

Theses, Dissertations, and Projects

---

2013

## Addiction and attachment : mental health clinicians' use of attachment theory in the treatment of substance use disorders

Emily Tate  
*Smith College*

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social and Behavioral Sciences Commons](#)

---

### Recommended Citation

Tate, Emily, "Addiction and attachment : mental health clinicians' use of attachment theory in the treatment of substance use disorders" (2013). Masters Thesis, Smith College, Northampton, MA. <https://scholarworks.smith.edu/theses/970>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact [scholarworks@smith.edu](mailto:scholarworks@smith.edu).

Emily Tate  
Addiction and Attachment: Mental  
Health Clinicians' Use of  
Attachment Theory in the Treatment  
of Substance Use Disorders

## ABSTRACT

This study explores mental health clinicians' use of attachment theory in the treatment of substance use disorders (SUDs). There are many quantitative studies that show a correlation between substance use and insecure attachment style, yet there is little research that looks at whether or how mental health clinicians are using attachment theory in treatment or the possible benefits and limitations of its use.

This is a qualitative study that sampled ten mental health clinicians to see if and how attachment theory is used in treating SUDs. It also explored the benefits and limitations of using attachment theory in the treatment of SUDs. Participants' responses reveal that all participants held a general understanding of attachment theory and all except one participant did not deliberately consider attachment theory in the treatment process. However, all participants spoke to considering attachment-style in the treatment process. Evidenced-Based Practices (EBPs) were cited as one of the most common treatment approaches. Overall, attachment theory shows a utility in treatment, however, it should be used in conjunction with other treatment approaches and models as the study also shows its limitations for use. Also, the study reveals the need for future studies to look at treatment outcomes of the use of attachment theory in the treatment of SUDs.

ADDICTION AND ATTACHMENT: MENTAL HEALTH CLINICIANS' USE OF  
ATTACHMENT THEORY IN THE TREATMENT OF SUBSTANCE USE DISORDERS

A project based upon an independent investigation  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

Emily Tate  
Smith College School For Social Work  
Northampton, Massachusetts 01063  
2013

## ACKNOWLEDGEMENTS

This thesis could not have been accomplished without the support of many people. I would like to thank my thesis advisor for her guidance, encouragement and flexibility throughout this process. While it feels as though there is always more to write and that perhaps nothing is ever finished, she helped me to feel fulfilled about this achievement. I would also like to thank my supervisor, Jody Grablewski, LICSW, for her support and assistance throughout this process; my partner and best friend for being so caring and understanding and willing to humor me as I toiled through to the end; and, my parents because I would not be here today without you- including my father, Robert Tate Jr., who paved the way for me at Smith College School for Social Work thirty-one years ago and my mother, Sandy Thompson, who instilled in me a desire for social justice and an aspiration to be as caring and generous as she is. Finally, I would also like to send out a huge thank you to the talented people who so generously donated their time and knowledge by participating in this study- I hope to be as thoughtful and knowledgeable in my work as you are.

## TABLE OF CONTENTS

ACKNOWLEDGEMENTS .....	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I INTRODUCTION .....	1
II LITERATURE REVIEW .....	4
III METHODOLOGY .....	30
IV FINDINGS .....	37
V DISCUSSION.....	81
REFERENCES .....	99
APPENDICES	
Appendix A: Human Subjects Review Committee Approval Letter .....	110
Appendix B: Recruitment Email.....	111
Appendix C: Informed Consent .....	112
Appendix D: Interview Questions Preview.....	114
Appendix E: Demographic Questionnaire .....	115

## CHAPTER I

### Introduction

The purpose of this study is to explore mental health clinicians' use of attachment theory in the treatment of substance use disorders (SUDs) . The study also explores whether clinicians who do not use attachment theory use different approaches instead. The study will look at both the limitations of attachment theory as well as the usefulness of attachment theory in the treatment process. Also, in the instances in which participants do use attachment theory in treatment, examples of “translation rules” from theory to practice will be discussed.

According to the Substance Abuse and Mental Health Services Administration (2010), 9% of the U.S. population meets the criteria for SUDs and currently there are more than 20 million people who are in recovery from SUDs. In 2011, the Drug Abuse Warning Network (DAWN) estimated that the number of drug-related suicide attempts had increased by 41 percent from 2004-2011. Studies have shows that annually substance abuse costs the nation \$510.8 billion dollars (Miller & Hendrie, 2008). SUDs are often an area of conflict as to the etiology of and effective treatment for this disorder (Shaffer & Robbins, 1991). One of the many ways in which SUDs have been conceptualized is as an attachment disorder (Flores, 2004). Attachment theory, developed by John Bowlby (1969), posits that self-regulation capacities are developed in the early relationship with the caregiver. Disruptions in the attachment system, which Bowlby defined as insecure attachment, can lead to vulnerabilities in the sense of self and others as well as relationship problems. “Attachment representations show predictive associations with a wide

range of pathological behavior including personality disorder(s), mood disturbance, and psychopathology” (Caspers, Yucuis, Troutman, & Spinks, 2006). Heinz Kohut (1977) expanded Bowlby’s theory of attachment even further to hypothesize that addictions often occur in individuals with insecure attachment to their early attachment figures. “Addiction is seen as an attempt to regulate the attachment system” (Padykula & Conklin, 2009). Many empirical studies have looked at this conceptualization and have found significant correlations between attachment style and substance use and have shown that individuals who have disruptions in the attachment system are more likely to use substances than those who do not. Also, research and literature on the human brain and attachment shows that insecure attachment affects brain development and that due to the plasticity of the brain, secure attachment relationships have the capacity to repair brain function that may have been underdeveloped due to insecure attachment.

While theory often informs an understanding of mental health disorders it often lacks what Fonagy (1991) describes as “translation rules,” or, in other words, a way to move from theory to practice, or to apply theory to practice. Attachment theory has implications for treatment in terms of the conceptualization of SUDs, the use of attachment style in treatment, informing the pace and goals of treatment, informing treatment approach, listening for attachment narrative in client’s dialogue, taking an abstinence approach to treatment and in developing and maintaining the therapeutic alliance. However, there is little research that shows if and how mental health clinicians are using attachment theory in the treatment of SUDs as well as the usefulness of using attachment theory in the treatment of SUDs.

This is a qualitative study that sampled ten mental health clinicians. A qualitative study was favorable, as little research has been conducted on this topic thus far. The interviews were semi-structured and used open and closed-ended questions to elicit possible attachment themes in

participants' dialogues when discussing their treatment process. This was a deductive study since the themes that this researcher chose to explore were derived from the literature and this researcher's experience with the literature. Therefore, another researcher may have chosen to explore different themes due to their experience with the literature. This researcher's particular interest in this specific theory is a limitation and a bias of this study. A content-theme analysis was used to analyze the data to look for connections and relationships with attachment theory as well as the potential usefulness as well as limitations of attachment theory.

Exploring clinicians' use of attachment theory in the treatment of SUDs and what influences this use may help to further the research on the treatment of SUDs as well as the use of attachment theory in practice. It may also serve to provide "translation rules," or implications, for using attachment theory in practice, specifically with regard to SUDs. Additionally, it may influence future studies to explore this topic further, in particular quantitative studies looking at the effectiveness of using attachment theory in the treatment of SUDs. It may also shed more light on the growing need for treatment options in treating SUDs.



## CHAPTER II

### Literature Review

One of the ways in which addictions have been conceptualized is as an attachment disorder. This discussion will review mental health clinicians' use of attachment theory in the treatment of substance use disorders. A brief overview of substance use disorders will define SUDs and attempt to summarize theories, etiologies and treatments. Then, attachment theory, including its origin and development, will be reviewed and the connection between SUDs and attachment theory will be presented. A brief discussion will then address the general use of theory in practice, noting its benefits as well as complications. Finally, the literature review will conclude by discussing the use of attachment theory in the treatment of SUDs. Examples from empirical studies will illustrate the connection between attachment theory, SUDs and treatment and will include implications for the use of attachment theory in general practice as well as for the use of attachment theory in treating SUDs. Possible barriers for implementing evidenced-based practices (EBPs) will also be discussed. The review will conclude by asserting that while there are empirical studies supporting the connection between SUDs and attachment theory, literature that illustrates the use and potential effectiveness of attachment theory in treating SUDs is lacking, as there is little literature and an absence of empirical studies that demonstrate the use of attachment theory in treating SUDs.

## **Substance Use Disorders**

The DSM IV-TR defines substance use disorders (SUDs) as dependence or abuse of a substance (American Psychiatric Association, 2000). *Substance* can refer to a medication (over-the-counter, prescribed or controlled), a toxin (PCP) or a drug of abuse (such as alcohol, marijuana, cocaine, heroin etc) (American Psychiatric Association, 2000). Substance dependence is defined as “a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems” (American Psychiatric Association, p. 192). Substance abuse is defined as “a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances” (American Psychiatric Association, p. 198). Cook (1991) states, “Addiction is an experience that a person continually repeats, even if it causes harm, because the experience either immediately increases a positive emotional state, decreases a negative emotional state, or both” (p. 411). SUDs can also be referred to as “addictions.”

According to the Substance Abuse and Mental Health Services Administration (2010), 9% of the U.S. population meets the criteria for SUDs and currently there are more than 20 million people who are in recovery from SUDs. In 2011, the Drug Abuse Warning Network (DAWN) estimated that the number of drug-related suicide attempts had increased by 41 percent from 2004-2011. Studies have shown that annually substance abuse costs the nation \$510.8 billion dollars (Miller & Hendrie, 2008). Shaffer and Robbins (1991) explain that, “Like any young scientific field, the addictions serve as a battleground of theoretical debate as to the “true” etiology and the “right” treatment for each category of addictive behavior” (p. 387). The authors use alcoholism to provide an example of the many different ways that addictions can be thought of, citing such examples as: “a primary progressive disease, a symptom of character pathology,

the result of efforts to self-medicate and affective disorder, or a moral weakness” (p. 388).

Substance use has also been described as self-medication for emotional distress as well as a way to cope with emotional instability (Newcomb, 1995; Petraitis, Flay, Miller, Torpy, & Greiner, 1998; Schindler, Thomasius, Sack, Gemeinhardt, & Kustner, 2007). McCrady and Epstein (2003) feel it is important to keep in mind the complexities of SUDs and not adopt a simplistic understanding.

Cook (1991) explains that “There are multiple pathways to addiction” (p. 411), noting that the etiology of addictions include genetic, environmental and psychological features. Due to these influences, some people are more susceptible to SUDs whereas others may be able to use substances in a more controlled, less destructive manner without negative consequences (Flores, 2004). One of the pervasive questions regarding addictions, for which there is no clear or definite answer in the literature, is how much is due to genetics and how much is due to environmental and social influences?

Kendler and Prescott (2006) looked at the findings of the *Virginia Twin Study of Adolescent Behavioral Development (VTSABD)* to explore the influence of environment and genetics in addictions as well as in other mental health disorders. The VTSABD is a cohort-longitudinal epidemiological study that sampled 2,762 white twins, ages 8-16 years, and their families. Kendler and Prescott found that the study shows that there is moderate to strong influence of genetic factors on substance use as well as some environmental influence. The authors point out that there are no genes specifically responsible for SUDs, however, there are genes that one can inherit making them more predisposed to the patterns of behavior associated with SUDs. One of the ways the authors suggest that one may be more predisposed to SUDs through genetics is in what they call “personality traits.” However, they do not acknowledge that

personality traits resemble both influences from genetics as well as the environment. Overall, the authors conclude that if children are raised in “protective environments”, the genetic liability for SUDs is not as likely to surface, implying that environments can be protective factors against SUDs.

In addition, Kendler and Prescott (2006) also describe mediators for alcoholism. One of the mediators for alcoholism is motivation for drinking. Longitudinal studies have found that those who perceive the outcomes of drinking as positive are more likely to use alcohol (Christiansen, Smith, Roehling, & Goldman, 1989). For example, alcohol may be used to lessen feelings of depression, stress or anxiety as well as to make social situations more comfortable and enjoyable (Kendler & Prescott). In support of Kendler and Prescott’s hypothesis that parenting style is a protective factor against SUDs, the study found that children of parents who abused alcohol as well as those who experienced parental loss such as death, divorce or separation are at an increased risk for alcoholism (Helzer, Burnman, & McEvoy, 1991; Vaillant, 1983). The study also found that alcoholism in women was more common if they received “cold and authoritarian parenting” (p. 304), implying that parenting style may influence substance use.

In addition to the multiple pathways to addictions, there are also multiple treatments for addictions. Evidence-Based Practices (EBPs) are strongly favored forms of treatment in SUD populations. The EBPs with the strongest evidence supporting effectiveness include: Contingency Management Therapy, Cognitive Behavioral Therapy, Motivational Enhancement Therapy and 12-Step Facilitation Therapy (National Registry of Evidence-Based Programs and Practices, 2008). Straussner (2012) explains that in Motivational Enhancement Therapy, one of the greatest successes in using this technique comes from the capacity in which the clinician is able to engage people with SUDs to enter into treatment. Straussner suggests that a strong

therapeutic alliance is one of the biggest predictors of positive treatment outcome, implying that the therapeutic relationship can be used to engage and keep clients with SUDs in treatment.

Straussner (2012) explains that due to the diversity of people with SUDs as well as the diversity in treatment philosophies, there is not one treatment approach that fits for all people with SUDs.

Flores (2004) states that treatment for SUDs will be approached depending on setting of treatment, level of substance abuse, preferred substance, motivation, type of therapy (e.g., individual, group etc.), the stage of change of the client is in as well as treatment goals (e.g., harm reduction or abstinence etc.). While Straussner and Flores acknowledge potential variables responsible for treatment approaches, they do not acknowledge the divergent educational and training backgrounds, for example knowledge of theory, of clinicians as a possible influence in the choice of treatment approach. Straussner's (2012) assertion that "diversity in philosophy" influences the conceptualization and treatment of SUDs is important, yet somewhat vague.

### **Attachment Theory**

Currently, one of the ways addiction has been conceptualized in theory is as an adaptive attempt to regulate the attachment system (Padykula & Conklin, 2009), or in other words, as an attachment disorder (Flores, 2004). John Bowlby's (1969) theory of attachment was first presented in *Attachment* (1969), and later revised in 1982, and postulates that the relationship that a child has with caregivers influences the emotional development of the child. In developing his theory, Bowlby observed children in their natural environments and drew on the work of object relations theorists and incorporated the work of Mary Ainsworth, who at the time was studying infant-mother attachments in Uganda. Attachment theory pulls from studies of "early separation, evolutionary biology, ethnology, cognitive science, and information processing theory" (Slade, 2000). In the developing stages, Bowlby's attachment theory was influenced in

part by Harry Harlow's (1958) experiment with rhesus monkeys that demonstrated young monkeys prefer warmth and comfort over food, especially in times of fear or suspected danger. This led Harlow to conclude, "One function of the real mother, human or subhuman, and presumably of a mother surrogate, is to provide a haven of safety for the infant in times of fear and danger" (p. 49).

Bowlby's (1969) attachment theory posits that in attachment behaviour, which he defined as interactions with the mother, the infant learns necessary skills for survival as well as develops an "internal working model" (IWM), which is how the individual views the world, themselves and others. One of these "skills" necessary for survival is the management of emotions and affective states as, "Attachment theory holds the position that it is impossible for individuals to completely regulate their affective states alone" (Flores 2004, p. 3). Bowlby asserted that it is necessary for mental health purposes for the infant to receive "a warm, intimate and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment" (Preface, xxvii-xxviii). Bowlby theorized that those with secure attachment, meaning they have a stronger emotional relationship with caregivers, are able to better regulate emotions and have fewer relationship problems. Disruptions in the attachment system, which Bowlby defined as insecure attachment, can lead to vulnerabilities in the sense of self and others as well as relationship problems. "Attachment representations show predictive associations with a wide range of pathological behavior including personality disorder(s), mood disturbance, and psychopathology" (Caspers, Yucuis, Troutman, & Spinks, 2006). Attachment styles, secure or insecure, in childhood affect relationships throughout adolescence and adulthood. Interpersonal styles in adulthood are thought to be directly related to attachment styles in early childhood (Flores, 2004).

Recent literature on neurobiology and the human brain also addresses the importance of the attachment relationship in childhood in terms of mental health in adulthood. “Studying the effects of disrupted attachment on the developing emotional security of infants and children has been particularly useful in understanding the essential components of brain physiology that contribute to overall mental health” (Miehls, 2011, p. 82). The literature illustrates that with insecure attachment relationships, certain parts of the brain develop less or their development is hindered. In a summary of the literature on neurobiology and its implications for clinical social work practice, Miehls finds that the literature suggests that as relationships influence brain development and that “relationships have the capacity to rebuild certain parts of the brain that influence our social and emotional lives,” (Miehls, p. 81). Miehls describes that the literature suggests that clinicians can help clients to alter their attachment patterns with a secure clinical relationship. This suggests the importance of both attachment in brain development and mental health and also the implications for the healing capacities of the therapeutic relationship on a neurobiological level. Overall, Miehls shows that the literature on neurobiology demonstrates the affects of attachment on brain development as well as the healing potential of secure relationships and therefore underpins attachment theory with a neurobiological connection.

Flores (2004) asserts that attachment theory would not be as accepted as it is today if it were not for Mary Ainsworth. Ainsworth (1969) is famous for her “strange situation” test. This test measured infants’ responses to the coming and going of their caregiver. Their responses to the leaving and then returning of the caregiver helped to classify them as securely or insecurely attached. Ainsworth expanded Bowlby’s theory of attachment to include four attachment-types: secure, insecure-avoidant, insecure-ambivalent and insecure-disorganized. Secure attachment style is classified by the infants' protesting upon separation from their caregiver and then

appearing at ease upon the return of the caregiver. Insecure-avoidant attachment style is classified by the infant hardly protesting upon separation from the caregiver and upon return of the caregiver displaying hesitancy to reunite. Insecure-ambivalent attachment style is classified as the infant protesting at separation and cannot be comforted upon the return of the caregiver. Insecure-disorganized style is classified by no pattern of response to the leaving and returning of the caregiver and often showing extreme behaviors such as freezing or collapsing to the ground upon separation. Ainsworth asserted that these attachment styles were not only due to the personality of the infants, but influenced by the parenting styles of the caregivers.

It has been argued that Bowlby's (1969) original theory of attachment, even with Ainsworth's contributions, can be somewhat limited, especially regarding translation to treatment, due to the fact that most of the work and observations were done with children (Flores, 2004). Flores states, "The work of relational models, especially the contributions of self-psychology, help compensate for attachment theory's limitations" (p. 68). Also, attachment theory proves to be somewhat biased in that it assumes the primary caregiver of the child is the mother, offering a heterosexist viewpoint of child development. In order to adapt attachment theory today, it would be necessary to not place as much emphasis on the "mother," but instead on the "primary caregiver."

Heinz Kohut (1972) expanded Bowlby's work to include adults in order to develop his theory of self-psychology. In doing this, Kohut continued to emphasize, just as Bowlby and Ainsworth had, the importance of the caregiver in the development of the self, especially in terms of self-control and capacity for mutuality in relationships (Flores, 2004). Bowlby (1969) discussed the importance of mutuality, the ability to see things from another's point of view, and cited a study by Light (1979) which showed that "the rate of development of a child's capacity to



grasp the viewpoint of another is probably much influenced by whether or not his mother takes account of his viewpoint in her dealings with him” (Bowlby, p. 354).

### **Substance Use Disorders and Attachment Theory**

Kohut (1977) expanded Bowlby’s theory of attachment even further to hypothesize that addictions often occur in individuals with insecure attachment to their early attachment figures. This theory was initially published in a monograph in 1977 that was a result of a conference where psychoanalysts, psychiatrists and psychologists examined SUDs from a psychodynamic viewpoint in the hopes at discovering implications for treatment of SUDs through psychodynamic theory. “We also believe that diligence in trying to comprehend this theoretical point of view will help to organize clinical observations and apply them more meaningfully and consistently in work with patients” (Blame & Julius, 1977, p. 12).

