is not always recognized either by psychoanalysts or by their opponents (Loevinger, 1966, 1987). At the same time, some psychoanalysts and some behaviorists found common ground in the instinct-derivative view of ego development. Although that remains a major theoretical issue, it does not bear directly on the enterprise of this book.

EGO AS FRAME OF REFERENCE

A second theoretical issue, one more closely related to the present enterprise, is whether ego development is best characterized as a gradual evolutionary process or as a set of discrete stages, with distinct jumps from one stage to the next. There are problems either way.

One of Adler's best-known concepts is "style of life," which at various times he equated with self or ego, the unity

[1] The topics of this chapter are discussed more fully in Loevinger (1976).

TABLE 1.1
Some Characteristics of Levels of Ego Development

		Characteristics		
Level	*Code*	*Impulse Control*	*Interpersonal Mode*	*Conscious Preoccupations*
Impulsive	E2 (I-2)	Impulsive	Egocentric, dependent	Bodily feelings
Self-Protective	E3 (Delta)	Opportunistic	Manipulative, wary	"Trouble," control
Conformist	E4 (I-3)	Respect for rules	Cooperative, loyal	Appearances, behavior
Self-Aware	E5 (I-3/4)	Exceptions allowable	Helpful, self-aware	Feelings, problems, adjustment
Conscientious	E6 (I-4)	Self-evaluated standards, self-critical	Intense, responsible	Motives, traits, achievements
Individualistic	E7 (I-4/5)	Tolerant	Mutual	Individuality, development, roles
Autonomous	E8 (I-5)	Coping with conflict	Interdependent	Self-fulfillment, psychological causation
Integrated	E9 (I-6)		Cherishing individuality	Identity

Note. The code for the previous version used I-levels and Delta; the current code uses E-levels. Adapted from Loevinger (1976, 1987).

of personality, individuality, the method of facing problems, opinion about oneself and the problems of life, and the whole attitude toward life (H. Ansbacher & R. Ansbacher, 1956, p. 174). Seemingly, according to Adler, those terms were meant to be different ways of describing a single thing or function. That is what is here called the *ego*. That view contrasts with that found in some psychoanalytic writings, where the ego is spoken of as a collection of different functions, with its "synthetic function" just one among many. Adler's view was elaborated in somewhat different style by H. S. Sullivan (1953), who preferred the term *self-system*.

The ego is remarkable for its relative stability; it changes slowly. Accounting for this stability is not always recognized as a major theoretical problem. Simply calling the ego a structure, as some psychoanalytic theorists do, and then adding that structures are, by definition, relatively stable is not a solution.

H. S. Sullivan (1953) formulated a theory of ego stability in terms of *anxiety gating*: A major purpose of the self-system is to avoid or minimize anxiety. A person tends to recognize only what is in accord with his or her already existing self-system, that is, his or her frame of reference. Discordant observations are anxiety producing, and they are consequently avoided by selective inattention. (Fingarette, 1963, preferred to say that the failure to integrate an observation into one's current frame of reference is what anxiety is, rather than the cause of an emotion called anxiety. Anxiety, to Fingarette, was meaninglessness.)

Thus, the search for coherent meanings in experience is the essence of the ego or of ego functioning, rather than just one among many ego functions. The ego maintains its stability, its identity, and its coherence by selectively gating out observations inconsistent with its current state—granting that one person's coherence is another person's gibberish. This assumption is the theoretical foundation for the use of sentence completions and other projective techniques to measure ego development. Projective techniques call on subjects to project their own frame of reference on the test material. In contrast, objective tests constrain subjects' responses within the test constructor's frame of reference.

Thus, the issue of ego stability is illuminated by Sullivan's theory of ego (self-system, he would say) coherence; the issue of how the ego develops remains, and is perhaps made even more difficult. Sullivan called on other aspects of development, including the drives, as impetus for renewed development. In psychoanalytic theory, *mastery* becomes a key term in accounting for development, although not exactly in Adler's terms (Loevinger, 1976).

If coherence is the hallmark of ego stability, then how does one identify the stable configurations? A working list of ego stages is presented in Table 1.1. This list is almost the same as the version used in the 1970 edition of this manual. However, it differs from other authors' lists of stages, but there are large overlaps. So far it has proved impossible to show by research that some configurations called *stages* are in any demonstrable way different from patterns that have been called *transitions* between stages. In some cases, what were originally seen as transitions are now labeled as stages. For methodological reasons that are detailed shortly, no quick solution to this problem seems likely.