Kohut, in the preface, explained addiction as an attachment disorder. If the attachment system is impaired, and this is where the child learns to regulate emotions, then the child has difficulty regulating emotions, which can lead to a host of other issues including interpersonal difficulties and addictions. Using substances then becomes an adaptive approach for the substance user to regulate emotions, where they have not learned to do so on their own. Kohut explained that drugs allow the person to have self esteem- to be self-confident, worthwhile and strong and “increase feelings of being alive” (Preface, viii). In a way, the addiction functions as a way to keep the person together and provide them with a sense of self as it acts as a compensatory behavior for a deficiency in the attachment system (Flores, 2004). However, “the addictive substance provides a false sense of self-regulation” (Padykula & Conklin, 2009, p. 352). Kohut explained that the drug is an “illusion” to comfort and security because the “psychic structure” is not actually changed and the “defect in the self remains” (Preface, viii). Kohut, in

keeping Bowlby in mind, believed that it was important to examine the family background and the attachment relationships of the substance user and put forth that, “The crucial question then is whether the parents are able to reflect with approval at least some of the child’s proudly exhibited attributes and functions, whether they are able to respond with genuine enjoyment to his budding skills, whether they are able to remain in touch with him throughout trials and errors (Preface, viii).

Since this conceptualization of addiction that draws on attachment theory, numerous empirical studies have explored this idea. These studies consistently find a link between insecure attachment and substance abuse (Schindler, Thomasius, Sack, Gemeinhardt, 2007; Schindler, Thomasius, Sack, Gemeinhardt & Eckert, 2005) and suggest that attachment strength is a protective factor against substance use and that insecurely attached individuals are more likely to use substances as a coping mechanism to meet their emotional needs (Caspers, Cadoret, Langbehn, Yucuis & Troutman, 2005; Kassel, Wardle & Roberts, 2006; Lee & Bell 2003; Perrier, Boucher, Etchegary, Sadava & Molnar, 2010; Reis, Curtis & Reid, 2011; Thorberg & Lyvers 2009). Overall, the majority of the research suggests a correlation between substance use and attachment style, finding that secure attachment is negatively correlated with substance use and insecure attachment is positively correlated with substance use.

While attachment style and substance use disorders show a correlation, there are also mediating factors that have been studied with attachment style and substance use, such as: perceived social support, self worth/happiness, self-esteem, emotional autonomy and self-reliance (Caspers, Cadoret, Langbehn, Yucuis, & Troutman, 2005; Kassel, Wardle, & Roberts, 2006; Lee & Bell, 2003; Reis, Curtis, & Reid, 2011). These mediating factors are consistent with attachment theorists' conceptualization of the functions of attachment behavior and therefore

make sense to study alongside attachment style and SUDs as a way to shed more light on the connections of attachment style on emotional functioning, Bowlby's internal working model (which here could be perceived social support, self-esteem, self-worth) and SUDs. Lee and Bell found that secure attachment is a protective factor for "risk behaviors." The study sampled 470 college students, 18-25 years old and measured attachment and autonomy (using the Inventory of Parent and Peer Attachment (IPPA) scale), alcohol and marijuana use, perceived problems associated with substance use and self-esteem. Demographic and background variables such as gender, family structure, parental educational level, church attendance and parental alcohol use were selected as other possible mediating factors. Other research does not include these socio-cultural and family history variables. Consistent with other studies, the results suggest that strong attachment and self-reliance coupled with higher levels of self-esteem are protective factors for substance use because of their influence on higher social and coping competencies.

Using cluster analysis the study also found that parental divorce and parental substance use are risk factors for substance use, but that insecure attachment is more of a risk factor for substance use than parental divorce and parental substance use. This study suggests that attachment style is a more influential factor in predicting substance use than other variables such as family structure. Hemovich and Crano (2011) conducted a study that also looked at family features as being protective or a risk factor for illicit substance use. The authors conducted a multivariate analysis from data obtained from the National Survey of Parents and Youth (4,173) participants. The data showed that family structure can be a risk or protective factor in regards to substance use. The results showed that youth from dual-parent households were least likely to use illicit substances and that parental monitoring and warmth are positively correlated with substance use. The results also showed that income, the child's gender and family structure

affected interactions and monitoring, but not warmth. This implies that attachment, or warmth, is not influenced by sociocultural or socioeconomic variables. A critique of this study is the combining of monitoring and warmth as it would be beneficial to see which variable has more of an influence on predicting illicit substance use.

Thorberg and Lyvers (2009) conducted a similar study to Lee and Bell (2003) measuring for correlations between attachment and substance use via the mediating factors of self-differentiation and negative mood regulation (NMR). The research sample consisted of 100 patients in an inpatient drug and alcohol center in Australia. The study measured adult attachment, NMR, fear of intimacy and differentiation using self-report questionnaires. Thorberg and Lyvers found that females showed higher levels of self-differentiation and autonomy than males, putting them less at risk for substance use. This gender difference has been found in other studies (Reis, Curtis, & Reid, 2011), suggesting that females may have more protective factors than males. This study implies social and genetic factors as having a correlation with substance use. However, as this study did not account for other factors, such as “monitoring” or “parental warmth” as the previous study had, it is unknown which variables such as sociocultural, socioeconomic, monitoring and parental warmth are more predictive of substance use. However, due to the complexities of the interwoven nature of these variables in development, functioning and substance use, perhaps they cannot be separated.

A critique of many of the studies on attachment and substance use is that the studies sampled college students and mostly did not account for demographic variables such as: race/ethnicity, religion, sexual orientation and socio-economic status in the sample. Therefore, these studies provide little information on how these variables mediate the relationship between attachment and substance use. The lack of acknowledgement of these variables is a biased

omission, assuming that behaviors are not influenced by sociocultural or socioeconomic factors. Another important variable exempt from the studies are mental health diagnoses of participants, such as SUD, depression, anxiety, personality disorder etc. This omission provides that the studies do not account for dual-diagnosis clients, perhaps assuming that mental health diagnosis are mutually exclusive. Also, these studies do not incorporate information on the genetics from the family of origin of participants. Therefore, these studies do not directly address the possibility of genetic factors in influencing substance use. Finally, the operational variable of “substance use” was not defined in any of the studies, leaving this variable open to interpretation. It was unclear at times if substance use and substance abuse were being used interchangeably.

While the above mentioned omissions are certainly limitations of these studies, they did show that substance use and attachment style are significantly correlated. Therefore, if SUDs are considered in this light, as an attachment disorder, how is attachment theory used in treatment? However, before exploring this question, the use of theory in treatment should be discussed.

### **The Use of Theory in Practice**

Fonagy (1991) cautions that following theory too closely when considering both the etiology and treatment of substance use disorders can create a narrow view and important variables and observations may be omitted. Shaffer and Robbins (1991) bring attention to constructivism and the way in which meaning is made and then apply this concept to addictions, cautioning that, ““When we observe nature we see what we want to see, according to what we believe we know about it at the time” (p. 390). Similarly, in his critique of using theory in practice, Fonagy (1991) raises questions about the validity of the use of theory in psychoanalysis. The important considerations put forth in this article can also be expanded beyond psychoanalysis to other treatments, for example treatments of SUDs, of which are, or can be,

informed by theory. Fonagy asserts that the logical relationship between theory and practice is an illusion, one that is inductive rather than deductive. He describes *induction* as, “any form of inference in which a move is made from a finite set of observations to a conclusion about how things generally behave” (p. 513), and *deduction* as an inference “marked by the fact that if what we infer from is true, it is quite impossible for what we infer to be false” (p. 513). Fonagy’s critique of theory as inductive, rather than deductive, or as arising from a trial-and-error basis, does not take in to account that many forms of knowledge arise from trial-and-error. For example, one of the ways in which knowledge in the field of medicine is obtained is through studies using trial-and-error and these studies are not discounted because they are inductive, or dismissed because the knowledge was obtained on a trial-and-error basis. Therefore, why in psychoanalysis is this any different?

What Fonagy (1991) cautions is that due to the inductive quality of theories, theory should not be used as a concrete truth as it runs the risk of putting “blindness” on the clinician. Fonagy’s caution of what is understood as “truth” can be applied to many different fields of knowledge. “The tendency to disguise the loose coupling of theory to practice by rhetoric is pernicious because it closes the door on imaginative clinical exploration by fostering an illusion of theory-based certainty” (p. 515). This supports a point that Flores (2004) raises when stating “...it is highly unlikely that a one-treatment-for-all, cookie cutter approach will work for all patients suffering from addictive disorders” (p. 24).

In addition to critiquing the use of theory in practice, Fonagy (1991) also explores the possible benefits to using theory in practice. He asserts that theory is a useful mechanism to observe behavioral and thought patterns and that it also “equips clinicians to handle and make sense of particularly intense and disturbing human encounters” (p. 519). Additionally, Blame and

Julius (1977), explain in *The Psychodynamics of Drug Dependence* that theory “will help to organize clinical observations and apply them more meaningfully and consistently in work with patients” (p. 12). Overall, Fonagy concludes that theory should be used as an “adjunct” to practice, but not as a “justification.”

How much theory is used in practice and why depends on a number of variables. There has been little to no research conducted on this topic. Lundgren, Chassler, Amodeo, D’Ippolito and Sullivan (2012) conducted a study on barriers to implementing evidence-based addiction treatment, which may shed some light on the topic. Lundgren et al. conducted a mixed-methods study exploring possible barriers to implementing EBPs and looked at variables such as: staff level of education (college, bachelors degree, master’s degree, doctoral degree or other professional degree), if the treatment organization was affiliated with a research institution like a college or hospital, the type of treatment unit (outpatient, inpatient or private practice) as well as program duration (how long the program has been used). The study found that stress within the organization was significantly associated with barriers to implementing EBPs. Lower level of program needs and newer programs were significantly associated with fewer barriers to implementing EBPs. In addition, Lundgren et al. explain that several studies have found that staff with more experience and higher educational levels are more receptive to implementing EBPs as well as staff and treatment programs affiliated with research institutions. Considering the variables and findings in this study and other studies, perhaps possible variables associated with using theory in treatment may be consistent with those in implementing EBPs.

### **Using Attachment Theory in the Treatment of SUDs**

While theory often informs an understanding of mental health disorders, such as addictions, it often lacks what Fonagy (1991) describes as “translation rules,” or, in other words,

a way to move from theory to practice. “Translation rules” on using attachment theory in the treatment of substance use disorders were not particularly prevalent throughout the literature. Most of the literature on using attachment theory in treatment referred to “treatment,” “counseling,” or “therapy” in general and was not specific to certain mental health disorders, such as SUDs. However, it seems as though the “translation rules” for using attachment theory in non-specific treatment could be applied to clients with SUDs. The overall goal of treatment using attachment theory is focused on changing the Internal Working Model (IWM) (Bowlby, 1969) of the client and helping the client to better regulate emotions (Dozier, Cue, & Barnett, 1994; Flores, 2001; Flores, 2004; Pistole, 1989). In treatment with clients with SUDs, a goal in addition to these is abstinence (Blaine & Julius, 1977; Flores, 2001; Flores, 2004;). Attachment theory compliments a stance of abstinence in addiction treatment, providing that the first goal of recovery must be abstinence (Flores, 2004), as opposed to focusing more on a harm-reduction oriented approach. However, Rubin (2003) stresses importance of beginning where the client is because if the client feels alienated from therapist or that the therapist has their own agenda, will weaken therapeutic alliance. In beginning "where the client is," abstinence might not necessarily be a vocalized goal of the client. Therefore, a goal of controlled and moderated substance use becomes the initial goal.

Flores (2004) describes “Attachment Oriented Therapy” (AOT) as “a way of eliciting, integrating and modifying attachment styles represented within a person’s internal working model” (p. 214). Similarly to Kohut (1977), Flores (2001, 2004) asserts that until the IWM is changed, the addiction will continue or one addictive behavior will be substituted for another. If a client learns to self-soothe and regulate their emotions then they will not look to outside sources, such as alcohol or drugs, to do this for them (Blaine & Julius, 1977; Flores, 2001; Flores



2004). To achieve these goals, the literature discusses using attachment theory in three main ways: to develop and maintain a “secure base” for a working therapeutic relationship (Ball & Legow, 1996; Dozier, Cue, & Barnett, 1994; Flores, 2001; Flores, 2004; Harris, 2004; Larsson, 2012; Pistole, 1989; Slade 2000), to provide the clinician with specific narratives and themes to listen for to help guide and focus the treatment (Blaine & Julius, 1977; Dozier, Cue, & Barnett, 1994; Harris 2004; Larsson, 2012; Pistole, 1989; Slade, 2000) and to inform the pace of treatment (Ball & Legow, 1996; Flores 2001; Flores 2004; Harris, 2004; Larsson, 2012).

The “power” of the therapeutic relationship is heavily emphasized in attachment theory treatment, or as Flores (2004) describes, AOT. This is not surprising considering attachment theory’s relational foundation. This “secure base” provides the client with the confidence to experience emotions, learn about their emotions and explore their self. This mirrors Bowlby’s (1969) observations of children regarding exploration. Bowlby found that exploration of the world is accelerated in the presence of the mother. Bowlby explained the process of exploration as this: first a new “object” elicits alarm or withdrawal, then the child will inspect the object at a distance. If the object seems safe and does not “startle the child” it will be explored more closely, at first with caution and then with more confidence and comfort. In treatment, this process, or the “object” in this process, could be the client’s self and the client may be less fearful to partake in this exploration with a “secure base.”

Pistole (1989) put forth an idea, originally noted by Osofsky (1988), that “the conditions under which the infant develops a secure attachment are remarkably similar to the conditions for effective therapy” (Pistole, p.68). The therapist serves as sort of a secure attachment figure for the client where the client can practice attachment behavior and develop the necessary attachment functions (Pistole). This would imply that the way in which the mother interacts with

the child to provide a secure attachment, is the way in which the clinician would need to interact with the client to create a secure attachment for treatment. Pistole recommends the therapist use empathy and sensitivity to verbalize and clarify the client's feelings, contain the client's emotions without reacting strongly to them and comfort the client by focusing on their strengths and skills. As the client has previously learned to regulate his/her emotions by dismissing them, the therapist should help the client to experience emotions in a contained and safe way using the therapeutic dyad (Pistole). Flores (2001) describes using attachment theory in treating SUDs in the group therapy setting and notes that in the initial stage of treatment, similar to Pistole's recommendation, the group leader should help the members to develop the capacity for affect regulation by labeling and mirroring feelings to help the members to understand their feelings. Ball and Legow (1996) put forth that this "secure base" can develop by showing empathy, modeling a caretaking role, integrating love and control (setting limits) and showing a sense of direction.

In developing a secure attachment "base" with the client, the clinician is triggering the client's "attachment system" (Larsson, 2012). This opens the door for the client to experience a range of emotions and therefore learn to regulate those emotions in a contained and nurturing way (Larsson, 2012). Flores (2004) states that, "Therapists must be able to challenge, soothe, care, love, and, if necessary, fight with the patient if they are able to provide a full range of emotional experience that can potentially come alive in any authentic relationship" (p. 259). Therefore, the therapeutic relationship mirrors a secure attachment relationship where warmth and empathy are experienced and therefore anger and frustrations are tolerated and that it is this emotional experience that is therapeutic.

In his discussion of using attachment theory to treat SUDs in the group setting, Flores (2001) states that the overall aim of the group is to develop healthy interpersonal relationships as, “The inability to establish healthy relationships is a major contributing factor to relapses and the return to substance use” (p. 75). While for Flores, this is a reason he favors group therapy, the development of a healthy relationship with a therapist outside of the group setting seems as though it has the potential to be equally as useful for the client.

While there are limited empirical studies that examine the use of attachment theory in treatment, there have been empirical studies that address attachment *themes* in treatment, while not specifically addressing them as such or mentioning attachment theory. For example, empirical studies have shown a link between more favorable outcomes in treatment and a positive therapeutic alliance (Horvath & Symonds, 1991; Martin, Garkse, & Davis, 2000). One suggestion of what makes a positive therapeutic alliance is the level of empathy from the therapist, which in studies has been shown to be the most consistent theme in therapist style that is predictive of positive client outcome (Miller, 2000; Walters, Delaney & Rodgers, 2001; Walters, Rotgers, Saunders, Wilkinson, & Towers, 2003) p. 290. “In fact, in some studies therapist behavior is a better predictor of outcome than any client characteristic” (Walters, Rotgers, Saunders, Wilkinson, & Towers, p. 290; originally cited in Project MATCH Research Group, 1998).

Using attachment theory in the development of a therapeutic alliance was explored in a case study of a 32 year-old man with schizophrenia and a SUD (Sawicka, Osuchowska, Waniek, Kosznik, & Meder, 2009). Sawicka et al. describe that it was difficult for this man to trust people due to his early relationship experience with his mother. In treatment, the therapist worked at becoming a secure attachment figure, or an attachment object for this client.

It appears that the basic principle [of the attachment object] is a regulatory function which is created by accepting the patient's emotions, giving information, explaining and the therapist's behavior cohesion in relation that is a clear, predictable object behavior. Such an affective containing in an attachment relation depends of accepting, keeping, approving anxiety and difficulty by the attachment object. Thanks to that, the patient is able to inspect his own situation, tolerate uncertainty and psychic tension through using own psychic apparatus that is the emotional and cognitive process (p. 62).

Sawika et al. posit that by providing this secure base, the clinician is able to manage the client's fear, stating that fear is "the basis of the attachment relation" (p. 62, originally cited in Adshed, 1998).

Another study used quantitative methods to also explore therapeutic alliance in relationship to treatment outcome (Crits-Christoph, Hamilton, Ring-Kurtz, Gallop, McClure Kulaga, & Rotrosen, 2011). While this study did not specifically address attachment theory as the previous study had, the definition of "alliance" parallels themes of attachment theory. The study used Bordin's (1979) definition of alliance which describes alliance as "composed of the emotional bond between patient and therapist/counselor, agreement of tasks of treatment, and agreement on goals of treatment" (p. 405). The study looked at client, program and therapist variability in relation to alliance and treatment effectiveness in terms of drug and alcohol use during treatment. The study sampled 1,613 patients and 112 counselors from a randomized clinical trial from 20 community-based outpatient substance abuse treatment facilities. The study concluded that by improving organizational functioning and the patient-counselor alliance, better treatment outcomes could be achieved.

The emphasis on the relational aspects of attachment theory, or the focus on developing a “secure” therapeutic relationship, is needed not only for the exploration of the self and emotions, but also to encourage abstinence. AA’s abstinence-based treatment model posits that it is impossible for the client to form a secure attachment with the clinician if the client is still using substances. It is not until the client abstains from substances that a healthy, secure, attachment style that promotes healthy interpersonal affect regulation can be formed (Flores, 2004).

In an empirical study (Smith & Tonigan, 2009) using a cross-sectional survey, 158 people attending AA were surveyed on their pre-AA and post-AA attachment styles. AA participation was associated with a decrease in anxious and avoidant attachment and an increase in secure attachment. These findings were interpreted within the context of AA’s emphasis on relationship development to achieve sobriety. However, a question raised from this study is, because attachment style changes, does this mean a reduction in drinking changes? It can be inferred from the research on attachment theory and addiction that most likely secure attachment style and alcohol consumption are negatively correlated. In the future, this study could be expanded to address this hypothesis.

In the literature, attachment theory’s practical application in treatment has also been discussed in terms of listening for attachment narrative in clinical discourse (Slade, 2000), or as Sawika, Osuchowska, Kosznik and Meder (2009) describe, using attachment theory to listen with a “clinical ear.” Larsson (2012) wrote a paper looking at attachment theory’s use in therapy and highlighted that “psychodynamic counseling psychologists pay attention to the narrative of client’s early attachment experiences” (p.16). In her development of the Adult Attachment Interview (AAI), Margaret Main (1995) demonstrated that there is a connection between attachment style and narrative style. The literature on attachment theory and treatment provides

different examples of how “attachment narrative” can be used in treatment. For example, Slade (2000) asserts that listening for attachment narrative provides representations of the experiences of the client that were validated or invalidated by the caregiver and/or representations of the degree of which the client had to deny his/her own needs in order to maintain the relationship with the caregiver. “They learned to deny or denigrate their own needs for comfort and reassurance” (Dozier & Barnett, 1994). Slade (2000) implies that if the clinician is aware of these experiences within the client’s attachment system, this will offer insights into the client’s attachment style. For example, people who were securely attached to their caregivers are able to reflect and talk about their experiences as a child in a way that is integrated and provides depth and detail (Dozier & Barnett, 1994; Egeland, Jacobvitz, & Stroufe, 1988). On the other hand, people with insecure attachment with their caregivers do not have access to distressing memories and tend to have a more idealized perception of their caregivers and talk about their relationship in a way that sounds rambling and may be hard to follow (Dozier & Barnett, 1994; Dozier & Kubiak, 1992).