STAGES

One of the newborn's earliest tasks is to construct for him or herself a stable world of objects. Constructing the world of objects and constructing the self are correlative. Many authors, especially many psychoanalytic theorists, refer to this period alone as ego development, but that leaves no distinctive term for the remaining stages that are the topic of our inquiry. This stage of ego formation is called the *first stage* and is acknowledged for theoretical completeness. It is beyond the scope of our work.

E2: Impulsive Stage

The lowest stage that is accessible by our methods of study is the Impulsive stage.[2] The child at this stage is a creature of physical needs and impulses, dependent on others for

[2]Capitals are used to denote stage names; lower case the everyday use of the corresponding term. No human characteristic arises all at once in one stage and disappears on passage to the next.

control. Deep and dependent attachment to caretakers is colored by physical needs. Other people are understood in terms of the simplest dichotomies, good and bad, clean and dirty. Good guys give to me, mean ones do not. The growing sense of self is affirmed by the word "No." There is little sense of causation. Punishment is arbitrary or retaliatory. Rules are poorly understood. Lacking the ability to conceptualize inner life, the child cannot distinguish physical from emotional malaise. This is normal behavior for the very young child; by school age, children optimally have advanced beyond it, but those who do not may be diagnosed as "impulsive personalities."

E3: Self-Protective Stage

The Self-protective stage, the first step toward control of impulses and hence of character development, occurs when the child becomes capable of delay for immediate advantage. Children at this stage appreciate rules and know it is to their advantage to play by them. They are creatures of more or less opportunistic hedonism; they lack long-term goals and ideals. They want immediate gratification and, if they can, will exploit others for their ends. Seeing interpersonal relationships as exploitative, they are themselves wary and self-protective. If they "get in trouble," it is because they were with the "wrong people." Thus, blame is understood but assigned to others, to circumstances, or sometimes to a part of themselves for which they do not feel responsible ("my eyes"). In small children passing through this stage in normal time, rituals and traditions tend to be prominent, a kind of embodiment of rules and controls. Older children and adults who remain at this stage see life as a zero-sum game; they may become hostile, opportunistic, or even psychopathic. However, most adults go beyond this stage, and probably most Self-protective persons find a place in normal society and may even be successful, given good luck, good looks, intellectual brilliance, or inherited wealth.

E4: Conformist Stage

In normal development, at school age or somewhere in the school years, the child negotiates the transition from the egocentric Self-protective stage to the group-centered Conformist stage. More psychologists and philosophers have described Conformity than any other stage. At this stage, the child identifies self with the group or its authority—be it parents, teachers, or peers. Rules are accepted just because they are the rules. This is the period of greatest cognitive simplicity: There is a right way and a wrong way, and it is the same for everyone all the time, or at least for broad classes of people described in demographic terms. What is conventional and socially approved is right. That is usually true with respect to conventional gender roles. However, a person who rigidly conforms to some unconventional gender norms is still a Conformist. Friendliness and social niceness are highly valued; disapproval is a potent sanction. The person is preoccupied with appearance, material things, reputation, and social acceptance and belonging. Inner states are perceived in the simplest language (sad, happy, glad, angry, love, and understanding), contrasting with an almost physical version of inner life at lower levels (sick, upset, mad, excited) and a richly differentiated inner life at higher levels. People, including the self, are perceived in terms of stereotypes based on social groups rather than in terms of individual differences. The way people are and the way they ought to be are not sharply differentiated. People at this stage usually describe themselves and others of their in-group in socially acceptable terms. Interpersonal interaction is seen primarily in terms of actions, not feelings, and the prototypic action is talking.

Group pressure can presumably encourage transition from the Self-protective to the Conformist stage. But what impels the transition out of pure conformity? Possibly, the young person during the primary school and secondary school years finds him or herself a member of different groups that demand conformity to somewhat disparate standards. One woman, for example, said that her mother punished her for some infraction by forbidding her to go to mass. She feared punishment in the Hereafter, but her mother was the clear and present danger. An individual can hardly endure such a dilemma without abandoning his or her absolute faith in at least one of the competing authorities.

E5: Self-Aware Stage

By whatever means, the person at the Self-aware stage has become aware that not everyone, including his or her own self, conforms perfectly all the time to the characteristics that stereotypes seem to demand. Once "what I am" is untied from "what I ought to be," the way is open to begin examination of self. The ability to conceptualize inner life expands; interpersonal relationships are described not merely as actions but also in terms of feelings. In many people at this stage, there is an acute sense of the distinction between self and group; emotions such as self-consciousness and loneliness are described. At the same time, the person perceives that there may be alternative possibilities in many situations that for the Conformist are covered by absolute rules or statements. Qualifications and contingencies are allowed, although they still tend to be stated in broadly demographic terms rather than in terms of individual differences: For example, some activity is okay if you are an adult, or if you are a boy, rather than if you are personally qualified or have a deep desire for it. Such modification of absolute rules may apply to anything from sexual mores to a woman having a career. The Self-aware stage is still basically a version of Conformity.

E6: Conscientious Stage

Growth to the Conscientious stage is another major and mysterious shift, for, as Freud (1930/1961) pointed out, so long as sanctions for misdeeds come from outside oneself,

they can be escaped, but a bad conscience is ineluctable punishment. How are people induced to make that shift? The psychoanalytic answer is by identification with others admired, loved, or even feared; the social learning answer is that in the long run a person without conscience is punished or socially disapproved. The social learning answer seems more adequate to account for growth to Conformity than to growth past that stage, and intuitively conscience seems to be less calculating than is implied by social learning theory. However, research has no clear answers.

The distinctive mark of the Conscientious stage is self-evaluated standards: I approve or disapprove of a given conduct not just because my family or my schoolmates or the authorities do, but because that is what I personally feel. Of course, most people at this level do choose to adopt conformity as an everyday rule, so the difference between this stage and the Conformist and Self-aware stages is not the behavior itself. At this stage, one is guilty not primarily, or not only, when one has broken a rule, but rather when one has hurt another person. Motives and consequences are more important than rules per se; *ought* is differentiated from *is*. Inner states and individual differences are described in vivid and differentiated terms. Long-term goals and ideals are characteristic.

The Conscientious person is reflective; self and others are described in terms of reflexive traits. The only reflexive traits that regularly appear at a lower level are self-consciousness and self-confidence. The Conscientious person is self-critical but not totally rejecting of self, as are some persons at the lowest levels (as well as depressed people of any level). The recognition of multiple possibilities in situations leads to a sense of choice; decisions are made for reasons. The person strives for goals, tries to live up to ideals, and to improve the self.

The moral imperative remains, but it is not just a matter of doing right and avoiding wrong; priorities and appropriateness are considered. Moral issues are separated from conventional rules and from esthetic standards or preferences. To make such distinctions entails greater conceptual complexity than at the Conformist level or lower. Achievement is highly valued, not only in terms of competition or social approval (which always retain some importance), but in terms of one's own standards. Work, rather than being purely onerous, is an opportunity for achievement, so long as it is not dull or boring. People at this level are more likely than those at lower levels to think beyond their own personal concerns to those of society. The conscientious character has the negative aspect that the person may feel excessive responsibility for others.

E7: Individualistic Stage

Where the Conscientious person has a vivid sense of individual differences, the person at the next stage (Individualistic) has a sense of individuality, of the personality as a whole or the style of life. There is a greater tolerance for individual differences than at earlier stages. The inner self and the outer self are often differentiated, a distinction anticipated at the Conscientious level in concern about deceptive behavior. Although a concern for the problems of dependence and independence is a recurrent one, at this stage the person distinguishes physical, financial, and emotional dependence; there is particular concern for emotional dependence. Relationships with other people, which have been becoming deeper and more intensive as the person grew from the Conformist to the Conscientious stage, are recognized as being partly antagonistic to the striving for achievement and the sometimes excessive moralism and responsibility for others at the Conscientious level.

There are other new elements at the Individualistic level, more fully developed at the Autonomous stage. These ideas include psychological causation and psychological development. Below the Conscientious stage, almost no one ever mentions spontaneously the development of personality or of traits. Another new element is a concept of people as having and being different in different roles. The prime example of role differentiation—that a modern woman is expected to serve as wife, mother, housekeeper, lover, working woman, and so on—has become such a staple topic of women's magazines that it turns up at lower levels too. It illustrates the fact that not all clichés are Conformist.