This information gathered by listening for certain themes within the client’s dialogue offers insights into their attachment style as well as to their IWM. These insights are then able to be explored and used in treatment. Slade (2000) states that, “As both Bowlby (1988) and Fonagy (1995) have noted, it is the “analyst’s capacity to reflect upon and mentalize these aspects of the patient’s story, and to provide a “secure base” for the patient’s mind, that leads to healing and internal consolidation” (p. 1170). Dozier and Barnett (1994) add to that by stating that through careful listening and reflection, the therapist is able to respond in ways that help to change the client’s IWM.

Overall, the literature supports that being aware of or having information on the client's attachment system proves useful in treatment. However, Slade (2000) suggests that while the classifications may not demonstrate a direct use, or be mutually exclusive, keeping them in mind may help to identify attachment-related themes in the client's story which can then be used in treatment. For example, Slade (1999), believes that understanding a client's attachment style allows the therapist to develop a greater empathy for the client as they are able to imagine early attachment style and affect regulation capacities and therefore speak more to the client's experience. For example, Cook (1991) discusses attachment theory's use in addressing client's feelings of shame in addictions counseling. Cook posits that SUDS can develop out of the shame feelings that are a result of insecure attachment style and therefore substances are used to minimize the negative emotional states brought about by shame feelings, especially around abandonment issues. Repeated neglect and/or rejection builds shame and this becomes an internal working model of the self (IWM). Threats of abandonment trigger internalized shame. Therefore, Cook proposes that in treatment the clinician should focus on three objectives: 1) help change the cognitive structure, specifically around feelings of shame, by examining the roots of this shame in the family structure and the validity of this shame in the current self-image; 2) help the client learn triggers to shame feelings to develop healthier coping patterns aside from addictions; 3) encourage the client to take responsibility for change, even though the problem may be related to family experiences. These three implications closely parallel CBT treatment approaches.

Schindler, Thomasius, Sack, Gemeinhardt and Küstner (2007) expanded the use of attachment theory to family therapy while suggesting that the four attachment types are "crucial in the field of substance abuse and addiction" (p. 112). The authors conducted a quantitative

study looking at 37 families with a drug dependent child and two biological parents. In 65% of the sample, a “triangulated” pattern was found where fathers had dismissing attachment style, mothers had preoccupied attachment style and the children had fearful attachment style. This study expands attachment theory to family systems, which has implications for family therapy and cites the AACAP Official Action (1997) in suggesting that family therapy is a standard treatment for substance use disorders in adolescence. However, while this study found that attachment theory can be applied to family systems, it did not specifically suggest implications for treatment of the SUDs within these families.

Another study looked at attachment style and its relationship to predicting treatment compliance of people with SUDs (Caspers, Yucuis, Troutman, & Spinks, 2006). Two-hundred and eight adoptees participated in a longitudinal study looking at possible associations between attachment, substance abuse and treatment participation. It was hypothesized that based on attachment theory, those with secure attachment would have more adaptive methods of emotion regulation and therefore would be more willing to seek out treatment. The findings of the study were consistent with the hypotheses and imply that attachment-style be taken into consideration when planning interventions to achieve higher success in treatment. Overall, the studies and literature support the usefulness in treatment of identifying clients’ attachment style.

Attachment theory can also be used in the treatment of SUDs to inform the clinician on the pace of treatment. Ball and Legow (1996) suggest that attachment theory can help guide the clinician in their use of different treatment approaches at different stages in substance abuse treatment. Using attachment theory, the authors suggest that the clinician should first establish a secure base and then later move to facilitate exploration of the client’s self. Flores (2004) states, “Just as securely attached children will move greater distances away from their caregiver, taking



more risks exploring their surrounding environment, securely attached patients will take more risks, exploring their inner-world during therapy” (p.48). Ball and Legow acknowledge that some clients may not want to move to more exploratory work and note that there are some characteristics that can be used as guidelines to suggest if this move is capable/necessary. Some examples of these characteristics are: negative mood states, willingness to better understand and notice behavioral patterns and a desire to explore the past.

Flores (2001) favors group therapy as a model for treating SUDs and uses attachment theory to outline the group leader’s role at each treatment stage. Flores states that early stage treatment should be aimed at abstinence and controlling cravings. This approach is similar to the approach taken in AA (Flores, 2004). In the second stage, the members work towards achieving a careful balance between affect release and affect containment. In the third stage of treatment, the members use skills they’ve gained to garner insights into their substance use and abuse, themselves and attachment styles. At this stage, the relationship with other members is used to facilitate this exploration. Flores believes that group therapy is useful in working with clients with SUDs as the frustration and intensity experienced in a therapeutic dyad may be too much for the client.

Considering the implications for treatment of SUDs and other mental health disorders using attachment theory, how are mental health clinicians using attachment theory in the treatment of SUDs and what might influence this use? Taleff and Swisher (1997) describe the core functions of a master’s level drug and alcohol counselor. They acknowledge the needs among alcohol and other drug (AOD) counselors’ training to include a knowledge base of technique, ethics and theory. However, in outlining what the authors explain as the “seven core functions” they do not elaborate on AOD counselors’ use of theory. They conclude that one of

the differences between a masters level clinician and a clinician without a masters degree is that the master's level clinician needs to "give more thought to the unique needs and conditions of the client" (p. 8) and using theory could be implied as one way to do this. However, it is not clear if this is being done, and if it is, how it is being done.

As it has been discussed, there is significant literature pointing to the connection between attachment theory and SUDs as well as empirical studies supporting this connection. It is in the attachment relationship with the caregiver that the infant learns to self-regulate emotions and to develop self-esteem and self-worth. Secure attachment has been shown to be a protective factor against SUDs. Using substances then becomes an attempt to regulate the attachment system where this self-regulating capacity was not previously developed. Illustrating the translation of attachment theory to practice, it is suggested that the therapist mirror many of the functions that would be present in a secure attachment relationship with a caregiver. However, few studies have yet to explore if and how mental health clinicians are using attachment theory in treating SUDs.

The review of the literature provides examples of some of the ways attachment theory can be used in treatment. However, few of the examples found in the literature are specific to treating SUDs. Considering that one of the ways SUDs have been conceptualized is as an attachment disorder and numerous empirical studies show secure attachment as a protective factor against substance use, how are mental health clinicians using attachment theory in the treatment of substance use disorders? The review of this literature provides a context and support for the need for further research to be conducted on the use of attachment theory in the treatment of SUDs.

## CHAPTER III

### Methodology

This study explores how mental health clinicians use attachment theory in the treatment of substance use disorders (SUDs). This is a qualitative study using semi-structured interviews with both open-ended and close-ended questions. A qualitative study is favorable as the research reflects little discussion of this topic. While there are studies that show a correlation between attachment style and SUDs, as well as substantive discussions regarding SUDs as attachment disorders, research showing how and if mental health clinicians use attachment theory in the treatment of SUDs is lacking. Qualitative research also will elicit a more in-depth narrative of the research topic being explored as well as make room for unexpected findings. A semi-structured interview is favorable as this study is taking a deductive approach exploring specific themes in relation to attachment theory. However, this researcher also felt as though it was important to have flexibility during the interviews to explore additional topics and themes as they arose. The interview questions explored attachment themes present in the dialogue of mental health clinicians while they discussed their experiences of treating clients with SUDs. These themes included: creating a therapeutic alliance, the conceptualization of SUDs, references to disruptions in the attachment system, the pace of treatment mirroring the formation of a secure attachment relationship, adherence to an abstinence-based treatment approach and treatment goals pertaining to emotion-regulation, changing the Internal Working Model (IWM) of self and others (Bowlby, 1969) as well as developing connections with others. While the attachment

themes used to frame the interview questions were influenced by the literature, they were also subjectively decided upon by this researcher to be included in this study. Therefore, this decision to explore these themes is a source of researcher bias in this study. Perhaps other researchers would have chosen other themes to explore based on their experience and relationship with the literature.

### **Sample**

The sample population for this study was mental health clinicians with experience in treating substance use disorders (SUDs). Mental health clinician was defined as someone with a license and/or degree in a mental health related field and who is currently employed and practicing in the mental health field. Experience in treating SUDs was defined as having six months or more of experience in treating clients with SUDs where the SUD was either the primary area of focus or treated dually in conjunction with another mental health disorder. The six-month requirement was chosen because this researcher felt as though six-months was sufficient time to be able to discuss the experience of treating someone with a SUD while also allowing the sample to reflect a range of experiences, with some clinicians having little experience and others having sufficiently more. Ten mental health clinicians were interviewed. The locations of the interviews were decided upon based on the convenience and preference of the interviewee. Most of the interviews took place at the mental health agency where the initial recruitment effort was made and three of the interviews were conducted by phone.

Participants were located using purposive, non-random, availability and snowball-sampling methods. Purposive and non-random sampling methods were used because there was not a strict quota for participant characteristics, however there was a need to achieve a diverse sample of clinicians with a range of experiences and backgrounds to increase the depth of the

study, as well as clinicians who fit the inclusion criteria. Availability sampling methods were used due to the resources available to this researcher. Snowball sampling was used to gain access to “hidden populations,” or clinicians that perhaps ordinarily would not have been accessed as a way to increase the diversity of the study. The recruitment process used emails that were initially sent to mental health clinicians in a community mental health agency in New Hampshire. These clinicians were then asked to forward the email on to anyone who they thought might be interested in participating in the study.

For the purpose of this study, clinicians from the following categories were sought out: a licensed drug and alcohol counselor, a mental health counselor, a social worker, a psychologist and a psychiatrist. A range of experience was also sought out including clinicians who had been practicing less than five years, clinicians who had been practicing 5-10 years, clinicians who had been practicing 11-15 years and clinicians who had been practicing for over fifteen years. A range of educational experience was also sought out, including clinicians with a bachelors degree, a master’s degree and PhD or M.D. Clinicians working in the following settings were sought out: community mental health, private practice, hospital and specialized addiction treatment facilities. Demographic variables such as gender and race/ethnicity were also recruited for as their influence on the research question was unknown and due to the exploratory nature of this study these variables may be relevant.

### **Data Collection**

An interview guide with open-ended and close-ended questions was used to guide the interviews. Open-ended questions were used in order to leave room for the participants to respond the way they wanted to in order to elicit responses with as little influence as possible from the researcher to limit bias. Due to the exploratory nature of the study, open-ended

questions were also favorable as they left room for unexpected findings. The interviews lasted between thirty minutes to an hour and were recorded using a digital audio recorder. Before the interview began, participants were asked to keep their responses to the questions specific with regard to treating clients with SUDs. It was acknowledged that it might be impossible for clinicians to completely isolate their responses only to treatment of this population, as treatment strategies with other populations may overlap and the experiences of different populations become interwoven. Participants were asked to imagine working with a client with an SUD if that would help or think about treatment in general, whatever they chose. Participants were then asked if they were familiar with attachment theory and were provided with a short definition of attachment theory in case they were not familiar with it. The initial questions in the interview were designed to elicit responses with regard to participants' understanding of attachment theory and SUDs and also to bring forth information on how these understandings may influence the treatment process. The second set of questions were designed to elicit responses with regard to clinical interventions and specifically in relation to attachment theory themes. For example: What narratives from the client do you listen for? How do you use the therapeutic alliance in treatment? What purpose does it serve? What considerations inform the pace of treatment? The last questions asked participants to mention anything they felt was relevant or had been left out of the interview.

### **Risks for Participation**

This study posed minimal risks to participants. Participants were informed that they may experience some distress during the interview process if they are reminded of specific clients or of challenges faced in treating this population.

### **Benefits for Participation**

Participants were informed that by taking part in this study they would have the opportunity to share and reflect on their experience in treating clients with substance use disorders. During this process, they may gain new insights or a new perspective on their treatment methods. They were also informed that hopefully this study would serve to increase the knowledge base regarding treatment of SUDs and the use of attachment theory in treatment.

### **Informed Consent Procedures**

Informed consent was explained to participants in a written document. Before obtaining any data participants were asked to provide their original signature on the informed consent form. Once the participants signed the informed consent letter, they were eligible to participate and an interview was conducted.

### **Precautions Taken to Safeguard Confidentiality**

In order to keep the study confidential, the participants' names were not included with the demographic data or with the transcriptions. Each participant was assigned a code number used to identify the demographic data and each transcription. The informed consent forms were kept separate from the data and locked in a filing cabinet. Before the interview began, participants were reminded to refrain from disclosing identifying information about clients. Once the interview was completed, the recording was uploaded onto a computer and password protected and then deleted from the digital recorder. The audio recording was then transcribed and any identifying information was removed from the transcription, such as names, descriptions and/or places that could reveal the identity of the participant. It was only after this was done that the data was then analyzed. Participants were informed that all data would be kept secure for three

years as required by Federal Regulations. After that time, the data would be destroyed unless it is needed beyond three years, then it will continue to be kept secure until it is no longer needed.

### **Data Analysis**

The data was analyzed using content-theme analysis to look for attachment themes in the responses of the clinicians in talking about SUDs and their treatment process. The themes extracted from the interviews were organized in terms of the themes predetermined by this researcher, and therefore is a bias in this study, and it was noted which themes from the data were more common. Patterns and themes among participants' responses with regard to their relationship to attachment theory were also observed. In order to develop a deeper understanding and relationship with the data, when analyzing participants' responses and themes the following questions were asked, as suggested by Braun and Clarke (2006): "What does this theme mean? What are the assumptions underpinning it? What are the implications of this theme? What conditions are likely to have given rise to it? Why do people talk about this thing in this particular way as opposed to other ways? What is the overall story the different themes reveal about the topic?" (p. 24). However, this researcher also was careful not to make assumptions about certain responses or themes and attempted to look at them mostly in terms of their relationship to attachment theory. This researcher also did not assign themes to responses based solely on the questions. For example, when talking about the pace of treatment, many participants made references to topics that were related more to treatment approach and not directly to the pace of treatment and therefore they were organized as such.

When needed, attempts were made to interpret the meaning behind the responses and themes in terms of their relationship to attachment theory and/or their relationship to the initial research question. It is inevitable that researcher bias had an influence on the interpretations and



meanings applied. For example, the interpretation this researcher applied to the themes was based on the literature and also based on this researcher's background and subjective experience with the data. Therefore, a researcher with a different background and a different experience with the literature may have interpreted the data in a different manner. Also, this researcher has a demonstrated interest in attachment theory, which may have influenced or biased the data analysis in a way that favors attachment theory. However, this researcher attempted to keep this in mind when analyzing the data in order to potentially limit this bias in the study.

The next chapter will present the findings of this study. The findings will be presented in terms of: SUD conceptualization, familiarity with attachment theory, treatment approach, using attachment style in treatment, looking at themes/narratives of clients' dialogue, the pace of treatment, abstinence versus harm reduction and the therapeutic alliance. The findings will also be presented in terms of their connection to attachment theory as well as where attachment theory shows usefulness or limitations in the treatment process. The findings will use quotations from the participants in order to illustrate themes.

The hypotheses behind this study included the expectation that while participants may not specifically address using attachment theory in the treatment process, that attachment-related themes will be present and therefore provide some examples of "translation rules" from theory to practice. It was also expected to identify, through participants' responses, places where attachment theory adds to or is beneficial to the treatment process as well as places where attachment theory is limiting to treatment.

## CHAPTER IV

### Findings

#### **Introduction**

The purpose of this study was to explore mental health clinicians' use of attachment theory in treating substance use disorders (SUDs). One way SUDs have been conceptualized is as attachment disorders and there are numerous empirical studies that show a connection between attachment style and substance use. However, there have been few studies that explore if and how mental health clinicians use attachment theory in the treatment process in working with clients with SUDs. This study contributes to the research on how attachment theory may be used in treating SUDs as well as contributes to the knowledge of how theory may translate to practice.

The data collected is from interviews with ten mental health clinicians. The interviews typically lasted from thirty minutes to an hour. The interview questions were organized in terms of the following themes: SUD conceptualization, familiarity with attachment theory, SUD treatment and the therapeutic alliance. These themes will also be used to present the findings. Demographic data was also collected from each participant in order to provide more depth to the study.

## **Demographic Characteristics of Sample**

This study consisted of ten participants (n=10). Of the ten participants, four identified as male and six as female and all identified as white. At the time of the interviews, all participants had been practicing for five years or over and seven of the participants had been practicing in the mental health field for over fifteen years. Out of the total time spent working with clients, three participants classified themselves as working with clients with SUDs 10-25% of the time, four participants classified themselves as working with clients with SUDs 25-50% of the time, and the remaining three classified as working with SUD clients more than 75% of the time. Eight participants held Masters degrees as their highest degree, while one participant held an M.D. and the other a Ph. D. Four of the participants' degrees were in Mental Health Counseling, three participants held degrees in social work, two in psychology and one in psychiatry. At the time of the interviews, seven participants were practicing in the community mental health agency in which this researcher initiated the recruitment process, one participant was employed at a veterans' hospital, one in general private practice and one in private practice specializing in addiction treatment. Two of the participants were licensed drug and alcohol counselors.

## **Conceptualization of Substance Use Disorders**

The participants were asked to explain how they view substance use disorders and/or their understanding of the reasons people use substances to see if participants conceptualized SUDs in a similar way to that of attachment theory. There were a number of different responses that participants put forth, with one participant stating “[there are] as many reasons as there are people” and another noting “...there are so many things that impact substance use.” These two statements summarize the data collected on this theme, as there were a number of different ways that participants conceptualized SUDs, with no two participants having the same understanding.

Overall, participants did not have one concrete way in which they viewed SUDs and each presented many different conceptualizations. The number of different ways in which people conceptualized substance use disorders speaks to the complexity of the disorder. When asked how he understood SUDs, one participant even replied, “I don’t know that I do.”

The most common ways SUDs were described were: as a way to self-soothe, a co-occurring disorder/related to other mental health issues and as related to relationships. Substance use was often described as a symptom of or co-occurring with other mental health issues and as a way to self-soothe. One participant explained, “And, I find that most of the time the drugs and alcohol are a very small part of the problem, they’re more of a symptom- a symptom of depression, anxiety, low self-esteem, assumptions, misunderstandings, you know...” One participant described substance use as “self-medication” and another explained, “a lot of people might be smoking pot to self-soothe... they are using drugs and alcohol in order to deal with the stress that they are experiencing or the anxiety that they are experiencing.” Another participant also stated, “a lot of people cope with trauma by using substances.” Another way that this was described by participants was as an “avoidance strategy.” One participant stated this literally, saying, “Mainly, I would say, the typical pattern is that it is a big avoidance strategy...resulting in potentially physiological dependence, certainly psychological dependence as well.” Another participant referred to people who have SUDs as “escape artists, they’re leaving their bodies in a lot of ways.” The avoidance of emotions was described by two participants as conceptualizing people with SUDs as having something buried emotionally: “...they are using the alcohol and drugs to burry all of the emotions so they haven’t dealt with that stuff at all, they haven’t learned how to deal with it...”

Describing substance use as a way to self-soothe relates to attachment theory in that attachment theory posits that people with insecure attachments do not learn self-regulatory functions and therefore turn to substance use as a way to self-regulate. However, participants elaborated on this beyond the scope of what attachment theory offers, for example, attachment theory does not discuss SUDs as related to trauma or other mental health issues. This is an example of how theory can both be useful in terms of its ability to offer ways of conceptualizing client cases and at the same time can also be limiting.

Another common way that participants described SUDs was as in someway relating to relationships, which was described in different ways. One participant described SUDs in the context of social anxiety, which is also related to the above theme as a way to self-soothe or as co-occurring disorder. This participant stated, “Most addicts cannot connect well with people, most addicts isolate, most addicts get very anxious socially...” Participants also talked about substance use in the context of difficult childhoods in the sense of not receiving the necessary support or safety, or as one participant put it, the substance use is a substitute for a missing attachment, “Over time it is hard to have attachments to other things in life when you are attached to substance use...it has sort of become a substitute for not having that in your life in other ways.” Substance use was also talked about by participants as clients with SUDs having an ‘attachment’ or a “relationship” with the substance. One participant stated, “...if they don’t have really good relationships, then their major relationship is with the substance...Then it becomes their friend, their support...”

Conceptualizing SUDs as in some way relating to relationships, especially in terms of development, shows a connection to attachment theory in that attachment theory assumes that without a secure attachment relationship with a caregiver, necessary developmental tasks, such

as self-soothing and developing a sense of self, will not be achieved and therefore this may lead to mental health disorders, such as SUDs. Attachment theory also proposes that clients with SUDs have a primary relationship with a substance and therefore are unable to form relationships with others. However, participants did not directly address that SUDs are related to attachment style with the caregiver, which is a large focus of attachment theory, therefore, participants did not directly conceptualize SUDs as an attachment disorder.

There was one participant who felt as though SUDs were specifically not directly related to attachment, but rather more directly to personality disorders, stating:

...rates of SUDs in people with personality disorders are higher than average and so the attachment stuff would relate more towards reducing personality disorder signs and symptoms which would eventually reduce the substance use, in theory...So, again, the attachment isn't directly related to the substance abuse treatment, it's more like the personality disorder that may be related to the substance abuse.

This participant's response demonstrates the complexity of the connection between co-occurring mental health and substance use disorders and suggests that in talking about one it is impossible to not talk about the other due to the close and interwoven nature of SUDs and other mental health disorders. In the original literature on SUDs and attachment, this concept is not demonstrated.

All of the participants described SUDs as having both a biological and environmental component and two participants gave conflicting responses with regard to the degree of the biological influence. When describing the biological component to SUDs, one participant described it as, "It may be written in their DNA." Another participant described it as people with SUDs "have this propensity for addiction." Some participants viewed the biological piece in

terms of an intergenerational transmission or a pattern in the family and other participants viewed it as something physiologically that makes one more prone to developing a SUD. One participant stated “I feel that sometimes there is more of a genetic link here, that people might be sort of vulnerable to developing that [SUD] as a result of that,” while another participant described,

...the genetic piece seems to be less of an important thing and it's more about who people use with... the genetic piece is probably 30-35% of what's driving it- that's still a big part of it, but there's 65% of it that's probably more about who they are using with and that's really the driving force.

Participants seemed to view the environmental component as “who they are surrounded by.” One participant described this as what is modeled for them in the home, “So I conceptualize it, and I think, developmentally and I think of the interchanges in the early caretaking environment. It may be parental pathology, mental illness, substance use disorders- poverty, social dislocation...” Another participant described, “And you know, they've seen it in the home...so I mean, there's certainly a learning aspect to it.”

In the discussion of the environmental component of addictions, participants did not directly address SUDs as relating to the attachment style developed in the caregiving environment - as attachment theory does. However, most participants viewed the environmental piece as what is modeled for them or as who they are using with as important pieces of SUDs- which attachment theory does not address. Therefore, again, this is an example of both the use and limitation of attachment theory. Also, the discussion of the biological component of SUDs is not addressed in using attachment theory, which, again, shows a limitation of attachment theory.

Eight of the participants spoke in some way to the cultural context associated with substance use, which has implications for not only the individualized problem of SUDs, but also the larger cultural problem of SUDs. One participant explained, “Certainly it’s a huge part of our culture, it’s probably 50% of the culture, at least, drinks and at least 30% of the culture will have significant problems with abuse of substance during the course of their lifetime- that’s a huge amount of people, so it’s a huge problem.” A few participants spoke about age as part of the cultural context. One participant stated, “I think it is something that is really culturally sanctioned...especially for young people.” When talking about reducing a client’s drinking, another participant explained, “The alcohol thing, it’s the age range where people binge, so that’s going to be harder for him. So, we’ll see how that goes.” Attachment theory does not address the cultural context associated with SUDs. This, again, demonstrates a limitation of only relying on attachment theory when conceptualizing substance use disorders.

Overall participants each had many different ways of conceptualizing SUDs and the most frequently cited ways showed some connections with the way attachment theory conceptualizes SUDs, while also revealing the limitations of attachment theory in looking at SUDs. The most common ways of conceptualizing SUDs included: a symptom of something else/a co-occurring disorder with other mental health issues, a coping mechanism or way to self-soothe, and as related to difficulties with others including disrupted childhoods, missing relationships and social anxiety. All participants also spoke to SUDs as having both an environmental and biological component and two participants gave contradictory responses with regard to the degree of the biological influence. The many different ways of presenting SUDs may speak to the complexity of understanding and treating SUDs.



## **Familiarity with Attachment Theory**

Participants were asked about their familiarity with and understanding of attachment theory. In the later interviews, participants were also asked about their general use of theory in practice and if they find theory useful. Of the three participants who responded to the question about using theory in general, they all discerned that theory had some use to them. One participant spoke to theory in terms of acknowledging its presence in the evidenced-based treatment model she uses, however, she said that, “I don’t think about using theory that much in treatment, it’s not something that is in the forefront of my mind.” Another participant described his use of theory as “like a background program running.” He explained that he uses theory “quite a bit” and went on to explain, “...I’m always thinking about where this person might fit in or how I understand this person from the sort of theoretical model or models that I am familiar with. So, theory does quite a bit inform how I practice.” The third participant described theory as “essential” stating that, “It informs the nature of the work and the direction of the frame of recovery.”

Participants were also asked about their familiarity with attachment theory. All ten of the participants reported having some knowledge of attachment theory, as this was an inclusion criteria for the study, however, their degree of familiarity and use of attachment theory in practice varied. While overall, all participants held a general familiarity with attachment theory, only one participant described deliberately using attachment theory in practice. The nine other participants felt as though they used attachment theory at times in treatment, but, as one participant described it, had “no particular orientation towards attachment theory.” Some examples of participants’ responses include: “In general, yes...,” “I had a little bit of that in graduate school a long time ago and that was tied in with object relations, but I don’t think about

it a lot at this point,” “I have, you know, no deep understanding of attachment theory,” “It’s a word that gets used, so it’s indirect... we spoke about it early on in terms of object relations theory and, let’s see, ego psychology,” and “...I have some experience, but not clinically though.”

Two participants classified themselves as holding more of an understanding of attachment theory. One of these participants was the one who deliberately uses attachment theory in practice and the other participant explained, “I’ve taught the research of Bowlby and Ainsworth so I am pretty familiar with it.” However, this participant specifically described not using attachment theory in treating SUDs and feels that it is not well researched.

Participants were asked about their general understanding of attachment theory in order to compare their understanding to the one put forth in the literature in this study. All of the participants agreed that insecure attachment can lead to difficulties in self-soothing and self-regulation as well as impact relationships formed later in life, which is the same understanding that the literature proposes. One participant explained, “I understand the basic premise about early attachments and how that helps individuals develop a sense of security as well as emotion regulation...” Another participant stated, “I know a little bit about and understand that certainly how we have formed attachments to people earlier in our lives can impact our ability to have attachments with people later in our life.” The participant that deliberately uses attachment theory in practice stated that he also has an additional understanding of attachment theory, putting forth that not only does he think about the early caregiving environment in someone’s development, but also thinks about the “origins of conception” and the development of the child “inside the womb” in terms of attachment.

## **SUD Treatment**

The original interview questions asked participants to describe their treatment process in treating substance use disorders to see if there were connections to attachment theory. The questions as asked looked to shed light on the treatment process with regard to treatment approach, pace of treatment, the goals of treatment, narratives listened for in treatment, attachment style in treatment as well as participants' views on an abstinence versus harm-reduction approach as the literature on attachment theory presents implications for using attachment theory in treatment with regard to these themes.

**SUD Treatment Goals:** Participants were asked to describe some of the goals they see for clients with SUDs to see if there were attachment-related themes. Some participants discussed goals in terms of the end goal or long-term goal, while other participants discussed goals in terms of smaller goals along the way, or short-term goals. Three participants mentioned developing healthy relationships and/or increasing connections with others, which shows connections with attachment theory as attachment theory has been expanded to look beyond the caregiving relationship to postulate that developing healthy relationships, or secure attachments, can help with relapse prevention. One participant described this as “establishing some mentor-like relationships in their life so that they can have a good family and a lot of times, it’s true for substance abuse folks, their skills around picking healthy people are very, very limited...” Another participant stated, “How do they have structure in their life that supports not using or less using? How do they form relationships that are more supportive to that?” Another participant described this goal as, “...one of the big things that’s also for people is to begin to learn that they’re not alone with these issues and in fact a way to get better is to get to reach out to others.” Therefore, the importance of connecting to others includes: picking healthier and

perhaps more supportive people to be around while also reaching out to others who are also in recovery to feel a sense that they are not alone.

Seven of participants described the goal of developing “replacement behaviors.” One participant described the importance of this as, “...if you remove substance use and you don’t have any other tools in place, the likelihood of relapse is really, really high.” Another participant described this goal as, “I like to help people find something to take the place of the effect of the substance abuse.” Another participant described this as “learning to live without” the substance use and that this “opens up a whole new world for people.” Another participant described this as, “building skills for coping with life so that there are options aside from substances.” Developing replacement behaviors is described here as a way to prevent relapse as well as a way to offer people other choices in life and other ways of living and is not specifically described in terms of developing emotion-regulation skills, as attachment theory would propose. Therefore, this is an example where attachment theory is both useful in offering treatment goals, while also limiting.

Eight participants also spoke to the goal of “self-care.” Some participants spoke to this as the goal of developing self-esteem and some participants referred to this as developing a sense of self and other participants spoke to “self-care” in terms of improving physical health. These goals are connected together under the theme of “self-care” because they all speak to caring for and thinking about yourself in one way or another. The goal of developing a sense of self is one of the goals attachment theory suggests in working with clients with SUDs, however, attachment theory does not look at physical health as part of this goal while it seems as though these two are connected. One participant explained developing a sense of self as, “...they just don’t see themselves as an opiate addict. They see themselves kind of in other ways, their view of themselves expands.” Another participant stated, “Overall, good self-care, getting in touch with

yourself, being a good friend to yourself, self-love I think are for me some of the most important goals for clients that I try to promote...” Another way that this was described was in “trusting themselves.” One participant explained, “...so it’s about reintroducing them to trust themselves. They may have had people in their life say to them that they don’t want to do that, so now it’s about giving them approval to go there, to work with those instincts again.” This same participant also spoke to this as changing the “negative self-talk” and explained, “...these folks are not good to themselves and have a lot of negative thoughts that keep them going and self-talk is something that needs to change.” Another participant described this in terms of developing compassion for themselves due to the degree of shame involved, “and also there is a huge degree of shame around this particular issue...and a lot of self-hatred and how to help somebody to...have compassion for themselves.” Participants’ responses show a connection to attachment theory in terms of the goals of developing a sense of self/better self-esteem and developing secure and healthy relationships and offering ways in which attachment theory can be translated to practice. The participants’ responses that do not show a connection with attachment theory shed light on some of the limitations of attachment theory and potential blind spots that could arise from only using attachment theory in the treatment process.

**SUD Treatment Approach:** Participants were asked to explain their general treatment approach to treating clients with SUDs to see if there were connections to attachment theory. Some of the participants’ responses spoke to where their influence and orientation towards treatment comes from and therefore, later interviews asked participants to speak directly to where their treatment approach and orientation comes from. From the responses, training, education, professional experience, setting and life experience influence participants’ treatment approach, with the influence of setting being present in eight of the participants’ responses. The

two participants that are in private practice did not talk about setting as much as influencing their direct treatment approach, specifically in terms of using evidenced-based models (EBPs). One participant stated, “I have a tendency to draw from anything that I’ve learned that would be useful and helpful.” This implies that this participant does not follow one treatment approach for all clients, but perhaps takes more of an integrative or eclectic approach. This participant’s reflection was echoed throughout all of the participants’ discussions of their general treatment process, where participants were not specifically tied to one treatment approach and rather integrated many different approaches, theories and styles.

Eight of the participants specifically made references to the setting in which they practice in terms of how that influences their treatment choice. For example, four of the participants identified using DBT treatment, which is the treatment model of the setting in which they work. In asking how she chooses her clinical interventions, one participant explained, “In part, I choose them based on working on a DBT team and wanting to be adherent to the DBT framework.” She later went on to describe that the population with which she works with also influences her treatment choice, “Because I work with a particular population, my interventions are often MI [motivational interviewing], DBT, CBT-oriented...because both the population and the setting I think determine some of that maybe.” This same participant then described that one of the beneficial aspects of working in her particular setting was the “longevity of care,” so again, setting influences the treatment approach taken, where she is given more time to work with clients then perhaps if she practiced in another setting. Another client explained, “I came from a primarily CBT focused program so I would say that that would be my theoretical orientation...”

One participant spoke to the influence of funding and resources on treatment options available to his clients. In speaking about a group for people with SUDs, he explained that the

group was currently closed to new members, but with more funding, it would be able to service more clients. He stated, “We certainly could see a ton more if we wanted to, but the overhead of managing that whole thing is difficult at best and we don’t have a way of making a lot of money, breaking even, even.” Therefore, funding available at the setting in which he works influences the services available, like access to groups, to be offered to clients. This data is reported because group treatment was one of the favored models of treatment suggested by attachment theory and therefore considerations as to barriers for implementing treatment should be considered.

Finally, one participant spoke to his life experience as having a certain influence in his treatment approach. He explained:

I find working with addictions challenging and very difficult. And, there is a back-story for me that comes from coming from a family where I lived with an addiction and being in a family where I currently live with an addiction. So, I find addictions challenging. I work with them, but I always have to mind myself. This is one of those things that I could develop a counter-transference to, which would be colored by my own personal experience.

As setting influenced participants’ treatment approaches, the treatment approaches cited the most included evidenced-based practices (EBPs). While all participants held a general understanding of attachment theory and one participant specifically addressed using it in his practice, the nine other participants did not cite using attachment theory as part of their treatment approach. However, two participants cited part of their approach as “psychodynamic.”

All participants spoke to using evidenced-based treatment approaches (EBPs). All participants discussed using motivational interviewing techniques and many spoke to using CBT and DBT. Other EBPs mentioned were relapse prevention strategies and community

reinforcement treatment. One participant explained, “With the substance abuse clients I use almost exclusively community reinforcement treatment, motivational interviewing and relapse prevention strategies because they’re empirically validated.” For this participant, it seems that his treatment approach favors EBPs specifically because they are evidenced-based, where perhaps he would not look as much towards using treatment approaches that are not evidenced-based, such as attachment theory models. Another participant stated, “I am a big evidenced-based practitioner...I would say probably 75% of what I do is very CBT focused, although over the years I have incorporated more of a humanistic additional perspective...” While this participant notes that her treatment approach mostly favors an evidenced-based model, she has also chosen to supplement EBPs by incorporating a humanistic perspective.

During the interviews, all ten participants spoke to using motivational interviewing, which participants used in conjunction with the stages of change model. All participants described using motivational interviewing to help to develop the therapeutic alliance, or as one participant put it, to not get into a “head-lock” with clients, “I tend to think if it as really important to not get on the side of telling people not to use. That it’s really- the motivational interviewing part is so important and to not get in a head-lock with the person about it [substance use] being bad or good...” Another participant described this as, “They say with motivational interviewing you have to role with the resistance. If you start confronting people right away or right off the bat, they won’t come back.” Motivational interviewing was also described in helping to get the clients to a place where they are ready to do the work. One participant stated, “...what I find is that if you can bring out the opposing view of where they’re at- the good and the bad so to speak, the using and the not using... it gets to this decision point...[where] they wonder about what they are doing and where this is going and they might have some sort of



break through.” Some participants described using motivational interviewing in the beginning stages of treatment to understand the direction that treatment will take. One participant stated, “...assessment, rapport building, seeing where they’re at in terms of their level of motivation, those tend to be my first steps...” Another participant noted, “There are delineated states of alcoholism and a lot of times they are in complete denial so I try to address where they are at in their stage and gear my interventions towards that.” While motivational interviewing is not part of attachment theory, using motivational interviewing in service of the therapeutic alliance, which is one of the ways all participants used it, is supported by attachment theory as attachment theory relies heavily on the power of the therapeutic alliance in treatment outcome.

Aside from the evidenced-based practices, participants also spoke to using additional treatment approaches or techniques, which often times were used in conjunction with evidenced-based practice models. Two participants mentioned “psychodynamic” as one of their treatment approaches, but did not specifically cite attachment theory. One participant stated he has a background in psychodynamics, but that, “I don’t get too big into psychodynamic unless there seems to be something that’s there that the person can use.” Nine out of ten participants did not specifically discuss attachment theory as one of their treatment approaches, however, some of the approaches described show some connections with attachment theory.

All ten of the participants spoke about doing a “functional analysis” of the substance use to look at the “role” or “purpose” of the substance and to see how it fits into the client’s life. One participant stated, “You would have to look at the role of alcohol in someone’s life... I like to do what I call a functional analysis, which is an assessment of what prompts someone to use a drug...” Another explained, “...and, again, it serves a purpose to use substances and to try to identify what those purposes are for them,” and a third stated “...I think that a person needs to

take alcohol out of their life for a while and really look at what re the drivers, what is giving rise to this drinking habit, how do we understand this?” Another participant explained, “...it’s more just listening how it fits into their life, what’s their motivation...how it affects relationships and functioning and finances and lifestyle and then to work together if it’s something that they want to change.” While participants explained that substance use serves a purpose in someone’s life, they did not seem to have a predetermined idea of what that purpose would be. Attachment theory would address the substance use as an attempt at emotion-regulation. While, as a clinician, this may be helpful to consider, this also presents a limitation of attachment theory as well as perhaps it would close the door to looking at other possibilities that the substance use serves in the client’s life. This limitation of attachment theory was demonstrated in participants’ responses.

Three participants also spoke to “values focused” work. In this approach, the client is helped to discover “what is important to them,” to look at what their “aspirations” are to see how substance use may be getting in the way. One participant described:

I think values-focused work can be really important...having an understanding of what is important to them, where alcohol or substance use may be getting in the way of that, noting the discrepancies between what they want and what they are actually doing...”

Another participant described this idea of “looking at the discrepancies” as “...it’s about looking at both sides of the coin, looking at their drug using and looking at their aspirations...” “Values-focused work” is not addressed in attachment theory and therefore this shows a limitation of attachment theory as it is a treatment approach that would not be considered when relying on attachment theory.

Eight participants noted the importance of using other supports aside from an individual therapist, which shows some connections to attachment theory. Attachment theory supports using AA and group treatment, as it is thought that with SUDs the relationship may become too intense with an individual therapist and therefore treatment in a group setting is supported. Two participants addressed group treatment and two others addressed AA. Other examples of supports that participants discussed include: other clinicians on the team (if it was a team approach setting), other professionals and using community resources. One participant explained, “It’s about including all of the supports that we can get involved with someone...” Another participant noted their reasoning for this, stating “seeing an individual therapist alone is just not enough. I think in terms of multi-dimensional treatment, I think this is a multi-modal problem...” Another participant explained her reason for this in reference to her work with many people with Borderline Personality Disorder and not specifically clients with SUDs. She stated:

...I think it’s really important to connect them with the team rather than with just you. And, people with Borderline Personality Disorder and attachment issues, we don’t want them to just think that we are the ones who are saving them and we’re the be-all-end-all and that we’re so great and we’re their savior, that is like a big warning sign to me.

This same participant also spoke to the helpfulness of getting clients into group as providing more to talk about in treatment and also being able have a chance to see the clients interact with other people and talk about “[the] issues, [and] problems that might come up, [and] successes.”

Two participants spoke to having client’s join AA. One participant referred to AA as important because it is gets the client involved in a “recovery community.” Another participant spoke to AA as “a new family” and explained, “I certainly know the AA community well, I know people that they can talk to...because for an alcoholic, 12-step recovery is the way to go...

They really need to form a new family and sometimes their biological families are a disaster...and they can find that in the AA community...” Another participant noted using AA, if this was something the client was already involved in and didn’t specifically address seeking out AA for clients with SUDs.