E8: Autonomous Stage

Autonomy is a need that recurs throughout life in different forms. Erikson (1950) used the term *autonomous* for the stage here designated as Self-protective. The young child, even in the Impulsive stage, asserts him or herself by demanding to "do it by self." Here the term *autonomy* is reserved for a stage at the other end of the scale. Its chief characteristic is the recognition of other people's need for autonomy. There is also some freeing of the person from the excessive striving and sense of responsibility characteristic of the Conscientious stage. Moral dichotomies are no longer typical. They are replaced by a feeling for the complexity and multifaceted character of real people and real situations. There is a deepened respect for other people and their need to find their own way and even make their own mistakes. Crucial instances are members of one's own family, particularly one's children.

Conflicts between needs and desires are recognized and often acknowledged as part of the human condition, and thus they are not totally solvable. There is a high toleration for ambiguity and recognition of paradoxes. Humor is not hostile but tends instead to be existential, touching on the droll aspects of the nature of things. The Conscientious person's striving for achievement is transmuted into a search for self-fulfillment.

E9: Integrated Stage

Only a few individuals, probably less than 1% of an urban population in the United States, for example, reach the theoretical highest point, the Integrated stage. Data at present do not suffice to describe fully this theoretical high point.

Maslow (1954) probably provides what is the best description of the self-actualizing person. Because this stage is rare in most samples and there are major differences among qualified raters both as to the description of this level and application of the description in particular cases, under most circumstances it is best combined with the Autonomous stage.

There is a temptation to see the stages of ego development as a kind of ladder to be climbed and to suppose that the people at the highest stages are the best adjusted. There are probably well-adjusted people of all stages; surely, many children are well-adjusted, and they cannot be at the highest stages. In principle, ego maturity and adjustment must be described independently in order to ascertain empirically the relation between them. Those who remain below the Conformist level at maturity may be described as maladjusted from the point of view of some pillars of society; nonetheless, they may become quite successful in life. Because acknowledgment of inner conflict is one of the clearest signs of high ego level, some of those at the highest level may appear to be or may in fact be among those who are not well adjusted. On the other hand, some persons in the Conformist to Conscientious range may also have conflicts, acknowledged or not.

The relation between adjustment and ego level depends on one's definition of terms. From one point of view, each ego level has its own appropriate mode of adjustment, but in that case, not much is added by asserting a relation of ego development to adjustment. From another point of view, there are meanings to adjustment that do permit comparison of different ego levels. Then they must be defined independently, and one could argue that the result does not do justice to the characteristic adjustment of the highest levels.

Understandably, there is special interest in the lowest and highest stages, because both have some aura of mystery. The origins of the ego are fascinating for some of the same reasons as the origins of any psychological function. The highest stages are fascinating in part because they embody so much of what each of us aspires to or believes that he or she has achieved. But to describe ego development as simply the progression from the Impulsive stage to the Autonomous or Integrated stage, implying that the developmental course is a steady progression from low to high, would be a grievous mistake. The vast majority of people would not be described that way, and the process itself would be distorted, because neither the individual differences in ego development nor the dialectics of the most populous stages would be represented. What is most observable, either in slow progression or in individual differences within a cohort, is the range from the Self-Protective to the Conformist and from the Conformist to the Conscientious stages.

METHODOLOGICAL DIFFICULTIES

Table 1.1 summarizes our current views on the substance of the successive stages. In one way or another it differs from what any of the other investigators in the field has drawn up or would do when making a similar table. All of us deal with data, with hundreds or even thousands of cases, so why should there be such unresolved differences?

First, there is no one-to-one correspondence between any bit of behavior and its underlying disposition—in this case, ego level. No bit of behavior is or can be assumed to be more than probabilistically related to ego level.

Second, all kinds of development are occurring at the same times. There is no completely error-free method of separating one strand of development from another. A particular bit of behavior may, and in general must be assumed to, reflect more than one strand of development. Ego development is conceptually distinct from intellectual development and psychosexual development, but it is bound to be correlated with them during childhood and adolescence. There is not even a guarantee of "local independence"; that is, even for a group of constant chronological age, there may be a correlation between ego development and other strands of development. Thus, there is a confounding of variance that no amount of data will resolve into its component sources. If one depends entirely on empirical methods, one is at the mercy of confounded variance; so theory must always temper reliance on data, even more so because our data inevitably contain gaps.