Other approaches using the community included having clients go to their church. One participant described using the church if the person was too anxious to go to AA meetings. “I do especially use church, I don’t know what you call them, officials if people have really severe social anxiety because sometimes meetings are just not a realistic option.” Another participant spoke about the community in terms of holding access to resources. He explained using a “community-reinforcement approach...[where] your community is your world- job, home, your neighborhood- are all resources you can access.” The community was also described as a tool to help clients to get out into social settings to interact with people. Therefore, in addition to group therapy and AA, the participants provided other examples of supports to use in working with clients with SUDs to shed additional light on the topic.

Five participants described looking at the family as another one of their treatment approaches, however, participants did not specifically discuss looking at the family in terms of the attachment style formed in the caregiving environment- as attachment theory would. Two participants explained they don’t necessarily look at the family. One participant explained that she has clients bring in photos of their families from when they were young and she then will do a timeline on a big piece of paper. She uses this as a tool to then discuss with the clients “the difference between what you saw, like going to Disney and going on vacation, and how it felt...” Another participant explained that he gathers family information in order to generate a genogram

where he then will use that to look at patterns of substance use “because a lot of time there’s a pattern, it’s very much a part of it, of course it’s not the whole story, but a big part of it.”

Two participants explained that they do not necessarily look at the family. One stated, “A lot of people will look at the role of alcohol in the family of origin, I don’t tend to do that as much.” Another participant described not necessarily looking at the family because it can be too intense for the client, “I’m not necessarily digging into past relationships or their issues with their mom...I might sort of touch on it, but for some people it’s just too intense...” Therefore, while participants addressed ‘looking at the family’ as part of their treatment approach, participants did not address this in relationship to attachment theory, which would have included looking at the caregiving environment in terms of the attachment relationship formed. This provides an example both of where attachment theory could possibly be limiting as well as where attachment theory could have provided additional perspectives for the clinician to use in the treatment process to obtain even more understanding of the client.

Three participants specifically described “getting at” or “bringing out” client’s emotions as part of the treatment approach and this shows connections to attachment theory. Attachment theory posits that clients must be able to learn to experience their emotions in a safe and contained way in the therapeutic relationship and therefore uses the presence of emotions as a vehicle to enact change. The participants who described “getting at” clients emotions felt that SUDs are the result of something “buried” emotionally. They explained, “Some of what I do is...being present with where they’re at and helping them to bring out their emotion,” and, “I think there is something that is buried emotionally in their subconscious and I try to get at that, what that is.”

Two participants addressed the shame involved with SUDs and described helping the clients to work with the shame around addictions, which relates to attachment theory as one of the symptoms of insecure attachment is shame and asserts that clients then use substances to cope with the shame. One participant spoke to how she does this, which involves helping clients to separate the addiction from themselves:

...one way is by trying to help people separate the addiction from themselves...because there is so much shame and sadness and guilt and remorse and reluctance because in talking about their substance they are sort of talking about themselves and if there is a way to try to separate themselves from the impact of addiction... that's one really helpful way to do it.

Five participants also noted the importance of psychoeducation in treatment. Attachment theory does not address using psychoeducation, which demonstrates a limitation of attachment theory. One participant addressed using psychoeducation as a way to validate the client in relationship to attachment themes, which demonstrates a usefulness of using attachment theory combined with psychoeducation in the treatment process. She described, "I find that I use this psycho-educationally and for the process of validating their current day struggles. I may say, "Of course it's difficult for you to get close to a partner especially given that you've been through blah, blah, blah." Another example of validation she might provide to a client included, "Of course, when you think about what you've just described about your relationship with your mom it's really difficult to parent yourself, you didn't learn that skill."

All participants except one did not describe specifically using attachment theory in treatment and three participants specifically noted that they do not think about attachment theory when thinking about substance use disorders. One participant stated, "I consider attachment, but

not generally with substance abuse clients, more so with clients who have personality disorders.” Another participant noted, “I haven’t thought a lot about it in terms of specifically substance abuse and I know that it certainly impacts a lot of people with trauma…” Therefore, while it seems that participants may at times consider attachment theory in the treatment process, it is usually not when working with SUDs, but rather with personality disorders and trauma, which were the examples given here. Also, the participants’ responses shed light on places where attachment theory may be useful in treatment and/or add additional insights and also where it is limiting. Finally, treatment setting appeared to be one of the more influential factors in choosing treatment approach, specifically in relationship to participants using EBPs in their practice where participants who are practicing in an agency setting cited using EBPs more than the participants who are in private-practice. Overall, the data shows that all participants felt as though treatment is individualized and they did not endorse a one-size fits all approach to treatment or strictly follow one specific treatment model or theory.

### **Attachment Style in Treatment**

Participants were asked if they consider someone’s attachment style and/or disruptions in the caretaking environment during the treatment process. Although participants did not cite specifically using attachment theory in the treatment process, all participants said that they *do* consider disruptions in the caretaking environment or someone’s style of relating in the treatment process, however, may not directly “label” someone with a particular attachment style. One participant stated, “I don’t know that I sort of label people with a certain attachment style, but I think about it in terms of their behaviors and how they manifest themselves. I don’t really think about, *oh, this person has a secure or insecure attachment style or pattern.*” Of the participants that considered attachment in the treatment process, the most commonly cited ways they felt it

helps them is: to understand how the client interacts with the world in terms of their relationships and their perception of themselves and others and helps to develop the therapeutic alliance.

Eight of the participants felt as though understanding someone's attachment style helps them to understand how the client interacts with the world, including the perception of themselves and others as well as in the relationships they may have. One participant explained, "I feel that it is very important to realize that how the person performs in this world goes back to that first relationship and if the mom was perhaps distant in the relationship with the child, perhaps the child has an understanding that that is how they are supposed to be in their life..." He also said that, "...their past...it's still playing out. They may be sitting in front of you, but that- the movies of the past are present... so they are driven by fear and their decisions are based in fear..." Another participant explained, "...we have so many clients that have had really disrupted beginnings and continue to in their lives so in many ways early relationships mirror the ones that they have today." Another participant stated, "I absolutely think about how people's formative years and whether they've had a sense of security in their relationships early on impact their ability to have stable relationships later in life."

Four participants explained that understanding someone's attachment style helps them to understand the difficulties clients may experience with trust. One participant stated, "...so I realize that someone with really bad, serious issues in this area [attachment], that I can't expect that they are going to be coming in and trusting me or other people so you try to sort of gauge how warm you are in your interaction with them." Another participant stated, "I often think about a client's attachment, particularly when the attachment has been disrupted and there is a tenuous attachment and difficulty with trust."



Participants also felt as though it helps them in the therapeutic relationship. One participant spoke to this in terms of developing the therapeutic alliance: “I try to assess attachment style during the initial stages of treatment in order to figure out how to best connect with particular clients and begin to create the therapeutic relationship.” Another participant spoke to this in terms helping her to anticipate possible disruptions in the therapeutic alliance:

...so when someone hasn't had that experience [of trusting someone] or had it disrupted, then I anticipate that there are going to be those disruptions in the process of the therapeutic work as well and the comings and goings and their response to me as a therapist would be consistent with attachment theory and pretty fragmented and problematic.

Another participant spoke to this in terms of helping him to not recreate patterns of the past in the therapeutic relationship:

I have a lot of people, for example, who were abused by their parents and that kind of thing so I know that clinically I've got to try to be really centered and focused and empathetic and consistent with them because if I'm sort of recreating some of those patterns that they've experienced in the past it's likely problematic.

Another participant felt as though it helps her to understand how her clients are going to relate to her based on “what they already believe about females, what previous attachments to females have meant or been...and prior experience in [their] life absolutely influences how they present to me...”

Other, less common, ways in which participants cited that it helps them are as follows:

Another participant felt it helps him to specifically understand the client in relation to the family and the struggle with alcohol and drugs:

I think the whole idea of using attachment theory is really important because the families are so fragmented with alcohol and drugs being present...if they're both [the parents] involved with alcohol and drugs it's going to be extremely difficult for the kids to find their own way because they're going to be so easily taken off course and get involved with alcohol and drugs.

Another participant felt as though it helps him to have an idea of what to expect with some clients in terms of treatment prognosis: "I try to help them with some information... about the attachment problem and how difficult it [treatment] may be with them." Another participant felt as though "understanding people's early experiences" helps him "to contextualize and... understand their particular trauma." Here, using attachment theory in this way helps this participant to make sense and comprehend difficult and intense clinical material in a way that can be useful to him and therefore the client.

All of the participants described attachment style in terms of a "contextual variable," as one participant put it. In terms of working with clients and considering their attachment style or history in the treatment process, one participant felt that attachment style is not something that is going to be changed in the treatment process, so that this is not the goal of treatment. Rather, he explains understanding someone's attachment style as:

[it] becomes more of a contextual variable as opposed to something you can change... it's almost like not having a leg, you don't grow a new one, you just learn to adjust to it. I think attachment style kind of follows that. If someone has insecure attachment style, they're going to be insecure forever... So, you have to see it as something to work with as opposed to something- it's not really a target of change.

According to the literature on attachment theory, it is proposed that attachment style can be changed and that in triggering someone's attachment system, the therapist can then help the client to form new or more secure attachments.

Using someone's attachment style to understand how they relate to the world and to others is similar to how attachment theory conceptualizes the usefulness of looking at attachment style as attachment theory recognizes that attachment style impacts interpersonal relationships and how people relate with others and view the world- which in turn drives their behavior in the world and interactions with others. However, attachment theory does not offer an understanding of using attachment style to establish a therapeutic alliance, however, it does assume that understanding attachment style is useful in predicting potential client struggles as well as allowing the therapist to develop a greater empathy for the client, which then, in turn, would strengthen the therapeutic alliance. Overall, while participants did not initially address using attachment theory in the treatment process and did not cite deliberately using attachment theory, participants did use and find value in looking at attachment style in the treatment process to help them to better understand the client. This sheds light on how attachment style can be useful in treatment and offers that perhaps the use of theory in practice may not always be conscious or that pieces of certain theory may be used, however may be talked about in other ways or given different names.

### **Client Narratives and Themes in Treatment**

Participants were asked what they listen for in a client's story to see if participants listen for attachment-related themes. Four participants explained that they listen for the theme of relationships in terms of relationship patterns and what type of relationships they may currently have. One participant explained she listens for: "The quality of their relationships, do they have

stable relationships or interrupted relationships? Do they have relationships, are they sustained? What's the nature of those relationships? That's [relationships] a big one." This is related to attachment theory in the sense that attachment theory proposes that interpersonal relationships in adulthood are directly related to attachment style in childhood. Therefore, looking at the relationships of clients can offer insights into their attachment style, however, participants did not specially address using relationships to address attachment style.

Six participants also stated that they listen for narratives and themes associated with substance use. One participant explained, "I try to listen for...who's in their lives and also over time are there certain factors that kind of go along with using substances." Another participant explained that he listens for the way the clients talk about substances, "I like to hear how they talk about drugs, what words they use. I like to hear about when, where and how they use and how much they think about using- it gives you a pretty good idea about what stage they are in regarding change." Attachment theory does not address the usefulness or helpfulness of looking at the client's narrative around the substance use, it looks more at their narrative in terms of the cohesion of their speech as well as their childhood experiences, for example, what needs were denied in service of their relationship with their caregiver. Therefore, this narrative around substances offers another theme for the "clinical ear" that would perhaps get neglected in following attachment theory too closely.

Six participants also explained that they listen to a person's past experiences. A few participants described the ways that they listen for past experiences with trauma. One participant said that she listens for, "...trauma history, just the sort of narrative that someone has been through that influences their- that shapes their life now that would be likely to be a prominent influence in their life in the present moment." Another person described listening to someone's

past experiences as, "...if they've had challenges in their upbringing in terms of not really having bonded with parents," and went on to suggest how this might influence their view of the world and others as, "... the view that this is an unsafe world, people are out to hurt you, those are some of the themes." For another participant, she explained this as listening for "distrust." Another participant explained that he will listen to the narrative and theme of someone's "self talk," the way that they have come to think of themselves and look at where this might come from. He used a particular client to give an example:

Ok, here's one narrative- that deep down I'm a piece of shit and I'm worthless and not worthwhile- I'm thinking of a particular client, [her] aunt used to put [her down] all the time. The aunt raised her... and this client has a Ph. D and is thinking that she is a piece of shit, so there is a lot there to counter, but I had to get a sense of what her story was.

Again, a limitation of attachment theory is that it does not specifically look at trauma and the attachment relationship, however, it does offer a way, as one participant described, to help the clinician to understand the client's worldview and view of others. However, literature on attachment theory does propose looking at someone's cognitive structure to look at the origins of where their perceptions may come from. These examples both show limitations of attachment theory as well as how the ideas proposed in attachment theory may be translated to the treatment process.

Two participants said they listen for hopefulness/hopelessness in the client. One participant explained, "And then also I think I listen for people thinking about a future and if they have some ideas of what they are working toward in their life. That's kind of like a hopeful perspective. And a lot of times that gives me some idea about where people are in their recovery process too." Attachment theory does not look at hopelessness or hopefulness in the client and

therefore this offers a limitation of attachment theory, where using client hope or looking at client's hopelessness can be an important part of the treatment process.

The most common themes/narratives that participants addressed listening for in a client's story included relationships, narrative and themes associated with substance use and past experiences. This shows that, again, participants did not specifically listen for attachment-related narrative, however, the findings do show some relationship with attachment theory. The findings also show potential limitations of attachment theory as well as places where attachment theory, or listening for attachment-related themes, may have been more useful or could have been used as an additional "tool" in the treatment process in terms of using the "clinical ear."

### **Abstinence versus Harm-Reduction**

Participants were asked about their view on an abstinence-based treatment approach. Participants were asked this question because attachment theory views the therapeutic alliance as an important aspect of the treatment process for SUDs and proposes that the client cannot fully 'attach' to the therapist, or engage fully in the therapeutic alliance, unless the client has 'detached' from the substance. Therefore, attachment theory proposes that treatment will not be as successful unless it is approached using an abstinence model. All ten of the participants spoke to their position of taking more of a harm-reduction as opposed to an abstinence approach in treatment and not all of the participants felt as though abstinence was not always the end-goal of treatment. Two participants specifically addressed that they felt as though abstinence was an "obvious" goal or the "ultimate recovery." When talking about client goals, one participant stated, "Well, clearly the obvious is abstinence and the recognition that their drinking is something that they can't control and helping them develop that acceptance and that recognition and coming to terms with that." The other participant explained, "I feel like the AA/NA people-

that [abstinence] is what is part of their program and I found that they [clients] tend to embrace that and I just go with it because really when I look at it, I feel like that would be the ultimate recovery.” One participant described a goal as “staying clean and sober one day at a time. “ “One day at a time” could refer to the complexity and the longevity of treatment for clients with SUDs and therefore the need to take it one day at a time. “Staying clean and sober” could refer to his view that abstinence is an end-goal as well as something to look at as a shorter-term goal too.

The other participants did not feel that abstinence was necessarily the end-goal. This could be because they felt it was “obvious” and therefore did not mention it. One participant spoke to the goal of treatment as reducing the “pathological part of the substance use” and views this in terms of the DSM, “Basically, the goal of treatment is to reduce any of the problems in the four or five domains of impairment: legal, medical, social, vocational and so-forth. So, to reduce the impact [of the substance use].” This participant specifically spoke to his stance that the end-goal may or may not be abstinence. In discussing his view on an abstinence-based treatment approach, this same participant stated, “it’s right for somebody, but not right for everybody would be the summary statement.” Attachment theory addresses SUD treatment with the end-goal of abstinence and therefore does not leave room for this to be decided on an individual basis, as this participant proposes.

All participants spoke to taking more of a harm-reduction approach in service of the therapeutic alliance and to keep clients in treatment due to the risk of alienating clients if they did not have this flexibility in their approach and followed purely an abstinence-based approach to treatment. One participant described a specific client: “...and he had mentioned that he had gone to treatment once and then left and I said, *what happened?* And he said, *well the person said I had to quit using or I wouldn’t get anywhere in treatment.* So I said, *ok, what did you do?*

And he said, *I walked out.*” Another participant described that she felt she had to change her approach over the years from a more abstinence-based to harm-reduction approach and went on to explain, “And if I tell a nineteen-year old, *well, this is an abstinence-based program, they either won’t come back or they’ll lie to you.*” Another participant felt as though she takes a harm-reduction approach so that clients won’t “hide” their substance use from her. For the participants, taking more of a harm-reduction approach is in service of the therapeutic alliance so as to help keep clients in treatment and to keep open and honest communication going. Many participants also spoke to the decision on which approach to take as being mostly client lead and one participant explained, “So, some people are ready for change and then I really want to follow their goal and if their goal is abstinence or harm-reduction then we’d work on that.”

Although participants felt as though the approach of abstinence versus harm-reduction was client-lead and all participants endorsed taking a more harm-reduction approach in service of the therapeutic alliance, taking a harm-reduction approach was not always cited as the favored approach. Participants discussed certain variables that seemed to influence their idea of which approach should be taken. These variables included “where the client is at” (including the pathology of their substance use, the substance being used, the client’s motivation to change, their trauma history and their age) as well as the treatment setting. In terms of “where the client is at,” many felt that level of motivation, or where the client was in the stages of change, influenced an abstinence versus harm-reduction approach. One participant explained that her approach is determined by, “...level of motivation and where they’re at in terms of their ambivalence about whether they want to remain abstinent, whether they might be interested in cutting back, whether they just aren’t sure what their substance use means at this point...”

Participants explained that if clients with SUDs are in denial, or not ready to quit, they will take a



more harm-reduction approach. Another participant explained that abstinence would be a beneficial approach “for some people that have emotional dysregulation as part of their background- if there’s a lot of trauma.”

Some participants described that it depends on the substance:

Well, it’s kind of interesting because I feel that in some ways it depends on the substance and that I feel that definitely certain substances... you just don’t take them... For example, I think opiates aren’t something that people can take, certainly not recreationally- which a lot of people take- and they’re not necessarily taking them for pain and then they become addicted.

This same participant went on to describe that she feels that marijuana is a substance that generally more people can use recreationally, “I know that some people smoke marijuana recreationally and I could see people maybe using that to some extent.” Another person felt as though with a substance like heroin, abstinence would be the goal, “...like if someone’s shooting heroin I would probably send them to a residential facility... and then when they come back [to see me], definitely abstinence is the goal.”

Many participants spoke to the level of pathology of the substance use as influencing an abstinence-based versus a harm-reduction approach. One participant described, “I really also try to come from more of a harm-reduction place and not a place of abstinence, unless someone is completely unable to- you know, if someone has a hardcore addiction and can’t use at all and that’s clear, that’s one thing.” Another participant stated, “...if someone has had good control over their use of let’s say, alcohol, or even marijuana, if they can regulate it to the point where it’s not causing any problems...then I’ll look at a controlled drinking or harm-reduction model.”

Three participants referenced the age of the client when looking at an abstinence versus harm-reduction approach. One explained, “the alcohol thing, it’s the age range where people binge, so that’s going to be harder for him, so we’ll see how that goes.” Here age, and culture, the culture of binge drinking among young adults, influences this choice. Another participant stated:

...age goes into that formula as well [abstinence versus harm-reduction]. I’m not real fond of telling someone under twenty-five to give up all drugs unless they clearly have a problem with that...When they are sixty, telling them they should give up alcohol is a little different than telling a 22 year-old, they are more willing to hear it...

For this participant, age also is, as he states, “part of that formula” (to determine abstinence or harm-reduction), if a person is not in danger.

For participants, taking an abstinence versus harm-reduction approach also seemed to depend on treatment setting. One participant spoke to working with the courts and with DUI clients and explained that the court requires clients to be “clean and sober” for six months, so for this work with these clients, he adheres to an abstinence-based approach based on what the court says. Another participant explained that for a buprenorphine program in his clinic, it is a requirement that clients are abstinent to be in that program. He explained, “And, for that program, for people to be in it, they have to get abstinent, they have to stay abstinent, so that’s what that particular program is, we’re not set up to do it another way...”

Attachment theory does not leave room for this flexibility in choosing the approach in of abstinence versus harm-reduction as it favors an abstinence model. Attachment theory supports abstinence as it proposes that the client cannot fully attach to the therapist, and therefore be successful in treatment, unless first detaching from the substance. However, a contradiction that

is revealed in this model and that is supported by the data collected is that participants feel as though actually taking a harm-reduction stance as opposed to an abstinence stance can be in service of the therapeutic alliance and can help to keep the client in treatment, where taking an abstinence stance could possibly alienate the client. Also, as attachment theory is concrete in its stance of taking an abstinence-approach, it does not leave room for or offer guidelines to assist the clinician in determining the best approach to treatment. Again, the participants in the study shed light on this as they offered guidelines in which they use in order to determine the best approach to use.

### **The Pace of Treatment**

Participants were asked about how they pace treatment in working with clients with SUDs as well as how they gauge when a client is ready to do the work to see if there were connections to attachment theory because attachment theory proposes that treatment should mirror the development of a secure attachment relationship and literature on attachment theory proposes that first a ‘secure base’ must be developed before moving to do more exploratory work and that the release of affect should not come too soon in treatment. Most participants addressed that the pace is client led and that as a therapist, they are not going to “push” or “force” the client. One participant described, “I kind of let them be in control of the pace unless they are going too fast and then I do try to pull it back down.” Overall, participants did not have a model for how they approach treatment in terms of pacing, however participants spoke to different variables that will affect the pace of treatment.

Overall, while participants let client’s lead, they reported that they do not want to go too fast or “let client’s get too ahead of themselves” and that often times change is slow. One participant explained, “I think that in some ways our role is to not let people get too ahead of

themselves too quickly because it can lead to failure which is more demoralizing...” Two participants spoke about this in terms of bringing out the emotions of the client, which has connections to attachment theory. One participant explained that he doesn’t want to get at the emotions too soon in treatment, “...the emotions are very powerful and you don’t want to do that [get at emotions] too soon in treatment, you want to coach them, lead them along gently.” He sees his role as being a gentle leader in terms of pacing the treatment. Another participant addressed needing to have a therapeutic alliance before looking at emotions. She explained, “... and that’s really what we want to find out is how you feel... and I think to do that work you have to really build trusting relationships with your clients.” For this participant, the therapeutic alliance needs to be developed first, before other work can be done. The participants’ responses show a connection to attachment theory in that first the clinicians look to establish the therapeutic alliance and the fact that they do not want to get at or bring out the emotions too soon in treatment, or let the client go too fast or get too ahead of themselves. The data, therefore, sheds some light on the translation of attachment theory to practice

Participants also addressed that the level of pathology of the substance abuse and/or “the duration of problems” and trauma histories as influencing the pace of treatment. One participant explained, “And I think a lot of times what changes the pace of treatment is just sort of how much pain and suffering the person has experienced around the addiction.” Another participant explained, “...if people have any PTSD issues... I probably wouldn’t go there for a long time...It’s complicated you know and I haven’t talked about it like this in a long time and I am feeling tired!”

Participants also described that the “hierarchy of needs” will affect the pace of treatment. One participant explained, “Because some of it depends on what their living situation is and how

safe that is and how they're able to get basic needs met... those take precedent." Another participant explained, "...there's the hierarchy of needs of priorities, so you'd want to treat the most urgent situation first, ideally..." If client's basic needs are not met, then those issues will get addressed first before other pieces are addressed.

Participants also explained that the stage of change that a person is in will affect the pace of treatment. One participant framed this in terms of "shame." She explained:

You know, there's a lot of shame. Shame is the biggest barrier to helping people to move on because they're just so defended because they feel so lost about themselves... I will have people come in here for OUIs and they'll say, *you know, this is just really wrong, they made a whole mistake, a huge mistake...it [the breathalyzer] wasn't really a 2.2, I have asthma and I did it wrong.* I mean, you're not going to be able to do anything with somebody like that.

Another participant explained that:

First and foremost, I suppose, is the patient's readiness to engage in the healing process or the treatment process... So how I would pace that is come to an understanding of this person's resistance and exploring if there's any place, like with motivational interviewing, where we can gain some traction and take it from there.

Participants were asked how they know when a client is ready to do the work and to move forward in treatment. Some participants addressed honesty as an important factor of moving forward. One participant explained, "The degree of honesty within the substance abuse clients is really important because if they're not able to be honest at all, then we aren't going to get very far..." This same participant also spoke to the importance of having some "internal safety" on the client's part before moving forward. "So they can have some sort of internal safety

for themselves and when they can feel okay about going forward, there are probably other things in their life that they need to change in order to feel safe and so they need to take the steps to get there...” Self-awareness and insight on the clients’ part were other ways participants could tell when clients are ready. One participant explained that she can tell when clients start “divulging” more and when they are able to look at different perspectives. Another participant explained this as “self-awareness” and the “insight that they present.” Two participants also described that client’s taking a “proactive” stance is a sign that they are ready. One participant described taking a proactive stance as possibly more indicative of this than an objective measure of reduction in amount of substance use. He explained, “So, even though their rate may have gone up... their willingness to do something to change has increased, so that kind of proactive-ness as opposed to not necessarily an actual decrease in rate, because I have see many people cut back on drugs and alcohol with no interest in changing...” Another participant explained that he can tell when client’s “realize that they have to do this and they are willing to make the changes on their own, that’s good.”

The literature on attachment theory establishes some guidelines to assist the clinician in determining the pace of treatment and when to move forward, some of which were mentioned by participants. For example, the literature proposes that client’s willingness to explore the past and negative mood state will inform the pace of treatment. However, participants also offered additional insights into what will affect the pace or treatment or clues as to know when the client is ready to do the work and therefore reveal some of the limitations of attachment theory.

### **Therapeutic Alliance**

Participants were asked to explain how they view the therapeutic alliance, how they develop the therapeutic alliance and how they see it involved in the treatment process to see if

attachment themes were present as attachment theory relies heavily on the therapeutic alliance in terms of treatment outcome and views the therapeutic alliance as essential in the treatment process. Attachment theory also proposes that the therapeutic alliance is developed under the conditions similar to those in the development of secure attachment in the caregiving relationship. Participants addressed the theme of “trust” and “safety” the most in talking about the therapeutic alliance. One participant explained, “...the alliance I feel can only be developed and sustained if there is that kind of safety for people to be who they are.” Another participant stated, “I mean, you have to develop some sort of relationship with an addict so they can trust you a little bit...” Another participant put forth, “...I would describe it as a relationship that’s really first and foremost built on mutual trust and respect and safety. I think therapy has to be some sort of safe haven.” Another participant explained, “they have to have some trust in the therapist to be disclosing, so they have to believe you are not going to hurt them.”

Other ways the therapeutic alliance was described were as: “a place to not feel judged,” a place where there are boundaries “[because] people with attachment issues have all sorts of issues around boundaries,” a safe environment and a connection “...it’s the connection that develops in which a client feels safe enough to be vulnerable and divulge information,” a place where the client won’t be rejected or punished, a “contained” relationship, “predictable” and collaborative- “working towards shared goals and there is still a very strong sense of working and wrestling together.”

Participants were asked how they develop the therapeutic alliance. Participants addressed that it is worked on in the beginning of treatment. One participant explained, “The therapeutic alliance for me is something that is worked on in the beginning of therapy and often needs to be revisited with the population I work with many times over the course of treatment.” When

talking about treatment approach at the beginning of treatment, another participant explained, “I’ve always thought about it as I try to meet them at the doors and tailor my therapy to them as individuals and my efforts are at building a therapeutic alliance.” Overall, participants described that in order to build a therapeutic alliance they are personable. This included such things as: using humor, not being “overly clinical and stuffy,” “I want to be reliable and I want to be authentic and trustworthy and human, including all the fallibilities that human beings have,” “I try not to be too bossy, doctor-like,” “[I] don’t come across on some sort of plateau of spiritual hilltop,” “..and part of the motivational interviewing thing is not coming across as being too much the expert.” Being personable also included using humor, as one participant described, “And, it has to not be 100% serious. You know, these are serious issues that also require some level of levity or the ability to not create a really depressing environment and atmosphere.” Another participant explained, “I try to use humor, I think that it’s not always appropriate, but I think that certainly humor can be very engaging.”

Participants also addressed: using empathy and mirroring: “it’s real important to put yourself in their shoes and see where they’re at and use their own language and use their own body language and their own style and reflect back to them and then go from there,” meeting the client “at the door,” setting limits and boundaries, using “warmth,” being non-confrontational: “...so I try to be as non-confrontational as I can... but you have to be gentle around it because people are hurt and they are prideful and I don’t want to damage that” and “reinforcement-techniques,” as one participant explained: “...my trick is that I remember an amazing level of detail about people’s lives so that they feel heard with that.” These show connections with attachment theory.



Participants also spoke to the importance of finding the comfortable working distance in developing the therapeutic alliance. One participant explained, “A working alliance, if the connection is too close, that’s not going to work and if it’s too distant that’s not going to work so you have to find the in-between.” Another participant explained this as, “I try to titrate where I’m at I the sense of: am I pushing too much? Are they okay with what’s going on? I try to get a sense of: are they becoming too anxious? Are they too uncomfortable? And if they are, I’ll back off and take it a little more slowly.”

Participants were asked to explain how they viewed the therapeutic alliance in the treatment process. The most commonly cited purposes that participants felt the therapeutic alliance served were: teach about healthy relationships, act as “scaffolding” or a “foundation” to treatment and help people come to therapy. One participant described, “I feel like the relationship is what may *tip the scale* for a client who is already ambivalent about coming in for therapy and making behavioral changes. With a more positive relationship, they may be more willing to actually come in.” Another participant described this as the therapeutic relationship is “defined by the client’s feet- which is whether or not they client walks in and shows up. And, if they don’t show up, it seems to me that there is a problem with the alliance... if the person isn’t coming in then you don’t have any relationship that you are working with.” In regards to the therapeutic alliance, this same participant explained that for some clients the therapeutic alliance is more important than with others. She explained:

...so, with some clients I feel that the relationship is really central and that my presence in their life and the process of our relationship is what drives change. And, then there are others where, and this is probably linked to attachment theory, where their relationship to me is really of no consequence, no consequence at all.

Participants also put forth that the therapeutic alliance can: help guide the client, help the client get in touch with emotions, give the client hope, be a “corrective emotional experience,” can handle “friction,” and model self-care, which shows some connection to attachment theory, especially helping the client to get in touch with emotions, helping to guide the client and can handling friction.

Participants’ responses show that they placed value on the therapeutic alliance, just as attachment theory does, and view it as an important or essential part of the treatment process. The ways in which the participants described the therapeutic alliance also demonstrate connections to attachment theory as the most common words participants used when describing the therapeutic alliance were “trust” and “safety.” Other ways the therapeutic alliance was described was as having boundaries, a place where there is no judgment, a connection, a place where the client won’t be rejected or punished, a contained relationship, predictable, collaborative and working towards shared goals. The most common ways that participants described developing the therapeutic alliance were: being gentle, non-confrontational, warm and personable, meeting the client where they are and using motivational interviewing. The conditions of the therapeutic alliance discussed by participants is very similar to the conditions under which a secure attachment relationship would be formed in the caregiving environment. Therefore, it seems as though the development of the therapeutic alliance mirrors the development of a secure attachment relationship regardless participants lay claim to consciously using attachment theory in the treatment process. Participants’ responses also offer insights or examples of how attachment theory can be translated to practice.

Some participants also elaborated on how they view the therapeutic alliance with client’s with SUDs. Based on participants’ responses, in the later interviews they were asked specifically

if they felt there could still be a therapeutic alliance if the client was engaged in substance use as the literature on attachment theory puts forth that the therapeutic alliance will be compromised if the client is engaged in substance use. Overall, all five of the participants who reflected on this question felt like it depended on the level of pathology of the substance use and that clients definitely could not come in to treatment under the influence. One participant explained:

Well, it's interesting because I think it might depend on the level of pathology of the substance. So, let's say a person abuses, but isn't addicted. I could buy into the idea that they could use moderately... and still be engaged in treatment... If it is someone who has a dependence and they want to use periodically, I just- not that they can't be in treatment and do that, but I feel like the two- it's going to be difficult."

Another participant explained:

If they are full on in using mode, their number one relationship is with the substance completely. But, you know, if they are more casual users and they go back and forth, it may not be as strong, it may be sometimes stronger than the substance, sometimes it's not...but you know, I think it's possible to still get in there.

Another participant explained, "And there is this thought that when someone is sort of active in their addiction it is hard for them to simultaneously have an attachment to their therapist, which is this whole thing of not showing up for treatment." Therefore, it seems that the level of pathology, or how "active" someone is in their addiction, influences their capacity to engage in treatment and the therapeutic alliance.

A theme that arose from participants' discussion of the therapeutic alliance was the influence of the setting on developing the therapeutic alliance. One way the setting influences the therapeutic alliance involves clients being mandated to treatment. One participant explained this

as, “Many see me because they have to, so the relationship is something like I am here because I have to. So, in a sense, they see me as a way of staying out of jail, complying with their probation conditions, and for them, there is less of a risk making it so they don’t come back.” Here, the influence of setting seems to take the emphasis off of the relationship in terms of using it to help clients to come to therapy. Another participant explained that it is difficult for him to develop the therapeutic alliance with clients who are mandated to see him per terms of their probation because the level of confidentiality and trust is broken since he is reporting to the probation officer and sometimes the court. He explained:

...and I certainly have been brought into court a couple times and I don’t like that situation at all because now I am being used against the client. [I’ll be asked] *did so and so say that they used on this particular day? Have they been using?* And, I’ll say, *yeah, they did, they did say that to me.* And, then they’ll use that and they’ll put people in jail because of it, because they were on probation at the time and they weren’t supposed to be using, so that’s awful.

Another participant spoke to the influence of setting as also possibly interfering with the client’s willingness to trust the therapist. This participant explained:

The tricky part with this population is that especially with a team approach where there’s prescribing involved, there may be real consequences to mis-using medications we prescribe which may interfere with a client’s willingness to be honest, forthcoming and trusting in therapy.

The participants offered insights into considerations to be aware of when developing the therapeutic alliance beyond what attachment theory offers. Attachment theory focuses on developing a “secure base” with the client that would mirror a secure attachment relationship,

but does not provide insights into other factors to consider when dealing with the complexity of SUDs. For example, attachment theory takes a simplistic stance of an abstinence-based treatment approach, however, participants felt as though a client could still engage in the therapeutic alliance while using substances, however, explained this was not always the case and offered variables to consider, like taking into consideration the level of pathology of the substance use or considering the treatment setting, when developing the therapeutic alliance. SUDs are complex and here the participants spoke to the complexity of SUDs and the therapeutic alliance beyond what attachment theory offers.

### **Summary**

These findings seem to demonstrate that though all but one of the participants do not consciously use attachment theory in the treatment process, that attachment themes were present in their discussions of their treatment process. The findings also show places where attachment theory could have also provided clinicians with additional insights into treatment while also indicating places where clinicians provided additional insights into treatment to reveal the limitations of attachment theory. Also, in the places that attachment theory themes were shown to be present, possible “translation rules” or possible ideas of how to move from theory to practice were revealed. The findings also show that while attachment theory was not specifically used among clinicians in the treatment of SUDs, EBPs were the largely favored treatment model, as EBPs were mentioned the most in terms of treatment approach.

## CHAPTER V

### Discussion

#### **Introduction**

The purpose of this study was to explore how mental health clinicians use attachment theory in the treatment of substance use disorders (SUDs) and look at what may influence this use in order to shed light on the use of attachment theory in treatment as well as on the treatment of SUDs. One of the ways that SUDs have been conceptualized is as attachment disorders and there are empirical studies that show a correlation between SUDs and attachment style, however, there has been little research conducted on if and how attachment theory is used in the treatment process. The key findings of this study will be discussed in terms of their relationship to the literature presented on SUDs and attachment theory. The discussion will also look at the key findings in terms of their implications for social work practice as well as policy regarding SUDs. Finally, the discussion will address the limitations of the study as well as recommendations for further research.

#### **Key Findings in Connection to the Literature**

The hypothesis underlying this research was that although participants may not directly speak of using attachment theory in the treatment process, that attachment-related themes would be present in their work with clients with substance use disorders (SUDs). Although most of the participants identified as having a general knowledge of attachment theory, they did not identify themselves as typically using attachment theory in the treatment of SUDs. However, the findings

of the study show that attachment-related themes were present in some areas of treatment, which supports the initial hypothesis of this study. This perhaps sheds some light on the connection of SUDs and attachment theory. The findings also suggest that certain factors influence treatment approach as well as the development of the therapeutic alliance. Treatment setting was cited as the most influential external factor in treatment approach (client characteristics would be considered more internal factors), especially in the use of evidenced-based practices (EBPs). The findings also show certain places where attachment theory perhaps added an additional knowledge or understanding to certain areas of treatment that participants neglected to mention and also demonstrated places where participants shed some light on additional areas that attachment theory neglects. This suggests that theory both has a use to assist clinicians in practice as well as limitations to its use. The findings also suggest that perhaps if there was more research on attachment theory and specifically its use in treatment as well as its effectiveness in treatment outcomes that it would be more widely considered in the treatment process. However, the findings do show that participants did not subscribe exclusively to one treatment approach and those participants that cited using EBPs also used other treatment approaches to supplement their EBP, some of which showed connections to attachment theory. Therefore, attachment theory seems to have some use to treatment as a supplement or if used in conjunction with other approaches or models as it can offer additional insights to the treatment process. However, the study also demonstrates the limitations of attachment theory, perhaps pointing to the risk of exclusively relying on one theory or treatment model in the treatment process.

The findings show that overall, while the majority of participants' did not state that they typically use attachment theory in the treatment process and they classified themselves as having a "general" understanding of attachment theory, participants did at times speak to attachment-

related themes when discussing the treatment of clients with SUDs and all participants spoke to considering attachment-style in the treatment process. The areas of participants' discussion that showed more connections with attachment theory and therefore offered ways that attachment theory can be translated to practice, included their conceptualization of SUDs, their understanding of attachment theory, their consideration of attachment style in the treatment process, the goals of treatment and the concept of the therapeutic alliance. Areas that demonstrated fewer connections to attachment theory or were missing considerations addressed in attachment theory included ways to tell when clients are ready to do the work, the use of the therapeutic alliance in the treatment process, general treatment approach, abstinence versus a harm-reduction approach, pace of treatment, and listening for specific client narrative and themes. These areas highlight both limitations of attachment theory as well as places where attachment theory may have shed additional light on the treatment process.

The finding that overall participants each had many different ways of conceptualizing substance use disorders (SUDs), speaks to the complexity of SUDs, which was put forth by McCrady and Epstein who acknowledge that SUDs are complex and it is important not to adopt a simplistic understanding (McCrady & Epstein, 2003). The finding that all participants also spoke to SUDs as having both an environmental and biological component, as well as most often being related to another mental health issue, connects to the literature and previous studies that speak to SUD development as having an environmental, biological and psychological component (Cook, 1991, Kendler, & Prescott, 2006). The finding that most participants conceptualized SUDs as a co-occurring disorder, or a symptom of something else, as well as a coping strategy also relates to the literature that asserts that alcohol may be used to lessen feelings of depression, stress or anxiety as well as to make social situations more comfortable and enjoyable (Kendler &



Prescott, 2006). This also relates to the literature on attachment theory that conceptualizes SUDs as an attempt at emotion-regulation (Kohut, 1977). The finding that participants also commonly conceptualized SUDs as relating to relationship broadly relates to attachment theory in terms of SUDs originating from lack of emotion-regulation skills due to insecure attachments (Kohut), however, no participant specifically addressed SUDs as an attachment disorder, or as an attempt to regulate the attachment system (Padykula & Conklin, 2009) although one participant did state that she thinks one of the ways SUDs may develop is as a result of “missing attachments.”