Third, there is no error-free method of distinguishing probable signs of one ego level from signs of a probable correlate. To the extent that the correlates are other developmental variables, this principle is the same as the second one. Other correlates, such as socioeconomic status (SES), are not developmental. How can one be sure whether a particular kind of behavior results from low ego level or associated low economic and social level? In principle, with infinite amounts of data, one could decide; in practice, with the kinds of data available, one cannot be sure.

Fourth, no task can be guaranteed to display just what one wants to know about ego level. In a structured test, the investigator is projecting his or her own frame of reference rather than tapping the frame of reference of the subjects, which is what reveals their ego level. In unstructured tests, one cannot control what the subject will choose to reveal. Testers become very adept at interpreting minimal signs, but there is always the chance a person will conceal all or respond in a way that conceals usual ego level, in whatever sense others reveal theirs.

Fifth, every person in principle displays behavior at more than one level. Every behavior sample must be assumed to be diverse with respect to level. The basic tasks of psychometrics are to translate qualitative aspects of behavior to quantitative and to reduce diverse observations to single scores. There is no unique way to do either. Different psychometric procedures may lead to at least slightly different pictures of successive stages.

Sixth, there are intrinsic difficulties in assigning behavioral signs to any developmental level. A sign that appears at one level in tentative or embryonic version appears at higher levels in increasingly clear and elaborated versions. In sentence completions, a thought that appears at one level

as a cliché appears in deeper, more convincing, and more complex versions at higher levels. A paradoxical result is that when similar responses are grouped together as a category and the most representative response is used as category title, the title response will often be the one that comes from a protocol rated a level lower.

Seventh, a behavioral sign may be discriminating in one direction only; thus, there is an intrinsic ambiguity in assigning it to any level within those to which it applies.

Eighth is the issue of base rates (Meehl & Rosen, 1955). Given a particular replicated response, what is the probability that the subject comes from a given level? If one is concerned only with the particular sample, the answer is the obvious one, the central tendency of those who give the response. But test constructors are not concerned just with the sample before them. Most samples contain few extreme cases; so this rule will ordinarily yield no signs that would receive extreme scores. The proper question is more like: Given a particular ego level, what is the probability of showing this sign? Because extreme cases are rare, most decisions about extreme ratings will be based on small numbers of cases, leaving the test constructor at the mercy of the idiosyncrasies of a few people. The same consideration holds for all uncommon responses at median levels. Thus, particularly for ratings at extreme levels, theory is indispensable as a supplement to data.

Finally, consider the question about clinical insight as arbiter of the appropriate level for a given sign or response type. Clinicians rarely think of data in terms of the complex probabilities detailed earlier. They tend to think of every bit of behavior as determined by the patient's particular constellation of traits and circumstances. Responses that the ground rules of this manual (see chapter 3) call for rating, clinicians would say do not reveal ego level. Indeed, that is correct, for they are equivocal. Thus, the psychometric frame of reference is different from the clinical frame of reference. There is also a deeper reason why the clinician's intuitive perceptions may be misleading. Every developmental level builds on and transmutes the previous one. The unconscious or preconscious components of the attitudes of one level are the corresponding attitudes of earlier levels. Precisely because clinicians see the patient more deeply than any test can, they may misjudge the level of a particular sign or of a patient. Hence, clinical judgment fails as a court of last appeal, though with proper precautions it is a valuable line of evidence additional to theory and test and experimental data.

Main, M. & Goldwyn, R. (1994). Adult attachment scoring and classification systems. Version 6. Unpublished manuscript.

Classified on basis of PRESENT state of mind. Consider general criteria for Dismissing state of mind first, then sub-groups.