The finding of participants’ view of using theory in practice to help inform the nature of the work relates to Blame and Julius’ (1977) assertion that “[theory] will help to organize clinical observations and apply them more meaningfully and consistently in work with patients” (p. 12). The finding that participants did not speak about theory in terms of using it to strictly inform their interventions, as participants did not address solely relying on theory, as well as the finding that participants cited many treatment approaches to treating SUDs, follows Shaffer and Robbins (1991) caution that using theory has the potential to be somewhat limited in that, “When we observe nature we see what we want to see, according to what we believe we know about it at the time” (p. 390) and Fonagy’s (1991) caution that following theory too closely risks putting “blindness” on the clinician. The findings also shed light on the specific limitations of attachment theory.

The findings concerning participant’s understanding of attachment theory is consistent with Bowlby’s (1969, 1988) original conceptualization of attachment theory which was that insecure attachment leads to difficulties with emotion-regulation as well as mental health disorders and relationship problems. However, the participants were read a short explanation of

attachment theory at the start of the interview so this may have influenced this response. However, no participant addressed having a view opposing this understanding.

The stance that all participants took on the “individualized” nature of SUD treatment relates to Straussner’s (2012) recommendation of not taking a one-size-fit’s-all treatment approach due to the diversity of people with SUDs. The finding that all participants’ treatment choices included evidenced-based practices is constant with the National Registry of Evidenced-Based Programs and Practices (2008) that recognizes EBPs are strongly favored in terms of SUD treatment. One participant even specifically spoke to choosing his treatment models for clients with SUDs because they are EBPs. The literature states that several studies have found that staff with more experience and higher educational levels are more receptive to implementing EBPs (Lundgren, Chassler, Amodeo, D’Ippolito, & Sullivan, 2012). While the literature put forth that Contingency Management Therapy, Cognitive Behavioral Therapy, Motivation Enhancement Therapy and 12-Step Facilitation Therapy are shown to be the most effective forms of treatment, participants mostly cited motivational interviewing in their discussion of treatment approach and many participants also cited using CBT and DBT models. The finding that the treatment setting, education, professional training and life experience were addressed as influencing treatment approach, while the setting was mentioned most-often as influencing treatment approach, relates to Flores (2004) assertion that one of the variables that influences SUD treatment is setting.

The findings suggest that one of the limitations of attachment theory is that it is not empirically validated and perhaps would be more widely used by clinicians if it were evidenced-based. Perhaps this sheds some light on why out of ten participants, only one participant specifically prescribed to using attachment theory in the treatment process.

The findings show that in describing their general treatment approach, the most commonly cited approaches taken did not initially address looking for attachment-related themes or early relationships with the caregivers in treatment. However, although most participants did not specifically mention using group treatment, many discussed using additional supports aside from the individual therapist. This relates to the literature that explains that group therapy is favorable for treating clients with SUDs as the “frustration” and “intensity” in the therapeutic dyad may be too much for the client (Flores, 2004). One participant also specifically spoke to using a team approach as a favorable option in conjunction with individual therapy and explained that connecting the client to a team helps the client not develop a too intense relationship with the therapist were they feel as though the therapist is their “savior.” Also, one participant who described using AA because it can be a new “family” and this shows a connection to the literature discussing that the aim of the group is to help people develop healthy interpersonal relationships (Flores, 2001).

The participants that mentioned looking at the issue of shame relates to Cook (1991) when he discusses attachment theory’s use in addressing client’s shame related to insecure attachment style and substance use. Looking at the family relates to Kohut’s (1977) assertion that it is important to look at the family and bringing out client’s emotions relates to Flores’ (2004) and Pistole’s (1989) discussion on attachment theory and the importance of bringing out clients’ emotions in treatment.

The finding that all participants spoke to taking more of a harm-reduction approach as opposed to an abstinence-based treatment approach and that participants felt as though generally the client could still use substances in a controlled manner and still engage in a therapeutic alliance does not support the assertion of Flores (2004) in his discussion of Attachment-Oriented

Treatment (AOT). Flores asserts that the client cannot develop a secure attachment with the therapist unless abstaining from substances. However, the findings support Rubin's (2003) assertion in speaking about general substance abuse treatment in that in service of the therapeutic alliance it is more important to begin where the client is and abstinence may not be a goal of the client's. Rubin goes on to state that if the client feels alienated or as though the therapist has their own agenda, this will weaken the therapeutic alliance. It seems as though strictly taking an abstinence approach is a limitation of attachment theory as none of the participants subscribed strictly to this approach and felt as though the therapeutic alliance was in fact better maintained if the decision was mostly client-lead and if the therapist showed flexibility.

Participants shed some additional light on the topic by discussing that although their stance tended to be more harm-reduction, they consider certain variables in deciding which way to lean. The variables put forth included the pathology of the substance use, the type of substance being used, the client's motivation for change, the client's trauma history and the client's age. The treatment setting at times was also shown to influence which approach was taken. These relate to the variables Flores (2004) puts forth in determining which direction treatment will take, which are setting, level of substance abuse, preferred substance, motivation, type of therapy, the stage of change as well as treatment goals. However, Flores was taking an assumed abstinence-stance when addressing these variables and here, the participants were addressing them in terms of helping to inform their decision on whether to take an abstinence or harm-reduction approach.

None of the participants addressed specifically using Mary Ainsworth's (1969) four attachment classifications in treatment to label someone with a specific attachment style. However, when asked in the interviews, all the participants put forth that they do consider disruptions in attachment, or a client's way of relating, in treatment. The response by participants

relates to Slade (2000) who puts forth that the four attachment types may not have a direct use or be mutually exclusive, but that keeping them in mind may help to identify attachment-related themes in the client's story, which can then be used in treatment. Participants' responses show that they do find a benefit in thinking about/considering someone's attachment style or way of relating because it helps them to understand how the client interacts with the world (including their perceptions of themselves and others as well as in relationships), and in developing and maintaining the therapeutic alliance, which relates to the literature cited above and connects to the research shows that interpersonal styles in adulthood are thought to be directly related to attachment styles in early childhood (Flores, 2004). It also connects to Slade's (1999) assertion that understanding attachment style allows for greater empathy for the client. However, Slade goes on to say that this is because the clinician is able to imagine early affect-regulation capacities to speak to the experience of the client, and the findings do not show this as one of the ways in which participants generally used someone's attachment style in treatment. Schindler, Thomasius, Sack, Gemeinhardt, & Küstner (2007) state that the four attachment types are "crucial in the field of substance abuse and addiction" (p. 112) and the findings show that participants did not generally feel this strongly about specifically considering someone's attachment type.

All participants generally spoke to attachment style as a "contextual variable," meaning that it is something to work with rather than something that can change and this is not consistent with the literature on attachment-oriented therapy (AOT) that aims to work on "eliciting, integrating and modifying attachment styles represented within a person's internal working model" (p. 214). These findings also do not connect to the research on attachment style that found that AA participation was associated with a decrease in anxious and avoidant attachment

and an increase in secure attachment (Smith & Tonigan, 2009). The literature, therefore, implies that attachment style can be changed, while the findings do not address changing someone's attachment style as one of the treatment goals.

The finding of the most common themes/narratives that participants addressed that they listen for in a client's story is somewhat connected with the literature that describes listening for "attachment narrative" (Slade, 2000). Slade asserts that in listening for attachment narrative, the clinician listens for ways in which they client was validated or invalidated by the caregiver and ways in which the client had to deny their own needs to maintain the relationship with the caregiver. The findings are more closely related to Larsson's (2012) broader assertion that in psychodynamic counseling it is important to pay attention to the client's early attachment experiences." While participants described listening for the theme of relationships and past experiences no participant offered listening for this specific narrative put forth by Slade. Main (1995) also demonstrated that there is a connection between narrative style and attachment style and the findings show that participants generally did not think of using the client's narrative to understand their attachment style. This, however, could be do to the fact that the findings show that participants do not specifically consider or label someone with an attachment style in the treatment process. Research looking at mediating factors associated with attachment style and substance use showed that self-reliance, emotional autonomy, self-esteem, self worth/happiness and perceived social support correlate with attachment style and substance use (Caspers, Cadoret, Langbehn, Yucuis, & Troutman, 2005; Kassel, Wardle, & Roberts, 2006; Lee & Bell, 2003; Reis, Curtis, & Reid, 2011) and provides possible additional narratives to listen for in a client's story. Self-esteem and self-worth were addressed in terms of goals, however, the other mediating factors were not addressed when talking about goals or client narrative to listen for.

The most common goals for SUD treatment cited by participants show a connection to the goals suggested in the literature on attachment theory. These goals include developing emotion-regulation capacities as well as changing the Internal Working Model (IWM), or in other words the way that the client views themselves, others and the world (Dozier, Cue, & Barnett, 1994; Flores, 2001; Flores, 2004; Pistole, 1989). The literature implies that clients who learn to regulate their emotions will not look to outside sources, such as alcohol or drugs, to do this for them (Blaine & Julius, 1977; Flores, 2001; Flores 2004;). However, the IWM involves changing the way the client views others and the world as well, which were not directly addressed by participants as goals. The goal of developing healthy relationships/connections with others relates to Fonagy's (1995) discussion of the importance of group therapy when he states that, "The inability to establish healthy relationships is a major contributing factor to relapses and the return of the substance use" (p. 75). This finding also relates to attachment theory which posits that it is impossible to regulate affective states alone (Flores, 2004) and supports Bowlby's (1969) original conception of attachment theory that posits that our ability to regulate-emotions is developed in the relationship with the caregiver. This also relates to the philosophy put forth by AA of the importance of SUD clients developing connections to others (Smith & Tonigan, 2009). The goal of caring for physical health as put forth by participants is not directly addressed as a goal in the literature on attachment theory and therefore brings to attention a possible limitation of only using attachment theory in the treatment of SUDs.

In terms of pace of treatment, most clinicians spoke more in general terms about it being client-lead and that they don't want to go too fast, while the literature on attachment theory speaks to the pace of treatment in more specific terms. The findings that participants felt as though the therapeutic alliance is the first thing that they work on in treatment and that the

alliance needs to be present before the work can be done is consistent with Ball and Legow's (1996) assertion that first a secure base must develop before the later work of exploring the client's self. Most participants spoke in some way or another about exploring the client's self in treatment and two participants put forth that they did not want to get at emotions "too soon" in treatment and one participant specifically addressed that the therapeutic alliance must be in place before moving to the more emotional work. This also connects to Flores' (2004) statement that, "Just as securely attached children will move greater distances away from their caregiver, taking more risks exploring their surrounding environment, securely attached patients will take more risks, exploring their inner-world during therapy" (p.48). Overall, it seems as though participants did not have a specific model for different stages in treatment, such as the examples that Ball and Legow and Flores (2001, 2004) put forth, however, in the generalized discussion on the pace of treatment, attachment-related themes were present. Participants also shed some additional light when discussing the pace of treatment as they addressed certain variables that will affect the pace of treatment, which were not directly addressed in the literature on attachment theory and again may show a possible limitation of attachment theory.

Participants were asked when they would know when a client was ready to "do the work" or more forward in treatment because Ball and Legow (1996) outline certain characteristics to help guide when to move to more "exploratory work." The findings show that participants' responses support Ball and Legow's assertion that client willingness to look at behavioral patterns and explore the past indicate when a client may be able to move forward to more exploratory work. However, participants generally did not address a client's mood as an indicator to inform the pace of treatment, as Ball and Legow put forth as another indicator.



Participants were asked to discuss the therapeutic alliance because in attachment-oriented therapy, as put forth by Flores (2004), the power of the therapeutic alliance is emphasized in using attachment theory in the treatment of SUDs. The literature on attachment theory suggests that the same qualities of a secure attachment with the infant and the caregiver are present in effective therapy (Osofasky, 1988; Pistole, 1989). The findings show that participants addressed the theme of “trust” and “safety” the most in talking about the therapeutic alliance which has connections with the Harlow’s (1958) definition of the function of the caregiver, which states, “One function of the real mother, human or subhuman, and presumably of a mother surrogate, is to provide a haven of safety for the infant in times of fear and danger” (p. 49). This also connects to Pistole (1989) who describes that the therapeutic alliance can “be experienced as a safe base from which the client can explore aspects of his or her world.” The other ways in which the therapeutic alliance was described (as a “connection,” predictable, a place where they won’t feel judges and “working towards shared goals”) connects to Bordin’s (1979) definition of a therapeutic alliance which was described as being an emotional bond with an agreement of goals as well as with Sawicka, Osuchowska, Waniek, Kosznik, & Meder’s (2009) definition that states one of the functions of the “attachment object” (therapist) is to be predictable. Sawika et al. also put forth that the therapist gives information and explains their own behavior in the therapeutic dyad. Participants often mentioned the importance psychoeducation in their treatment approach, however, no participants specifically described explaining their own behavior as a treatment approach, however one participant did cite using a relational approach.

The findings show that in developing the therapeutic alliance, participants mostly spoke to being gentle and non-confrontational, reflect back, use warmth and humor, meet the client where they are, use motivational interviewing and reinforcement techniques and a few

participants spoke to the importance of boundaries in the therapeutic relationship. This is similar to the ways that Ball and Legow (1996) put forth that a secure base can develop as they cite: empathy, integrating love and control (setting limits), showing a sense of direction and modeling a caretaking role. One difference in the participant responses compared to the literature is “showing a sense of direction” as all participants spoke to using motivational interviewing and therefore being non-confrontational. In a way it seems as though the participants were *helping* clients find a sense of direction, rather than *showing* them.

The findings show that participants felt as though the alliance was an important part of the treatment process. This stance is consistent with research that has found a positive correlation between the quality of the therapeutic alliance and positive treatment outcomes (Horvath & Symonds, 1991; Martin, Garkse, & Davis, 2000). Attachment theory posits that the primary purposes the alliance serves in treatment is to help clients regulate emotions (Bowlby 1969, 1988; Caspers, Yucuis, Troutman, & Spinks, 2006; Kohut, 1977, 1972) help the client to come to therapy (Caspers, Yucuis, Troutman & Spinks, 2006; Pistole, 1989; Straussner, 2012), help the client to stop using substances (Flores, 2001, 2004) regulate the client’s fear (Sawicka, Osuchowska, Waniek, Kosznik, & Meder, 2009) and help the client to develop a sense of self (Ainsworth, 1969; Bowlby, 1969, 1988; Kohut, 1972, 1977). Also, Kohut felt as though a secure base, or in this case the therapeutic alliance, could also help the client to develop self-control and the capacity for mutuality. The findings that that therapeutic alliance can teach about healthy relationships, is somewhat related to mutuality, however not directly. Also, the findings show that participants generally did not specifically see the alliance as helping with self-control, or impulsivity, although a few participants did address reducing impulsivity as a goal of treatment. One of the more common cited reasons why participants felt the alliance was useful in treatment

was to help the client come to treatment, which is consistent with the literature on attachment theory. Also, the findings that a few participants feel the alliance can help client get in touch with emotions is similar to serving a regulatory function (Dozier, Cue, & Barnett, 1994; Flores, 2001, 2004; Pistole, 1989), though perhaps not exactly the same. However, this more directly relates to Pistole's (1989) discussion on using attachment theory in treatment in that the therapist should help the client to experience emotions as well as to Flores' (2004) discussion of the therapeutic alliance when he asserts that it helps clients to experience emotions and to explore their self.

While participants felt as though emotion-regulation was a goal for SUD treatment, participants generally did not address that the therapeutic alliance was a major component in meeting this goal. Also, participants generally did not put forth that the alliance was specifically what could help the client to stop using substances, which is not consistent with the literature on attachment theory concerning the use of the therapeutic alliance in SUD treatment (Flores, 2004). Also, participants did not specifically address "fear management" (Sawicka, Osuchowska, Waniek, Kosznik, & Meder, 2009) as one of the uses of the therapeutic alliance, although one participant did address clients fear in talking about SUD treatment in general.

Participants also shed some additional light on the topic, describing how the therapeutic alliance can be influenced depending on the treatment setting. This, again, relates to Flores' (2004) assertion, that setting is one of the variables in determining treatment approach. However, the literature on attachment theory does not look at how treatment setting may influence specifically the therapeutic alliance, and therefore the findings shed some additional light on the topic.

## **Limitations of Study**

This study must be looked at with consideration of its limitations. Although a qualitative study allowed for a rich and in-depth description of a topic where limited research has been conducted, the small sample size, and therefore lack of diversity within the sample, does not allow for generalizability. In addition there are further limitations due to the sampling methods. This researcher did not use theoretical sampling. Theoretical sampling is a sampling method used in qualitative research that locates participants based on analysis of the previous data collected in the study. This sampling method involves analyzing the data as the data is collected and then selecting participants based on questions or “holes” arising from this data. This allows themes and concepts to be developed more thoroughly and completely. Therefore the data collected from this study’s sample is somewhat limited and not as expansive as it may have been with theoretical sampling and therefore there are “gaps” in the research (Corbin & Strauss). Also, only one of the participants in the study heavily identified with having knowledge of and using attachment theory in practice. Therefore, the data collected may not have been as comprehensive in terms of looking at the use of attachment theory in treating SUDs as if all of the participants heavily identified using attachment theory in practice. Finally, most of the participants did not work exclusively with clients with SUDs, therefore the responses to the interview questions may have not solely focused on their treatment with SUDs.

Another limitation of this study was potential researcher bias when asking the interview questions and analyzing the data due to this researcher’s preconceived ideas and already established knowledge on attachment theory. This, as Shaffer and Robbins (1991) state, may have influenced this researcher’s observations due to what was expected or desired based on what was already known. Throughout the research process, this researcher attempted to keep this

bias in mind, however, as Corbin and Strauss (2008) put forth, it is impossible to separate the researcher from the research, nor should this be a goal, “Though readers of research construct their own interpretations of findings, the fact that these are constructions and reconstructions does not negate the relevance of findings nor the insights that can be gained from them” (Corbin & Strauss, p. 12). However, the authors do stress the importance of self-reflection throughout the research process to remember that the “data is talking through the ‘eyes’ of the researcher” (Corbin & Strauss, p. 33).

Another bias present in this study is this researcher’s own conceived importance of the therapeutic alliance in treatment. This may have possibly placed additional emphasis on the therapeutic alliance in the data collection and analysis process, where perhaps such an emphasis was not warranted or biased the results. For example, during the interviews participants may have responded to questions in a particular way due to the way the questions were asked and/or due to unconscious or conscious reinforcement by this researcher. Therefore, the reinforcement or non-reinforcement of participants’ responses to questions by this researcher is also another limitation of this study and may have influenced the direction of the responses. Therefore, as participants were influencing this researcher, this researcher was also influencing the participants. While this researcher attempted to keep this in mind throughout the interviews, Corbin and Strauss explain the feminist viewpoint, which is “due to this reciprocal influence... researcher and participants co-construct the research...” (p. 31).

### **Implications for Social Work Practice and Policy**

Exploring clinicians’ use of attachment theory in the treatment of SUDs may serve to provide “translation rules,” or implications, for using attachment theory in practice, specifically with regard to SUDs. It also sheds some light on places in treatment where looking at attachment

theory may provide additional insights and/or considerations in the treatment process to aide in the depth of the understanding of the client. The study also sheds light on some of the limitations of theory, showing treatment considerations and approaches that attachment theory does not consider or address. Overall, the study offers ideas and techniques to consider in the treatment of clients with SUDs. The many different ways that SUDs are conceptualized also speaks to the complexity of SUDs and addresses the need for further research and education around SUD treatment.

### **Recommendation for Future Studies**

To offer more information on the use of attachment theory in treatment, other studies should recruit for participants who specifically identify as using attachment theory in practice. Also, future studies could also recruit for participants who identify as only working solely with clients with SUDs to obtain a sample with more experience or more of a focus in treating SUDs.

Future studies should look at treatment-outcome of using interventions related to attachment theory as one participant suggested, “I think attachment theory is a unique theory, but I don’t think it is well researched.” While this study also may have shed some light on the treatment of SUDs, future studies should also specifically look at treatment outcomes of different treatment modalities and approaches in treating SUDs as one participant explained:

I wish more people worked with this population, I wish more people had education to work with this population. I think you have to be a generalist by default to have the ability to work with substance use disorders. I think people need to be educated more about working with this population.

Also, this study found that some participants identified the cultural context as influencing their approach to SUD treatment and therefore a future study could looking at how the cultural context

surrounding substance use impacts treatment choice and perhaps treatment outcome, which would also have policy implications.