DISMISSING OF ATTACHMENT

- current attempt to limit influence of attachment relationships and experiences in thought, in feeling or in daily life
- all (except Ds4) claim to strength, normalcy and independence
- dismiss imperfections in parents in face of contradictory or unsupportive evidence
- dismiss any potential negative effects of parenting on self
- contemptuously derogating and dismissing attachment figures or attachment related phenomena
- minor flaws in parents soon followed by generalisations and positive wrap-up
- emphasis on "fun" activities, material objects

Ds1 - Dismissing of attachment

- pervasive lack of love, closeness or support from attachment figures (sometimes silent, empty cruelties)
- direct rejection
- lack of memory for childhood
- idealisation of at least one parent strong (*reader inclined to think this idealisation is misplaced but necessary to defend conception of family as normal*)

Ds2 - Devaluing of attachment

- active devaluing
- possibly stems from rejection, possibly in response to involving/role-reversing parent
- can also make surprisingly perceptive remarks about people or aspects of childhood which might suggest a continuing capacity for attachment

Ds3 - Restricted in feeling

- pervasive lack of love, but childhood experience not fully dismissed
- direct rejection, but directly mentions rejection of lack of closeness, but does not think it has affected them
- lack of memory for childhood
- moderately incoherent (*often because says nothing much -my suspicion is of no family language for emotions*)
- less idealisation
- mention of hurt and missing and depending relatively absent (*emotional learning absent*)

Ds4 - Fear of loss of child through death

- This only applies when the fear cannot be traced consciously to any known source
- seems to override every background
- Coder need to find also alternative best-fitting Ds, E or F classification.

F. SECURE/AUTONOMOUS WITH RESPECT TO ATTACHMENT

- freely valuing of attachment
- moderately to highly aware of the nature of her experiences with her parents and with attachment AND the effects of those experiences upon her present state of mind

- discussion is relatively relaxed since topic is relatively open one
- freshness of speech, evidence of fresh thinking occurring within the interview, eg. correcting not so much factual things but what the interviewer might be thinking or needing to know to understand
- little psycho-jargon or "canned speech" (*what I would call the social cliched story line or "press release")*
- personal history is believable: either picture of one or both parents as secure base, or, if parents did not provide secure base, this is accounted for in coherent, reflective way regarding attachment.
- many have been actively engaged in escape or having identified parents' wrong-doing may be forgiving
- moderate to high coherence of transcript - little self-deception- difficulties reported in reflective, contained or humorous manner
- avowal of need to depend on other
- balance with respect to the view taken of relationships, accepting own part in relationship difficulties when appropriate, setting parents in relevant contexts when criticising them, or showing a sense of proportion and balance through humour (*all features of relativistic, at least formal thinking, E6 or above on Loevinger's scheme, mature defenses according to Vaillant*)
- not much identification with parents' negative aspects, only moderate idealisation and moderately angry preoccupation
- aware of the power of processes they cannot avoid, eg hear themselves saying or doing things they disliked in parents, and statements about this are not immediately qualified or denied
- compassionate sense of imperfection in self and others. Unlikely to consider themselves free of faults in parenting (*also signs of cognitive complexity*)
- Coder gets a sense of the development of a strong personal identity (*this does not have to mean identity achieved - some adolescents provide a very self-confident script of where they are at present - which does not seem to contain any thinking about self into the future*)..

F1. Some setting aside of attachment

- reevaluation and redirection of personal life as the successor to a harsh childhood. Attachment clearly valued but may be like Ds because of lack of memory (but here these seem to be actively set aside), and some idealisation.
- because of a background of poverty and family preoccupied with survival, there may have been limited involvement with attachment, limited expression of attachment, affection
- yet individual is coherent and retains a mild though unexamined sense of standing support from parents

F2. Somewhat dismissing or restricting

- some kind of dismissal of attachment which is ultimately belied by affection, compassion, humour, forgiveness or some other evidence of an underlying valuing of attachment
- like Ds in moderate lack of memory for childhood, moderate idealisation of one or both parents, fear of loss only partly connected to source, or defensive or belligerent stance towards attachment which is countered by affection or admission of concern

F3. Secure/Autonomous

- Highly diverse group - similar because of high coherence. May have characteristics of other F categories
- lack of idealisation
- good memory for childhood

- even if parents' qualities are wholly negative there is nothing to suggest this is unrealistic, not derogatory nor angrily preoccupied with parents' failings
- do not necessarily find current relationships satisfying
- 2 subgroups: F3a: those with largely supportive families and childhoods. May seem rather simple, little concern with psychological issues, but still clear and objective; F3b: Difficult experiences during childhood but state of mind now seems exceptionally thoughtful. Gives impression of now being highly developed with a strong sense of self.