## References

- AACAP Official Action. (1997). Practice parameters for the assessment and treatment of children and adolescents with substance use disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 140 – 156
- Adshed, G. (1998). Psychiatric staff as attachment figures. *British Journal of Psychiatry*, 172, 64-69.
- Ainsworth, M.D.S. (1969). Object relations, dependency and attachment: a theoretical review of the mother-infant relationship. *Child Development*, 40, 969-1025.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed., text rev.). Washington, DC: Author
- Ball, S. A. & Legow, N. E. (1996). Attachment theory as a working model for the therapist transitioning from early to later recovery substance abuse treatment. *The American Journal Of Drug And Alcohol Abuse*, 22(4), 533-547.
- Blaine, J. & Julius, D. (1977). *Psychodynamics of drug dependence: NIDA Research monograph No. 12; DNEW publication No. ADM 77-470*. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office.



Bowlby, J. (1969). *Attachment and loss: Vol 1: Attachment*. New York: Basic Books.

Bowlby, J. (1988). *A Secure Base: Parent-Child Attachment and Healthy Human Development*.  
New York: Basic Books.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.

Bretherton, I. & Waters, E. (Eds.). (1985). *Growing points of attachment theory and research*.  
Chicago: University of Chicago Press. (Monographs of the Society for Research in Child  
Development, Serial 209, 50, 1-2.

Caspers, K. M., Yucuis, R., Troutman, B., & Spinks, R. (2006). Attachment as an organizer of  
behavior: implications for substance abuse problems and willingness to seek treatment.  
*Substance Abuse Treatment, Prevention, And Policy*, 1. Retrieved September 20, 2012,  
from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1635415/>.

Caspers, K. M., Cadoret, R. J., Langbehn, D., Yucuis, R., & Troutman, B. (2005). Contributions  
of attachment style and perceived social support to lifetime use of illicit substances.  
*Addictive Behaviors*, 30(5), 1007-1011.

- Christiansen, B. A., Smith, G.T., Roehling, P.V., & Goldman, M.S. (1989). Using alcohol expectancies to predict adolescent drinking behavior after one year. *Journal of Consulting and Clinical Psychology, 51*, 93-99.
- Cook, D.R. (1991). Shame, attachment and addictions: implications for family therapists. *Contemporary Family Therapy, 13*(5), 405-419.
- Corbin, J. & Strauss, A. (2008). *Basics of Qualitative Research*. Los Angeles: Sage Publications.
- Crits-Christoph, P., Hamilton, J. L., Ring-Kurtz, S., Gallop, R., McClure, B., Kulaga, A. & Rotrosen, J. (2011). Program, counselor, and patient variability in the alliance: a multilevel study of the alliance in relation to substance use outcomes. *Journal Of Substance Abuse Treatment, 40*(4), 405-413.
- Dozier, M., Cue, K. & Barnett, L. (1994). Clinicians as caregivers: role of attachment organization in treatment. *Journal of Consulting and Clinical Psychology, 62*(4), 793-800.
- Egeland, B., Jacobvitz, D. & Sroufe, L. A. (1988). Breaking the cycle of abuse. *Child Development, 59*, 1080-1088.

- Flores, P. (2001). Addiction as an attachment disorder: implications for group therapy. *International Journal of Group Psychotherapy*, 51(1), 63-81.
- Flores, P. (2004). *Addiction as an attachment disorder*. New York: Jason Aronson.
- Fonagy, P. (1999). Relation of theory and practice in psychodynamic therapy. *Journal Of Clinical Child Psychology*, 28(4), 513-520.
- Fraley, R., Waller, N. & Brennan, K. (2000). An item response theory analysis of self-report measures of adult attachment. *Journal of Personality and Social Psychology*, 78(2), 350-365.
- Gibbons, M. B., Crits-Christoph, P., de la Cruz, C., Barber, J. P., Siqueland, L. & Gladis, L. (2003). Pretreatment expectations, interpersonal functioning, and symptoms in the prediction of the therapeutic alliance across supportive–expressive psychotherapy and cognitive therapy. *Psychotherapy Research*, 13, 59-76.
- Harlow, Harry. (1958). The nature of love. *American Psychologist*, 13, 673-685.
- Helzer, J.E., Burnman, A. & McEvoy, L.T. (1991). Alcohol abuse and dependence. In L.N. Robins & D.A. Regier (Eds), *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study* (p. 81-115). New York: Free Press.

- Hemovich, V., Lac, A. & Crano, W. (2011). Understanding early-onset drug and alcohol outcomes among youth: the role of family structure, social factors, and interpersonal perceptions of use. *Psychology, Health & Medicine, 16*(3), 249-267.
- Horvath, A. O. & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: a meta-analysis. *Journal of Counseling Psychology, 38*, 139–149.
- Kassel, J. D., Wardle, M. & Roberts, J. E. (2007). Adult attachment security and college student substance use. *Addictive Behaviors, 32*(6), 1164-1176.
- Kendler, K. & Prescott, C., (2006). *Genes, Environment, and Psychopathology*. The Guilford Press: New York.
- Kohut, H. (1972). Thoughts on narcissism and narcissistic rage. *Psychoanalytic Study of the Child, 27*, 360-400.
- Kohut, H. (1977). Preface. In J.D. Blaine & D.A. Julius (Eds), *Psychodynamics of drug dependence: NIDA Research monograph No. 12; DNEW publication No. ADM 77-470* Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office.
- Larsson, P. (2012). How important is an understanding of the client's early attachment experience to the psychodynamic practice of counseling psychology? *Counseling Psychology Review, 27*(1), 10-21.

- Lee, J. & Bell, N. J. (2003). Individual differences in attachment-autonomy configurations: linkages with substance use and youth competencies. *Journal Of Adolescence, 26*(3), 347-361.
- Lundgren, L., Chassler, D., Amodeo, M., D'Ippolito, M. & Sullivan, L. (2012). Barriers to implementation of evidence-based addiction treatment: a national study. *Journal Of Substance Abuse Treatment, 42*(3), 231-238.
- Martin, D. J., Garske, J. P. & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.
- McCrary, B., Epstein, E. & Sell, R (2003). Theoretical bases of family approaches to substance abuse treatment. In Rotgers, F., Morgenstern, J. & Walters, S. (Ed.), *Treating Substance Abuse* (112-139). New York: The Guilford Press.
- Miels, D. (2011). Neurobiology and clinical social work. In Brandell, J. (Ed). *Theory and Practice in Clinical Social Work* (81-98). Thousand Oaks: SAGE Publications.
- Miller, T. and Hendrie, D. (2008). Substance abuse prevention dollars and cents: a cost benefit analysis, DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse

Prevention, Substance Abuse and Mental Health Services Administration. Retrieved June 8, 2013 from: <http://store.samhsa.gov/shin/content/SMA07-4298/SMA07-4298.pdf>

Miller, W. (2000). Rediscovering fire: small interventions, large effects. *Psychology of Addictive Behavior, 14*(1), 6-18. Thousand Oaks: SAGE Publications

National Registry of Evidence-Based Programs and Practices. (2008). Twelve-step facilitation therapy: intervention summary. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved September 15, 2012 from <http://www.nrepp.samhsa.gov>.

Newcomb, D. (1995). Identifying high-risk youth: Prevalence and patterns of adolescent drug abuse. In E. Rahdert & D. Czechowicz (Eds.), *Adolescent Drug Abuse: Clinical Assessment and Therapeutic Interventions* (7 – 38). NIDA Research Monograph Series 156, Rockville.

Padykula, N.L. & Conklin, P. (2010). The self-regulation model of attachment trauma and addiction. *Clinical Social Work Journal, 38*(4): 351-360.

Perrier, C. K., Boucher, R., Etchegary, H., Sadava, S. W. & Molnar, D. S. (2010). The overlapping contributions of attachment orientation and social support in predicting life events distress. *Canadian Journal Of Behavioural Science/Revue Canadienne Des Sciences Du Comportement, 42*(2), 71-79.

Petraitis, J., Flay, B. R., Miller, T. Q., Torpy, E. J. & Greiner, B. (1998). Illicit substance use among adolescents: a matrix of prospective predictors. *Substance Use and Misuse*, 33, 2561 – 2604.

Pistole, M. (1989). Attachment: implications for counselors. *Journal of Counseling and Development*, 68, 190-193.

Project MATCH Research Group. (1998). Therapist effects in three treatments for alcohol problems. *Psychotherapy Research*, 8(4), 455-474.

Reis, S., Curtis, J. & Reid, A. (2012). Attachment styles and alcohol problems in emerging adulthood: a pilot test of an integrative model. *Mental Health And Substance Use*, 5(2), 115-131.

Rubin, E. (2003). Integration of theory, research and practice: a clinician's perspective. In Rotgers, F., Morgenstern, J. & Walters, S. (Ed.), *Treating Substance Abuse (343-363)*. New York: The Guilford Press.

Sawicka, M., Osuchowska, A., Waniek, J., Kosznik, K. & Meder, J. (2009). The phenomenon of dual diagnosis in the light of attachment theory – a case study. *Archives Of Psychiatry And Psychotherapy*, 11(4), 57-64.

- Schindler, A., Thomasius, R., Sack, P., Gemeinhardt, B. & Küstner, U. (2007). Insecure family bases and adolescent drug abuse: a new approach to family patterns of attachment. *Attachment & Human Development*, 9(2), 111-126.
- Schindler, A., Thomasius, R., Sack, P. M., Gemeinhardt, B., Kustner, U. & Eckert, J. (2005). Attachment and substance use disorders- a review of the literature and a study in drug dependent adolescents. *Attachment and Human Development*, 17, 207 – 228.
- Shaffer, H. & Robbins, M. (1991). Manufacturing multiple meanings of addiction: time limited realities. *Contemporary Family Therapy*, 5(13), 387-404.
- Sibley C., Fischer, R. & Liu, J. (2005). Reliability and validity of the revised experiences in close relationships (ECR-R) self-report measure of adult romantic attachment. *Personality and Social Psychology Bulletin*, 31(11), 1524-1536.
- Slade, A. (2000). The development and organization of attachment: implications for psychoanalysis. *Journal Of The American Psychoanalytic Association*, 48(4), 1147-1174.
- Smith, B. W. & Tonigan, J. (2009). Alcoholics anonymous benefit and social attachment. *Alcoholism Treatment Quarterly*, 27(2), 164-173.
- Straussner, S. (2012). Clinical treatment of substance abusers: past, present and future. *Clinical Social Work Journal*, 40(2), 127-133.



Substance Abuse and Mental Health Services Administration, *Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits*. HHS Publication No. (SMA) 13-4760, DAWN Series D-39. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. Retrieved June 8, 2013 from <http://www.samhsa.gov/data/2k13/DAWN2k11ED/DAWN2k11ED.htm#high7>

Substance Abuse and Mental Health Services Administration. (2010). Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10 4856Findings). Rockville, MD. Retrieved June 8, 2013 from <http://www.oas.samhsa.gov/NSDUH/2k9NSDUH/2k9Results.htm#7.1>.

Taleff, M. J. & Swisher, J. D. (1997). The seven core functions of a master's degree level alcohol and other drug counselor. *Journal Of Alcohol And Drug Education*, 42(3), 1-17.

Thorberg, F. & Lyvers, M. (2010). Attachment in relation to affect regulation and interpersonal functioning among substance use disorder in patients. *Addiction Research & Theory*, 18(4), 464-478.

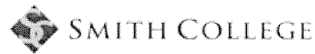
Vaillant, G. E. (1983). *The natural history of alcoholism: causes, patterns and paths to recovery*. Cambridge, MA: Harvard University Press.

Walters, S., Delaney, H. & Rodgers, K. (2001). Addiction and health: a (not so) new heuristic for change. *Journal of Psychology and Christianity*, 20(3), 240-249.

Walters, Rotgers, Saunders, Wilkinson, & Towers, T. (2003) Theoretical perspectives on motivation and addictive behavior. In Rotgers, F., Morgenstern, J. & Walters, S. (Ed.), *Treating Substance Abuse* (279-297). New York: The Guilford Press.

## Appendix A

### Human Subjects Review Committee Approval Letter



School for Social Work  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

February 6, 2013

Emily Tate

Dear Emily,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads "Marsha Kline Pruett PhD".

Marsha Kline Pruett, M.S., Ph.D., M.S.L.  
Vice Chair, Human Subjects Review Committee

CC: Claudia Bepko, Research Advisor

## Appendix B

### Recruitment Email

Hello,

Are you or someone you know interested in participating in a research project for my Master's thesis? I am exploring mental health clinician's use of attachment theory in the treatment of substance use disorders (SUDs). Attachment theory posits that our self-regulation capacities are developed in our early relationships with our caregivers and one of the ways SUDs have been conceptualized is as an attachment disorder.

For this project, I will be conducting 30-45 minute interviews that will take place at a time and location convenient to you. I will be asking questions that may elicit attachment themes in the treatment process, for example: How do you create a therapeutic alliance? How do you use this alliance in treatment? What do you listen for in the client's story/dialogue?

To be eligible to participate you must:

- 1) Have at least six months of experience treating substance use disorders where the SUD was either the primary area of focus or treated dually in conjunction with another mental health disorder
- 2) Have a B.A., B.S. or higher in a mental health related field
- 3) Be currently employed as a mental health clinician and working with clients with SUDs
- 4) Have some knowledge of attachment theory

If you meet the four requirements above and are interested in participating in this research project, please indicate so by placing an "X" on the lines below:

I meet all four requirements  
 I am interested in participating

Please reply to this email or email me back at [REDACTED]. Also, if you know of other mental health clinicians who may be interested in taking part in this project, please forward this email to them. Thank you so much for your consideration of this project and if you have any questions about this project or participating in this project please feel free to contact me by email.

Best,  
Emily Tate  
MSW Student  
Smith College School For Social Work  
[REDACTED]

## Appendix C

### Informed Consent

Dear \_\_\_\_\_,

Thank you for your interest in this study! My name is Emily Tate and I am a graduate student at Smith College School for Social Work and I am conducting research on mental health clinicians' use of attachment theory in the treatment of substance use disorders (SUDs). I am interested in SUD treatment due to the important and growing need to increase the knowledge on treatment practices for this population. This study will be presented as a thesis and may be used in future presentations and publications.

Your participation in this study is voluntary and by signing this form you agree to participate in the study. If you are participating in this study, it means that you have met the four inclusion criteria: 1) You are currently employed as a mental health clinician and are working with clients with SUDs, 2) You have a B.S., B.A. or higher in a mental health related field, 3) You have worked with clients with SUDs for at least 6 months and 4) You have some knowledge of attachment theory. Participation includes partaking in a 30-45 minute interview which will include a brief demographic questionnaire. The interviews will be audio recorded. In the interview I will ask you questions in relation to your use of attachment theory in treatment with clients with SUDs in order to elicit attachment theory themes. You may refuse to answer any of the questions on the demographic questionnaire and/or during the interview.

There is no financial benefit for participating in this study. During the interview you will have the opportunity to share and reflect on your experience in treating clients with SUDs and you may gain new insights or perspectives. The information obtained from this study will hopefully help to provide mental health clinicians' with information on SUD treatment and the implications for the use of attachment theory in treatment.

This study has minimal risks for participation. The interview questions may potentially cause you some distress if the questions remind you of specific clients or challenges in treating this population. Also, it may not be possible to keep confidential the fact that you are participating in this study, for example, depending on the location of the interview, you may be seen participating in an interview with me. I will do everything to minimize this risk. If you are concerned of this risk, you may choose not to participate in this study.

Data collected in this study, including your identifying information, is confidential. You will be assigned a code number and your name will not be attached to the demographic data questionnaire or the interview transcription. Once the audio recordings are uploaded onto my computer, they will be password protected and then be deleted from the digital recorder. When the recordings are transcribed, any identifying information will be removed. The informed consent forms will be stored in a secure location that is separate from the other study materials. In any publications or presentations, demographic data and quotations will be disguised so as to protect your confidentiality. In order to protect client confidentiality, I will not seek out specific client information and I ask that you not reveal identifying client information. The data collected

in this study, included the digital recordings uploaded onto the computer, will be stored in a secure and password protected location for three years as required by Federal Guidelines. After that time the data will be destroyed if it is no longer needed for research purposes. If the data is still needed for research, it will continue to remain secure until it is no longer needed and then it will be destroyed.

You may withdraw from the study at any point during the interview and/or choose not to answer any of the questions. You also may also choose to withdraw up to two weeks after the interview is completed. After this point, the data will be in the process of being analyzed and it will not be possible to remove it from the project. If you choose to withdraw, any data related to your participation will be destroyed.

If you have questions or concerns regarding your rights, you may contact me by phone at [REDACTED] or by email at [REDACTED]. You may also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Thank you for your interest in this study.

Best,  
Emily Tate  
MSW Student  
Smith College School for Social Work

**YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

**Investigator's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Participant's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Appendix D

### Interview Questions Preview

All of these questions will pertain to treatment with your clients with substance use disorders (SUDs). While it may be impossible to completely isolate your responses to only your experiences of treating clients with SUDs as there may be an overlap in treatment style with other populations, please try to keep in mind that this study is specific in regards to eliciting information regarding clients with SUDs. When answering, try to imagine working with a client with a SUD. It may be helpful to think about specific clients or it may be helpful to think about treatment in general. This is your choice.

1. Attachment theory posits that our self-regulation capacities and relationship patterns are developed in our early relationships with our caregivers. If there are disruptions in this relationship, self-regulation capacities and relationship patterns in adulthood will be affected. Are you familiar with attachment theory?
2. What is your understanding of attachment theory? Do you consider attachment style in the treatment process? If yes, how is it used? If no, what are your reasons for this and do you consider other theories?
3. How do you understand SUDs? How is this information used in treatment?
4. Can you describe your general treatment process/style in treating clients with SUDs?
5. How do you choose your clinical interventions?
6. What is your view on an abstinence-based treatment approach?
7. What do you see as one of the general goals of treatment for SUDs aside from refraining from substance use? How do you work towards this goal? How can you tell when a client has made progress?
8. What narratives from the client do you listen for? How is this used to understand the client? How do you incorporate this information into treatment?
9. If a client has a disruption in the attachment system, how is this information used in treatment?
10. How do you define or describe the therapeutic alliance?
11. How do you develop the therapeutic alliance with a client with a SUD?
12. How do you use the therapeutic alliance in treatment? What purpose does it serve?
13. What considerations inform the pace of treatment? How do you know when a client is ready to do the work?
14. Is there anything that you would like to tell me that you feel was left out of this interview?

## Appendix E

### Demographic Questionnaire

1. Gender:

Male \_\_\_\_  
Female \_\_\_\_  
Transgender \_\_\_\_  
Other (please indicate) \_\_\_\_

2. Race/Ethnicity: (please check all that apply)

White \_\_\_\_  
Black or African-American \_\_\_\_  
Hispanic or Latino \_\_\_\_  
Asian \_\_\_\_  
Native American or Alaskan Native \_\_\_\_  
Native Hawaiian and Other Pacific Islander \_\_\_\_

3. Number of years practicing in the mental health field:

Less than 5 years \_\_\_\_  
5-10 years \_\_\_\_  
11-15 years \_\_\_\_  
Over 15 years \_\_\_\_

4. Out of the number of years you have been practicing, how would you classify by percentage the amount of time spent working with client's with SUDs:

Less than 10% of the time \_\_\_\_  
10-25% of the time \_\_\_\_  
25-50% of the time \_\_\_\_  
50-75% of the time \_\_\_\_  
More than 75% of the time \_\_\_\_

5. What is the highest degree you currently hold?

B.A. or B.S. \_\_\_\_  
Graduate degree \_\_\_\_  
Ph. D. or M.D. \_\_\_\_

6. What field is your degree in?



Mental Health Counseling \_\_\_\_  
Social Work \_\_\_\_  
Psychology \_\_\_\_  
Psychiatry \_\_\_\_  
Other \_\_\_\_\_

7. What is the setting you currently practice in?

Hospital \_\_\_\_  
Community Mental Health \_\_\_\_  
Private Practice \_\_\_\_  
Specialized Addiction Treatment \_\_\_\_  
Other \_\_\_\_\_

8. Are you a licensed drug and alcohol counselor?

Yes \_\_\_\_  
No \_\_\_\_