F4. Strong valuing of relationships with some accompanying preoccupation with attachment figures, with separations or with past trauma

- open avowed treasuring of feelings or affection
- mild positive or negative preoccupation with the past or past relationships or with attachment experiences in general
- like Es may show a tendency to psychological analysis of events and individuals
- Some seem strong-willed highly developed characters who enjoy demonstrating their present or early sense of character during the interview
- may be over-forgiving
- 2 subgroups; F4a: those whose experiences were largely supportive but were accompanied by some kind of difficulty in parental character or experience. Some open preoccupation with attachment issues which hold person back from full personal autonomy. Coder may have the impression that family difficulties were relatively slight. May seem young and sentimental;
- F4b: Individuals with difficult childhood that may include traumatic experiences, such as loss of attachment figure through death or sexual or physical abuse within the family, which presently occupy attention. May be somewhat incoherent, but ultimately rational and convincingly conscious.

F5. Somewhat resentful/conflicted while accepting of one's own continuing involvement

- moderately angrily preoccupied with their relationships to their attachment figures but nonetheless coherent and contained, and sometimes humorous.
- These individuals are still complaining about and caught up in the relationship, but their awareness seems much greater than that of Preoccupied individuals.

E. PREOCCUPIED WITH OR BY EARLY ATTACHMENTS OR PAST EXPERIENCES: CONFUSED, UNOBJECTIVE AND MENTALLY ENTANGLED

- these interviews tend to be much longer than other interviews
- confused, unobjective and preoccupied
- passive and vague, fearful and overwhelmed or conflicted and unconvincingly analytic
- although in some cases they seem very open in their focus upon their parents and attachment-related experiences, this focus seems ultimately neither fruitful, objective or incisive, despite an often extensive discussion of feelings, experiences and relationships.
- sense of personal identity seems confused or weak
- most frequently it can be inferred that parenting experiences were lacking in love or supportiveness, yet were not notably rejecting
- one parent was often (but not always) role-reversing/involving
- in some cases mother may have failed in protectiveness (i.e. panicking in emergencies, or failing to stand up to an abusive father)
- in some cases mother fell apart in childhood emergencies so that she herself required care or parenting

- in some cases child-parent difficulties may be less overt. Perhaps the parent is described as normally loving but there is sense of negativity. Perhaps the parent sought a special closeness which was inappropriate.
- the parent may have continually criticised the child's state, accomplishments, failures in duty or appearance - criticisms which seemed to have had the aim of persuading the child to please through continual attentiveness to the parent rather than turning the child's attention away from the parent towards accomplishments. Outcome is that the child frequently felt guilty.
- May have been an emphasis upon family relationships, upon the past family past or history (*i.e. the individual child is not important except to enhance the family, or to occupy an assigned role in the family*)
- With regard to present state of mind: a seeming inability to move beyond a sense of the self as involved or entangled in early relationships or malignant experiences
- apparent lack of personal identity apart from that of the family or apart from overwhelming experiences
- inability to see the role of the self in any relationship system, or evaluate the role of the self within relationships unless with guilt and self-deprecation.
- lack of ability to focus fruitfully, objectively or incisively during the interview, despite a lot of talk
- seem to be captured by memories as if still in them, do not seem to be able to gain distance from them
- swing between memories of parents' behaviours in the past and current interactions as if the behaviours and situations are equivalent or continuing. (*i.e. no sense that they are no longer the child of the past*)
- attempts to give an overview may be met immediately by oscillatory tendencies, i.e they may make a negative generalisation about the parent and then disclaim it and give a positive generalisation. There is a personal element of struggle, ambivalence and indecisiveness in such oscillation which readily distinguishes it both from the fresh thinking and corrective monitoring of some Autonomous subjects and from the positive wrap-up which represents a restatement of an originally positive stance in the Dismissing subject
- tendency to bring present relationship with parents into interview even as first response to question about the past.
- if person has children, tendency to repeatedly bring relationship with own children into the interview
- in the interview there may be subtle confusions between self and parent or time when situation occurred. Pronoun slips and tense slips may be markers of these confusions. May suddenly address parent or speak parents' words without marking the change of speaker or indicating direct speech. Often use excessively lengthy quotations of parent's speech. Sometimes falls in to language use of a small child.

E1. Passive

- the most striking feature of this interview is the implied passivity of thought processed regarding an ill-defined experience of childhood.
- speech may wander to irrelevancies, or become confused, vague or incoherent
- it is difficult to determine the individual's experience of childhood except for excessive involvement in family relationships ranging from guilt-inducing criticism to role-reversal
- the individual may have a vaguely good, even hallowed view of her childhood, her parents or the past in general
- some peculiarly childlike statements. If there has been a struggle for autonomy in this individual, it is limited or has remained inaccessible to awareness.
- subjects are not assigned to E1 category unless they have high scores of Passivity of Discourse scale

E2. Angry/conflicted

- high ratings for current, involved anger towards one or both parents serve as the chief marker of this category, and are required for assignment to E2 category, but high ratings do not automatically justify E2 assignment
- interview usually very long as the subject goes into great detail of difficulties with one or both parents and own reactions to distress and anger
- subject's background appears to coder and not infrequently to subject, as one of high involvement and often of role reversal
- sometimes the description of parental behaviour in the past is too vague, or the incidents described are too small, to appear to justify the reaction taking place within the subject
- subject often impresses coder with being unable to see things from another's point of view, although she may claim to through use of pseudo-psychological language
- subject may engage in mind-reading the parent, eg. claiming to know more than is possible about her parent's feelings, motives and intentions
- despite much talk about feelings, she may strike coder as cold or detached.

E3. Fearfully preoccupied by traumatic events

- this classification is rarely used in normal samples. Usually it is either directly stated or can be inferred that the individual has had fearful experiences related to attachment
- She may seem neither actively angry and preoccupied with a particular parent, nor genuinely passive, but the nature of the past means that she cannot escape being preoccupied with it as a whole
- Two subgroups: E3a: Confused, fearful and overwhelmed by traumatic/frightening experiences. Cannot talk without introducing the topic. Confusion may be an aspect of the discussion, eg. she may not be sure that they even occurred - might have been a dream. May also talk about terrifying dreams.
- E3b: Distressing loss of memory in apparent relation to traumatic experiences. This category should be used if an individual has definitely or probably suffered trauma; reports having very little childhood memory or else memory is recently being recovered; and is ALSO distressed by the memory loss rather than regarding it as normal. Do not use this category for primary placement for individuals who are indifferent, calm or essentially accepting regarding memory loss for some period potentially associated with trauma, but E3 may be used as an alternate category placement.
- The E3 category has no particular fit to infant attachment sub-categories, so when used as primary category, a secondary, best-fitting alternative should be assigned.

CANNOT CLASSIFY

- an individual cannot be categorised as Ds, E. or F, because there is such a striking mix of mental states that no single ORGANISED state or strategy is obvious
- not to be used just because coder is having difficulty deciding between related categories, eg. Ds3 and F2 or F4 and E1
- may be used when subject changes category in mid-interview, as though completely shifting state of mind with respect to attachment in mid-interview.
- may be used if the subject seems to be in completely differing states of mind in describing different people, ie. to be E2 with respect to the father, Ds2 with respect to the mother

- not necessarily Unresolved
- need to list the alternative categories considered

UNRESOLVED (DISORGANISED/DISORIENTED) STATES OF MIND WITH RESPECT TO EXPERIENCE OF LOSS

- there must be a specified loss of an attachment figure (including intimate friends)
- if loss has occurred in preceding year it can still be scored but should not be used in research where it may have different implications to earlier losses
- there must be lapses in the monitoring of reasoning, lapses in the monitoring of discourse and/or reports of extreme behavioural reaction (effectively, past lapses in the monitoring of behaviour).
- lapses of reasoning are only counted in passages addressing the topic of loss
- exemplary passages given by Mary Main require a very alarming level of confusion before achieving level required for a U/D classification as primary category
- a best-fitting alternate classification is required for all primary U/D categories.
- interviewer should be prepared to allow long silences in such discourses (examples given as significant are 50 second plus pauses)
- loss of pets or unborn children if brought up be subject can be scored by same criteria but should be analysed separately

UNRESOLVED (DISORGANISED/DISORIENTED) STATES OF MIND WITH RESPECT TO EXPERIENCE OF LOSS

- This scale considers the subject's response to frightening/abusive experiences involving parental figures
- only those statement directly pertaining to the abuse are used for determining the score
- first the coder must decide whether an experience qualifies as abuse (*and the criteria Mary Main has specified were vigorously debated at the AAI Institute training*)
- even if there is evidence of extreme abuse, it requires considerable evidence of disorganisation to reach the level where this will be the primary classification