The Impact of Attachment to Substance in Substance Dependent Individuals’ Psychotherapy Relationships: An Exploratory Mixed-Methods Study

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Doctor of Psychology (Clinical)

This thesis is presented in partial fulfilment of the requirements for the degree of Doctor of Psychology (Clinical), Murdoch University, 2017.
I declare that this thesis is my own account of my research and contains its main content work which has not previously been submitted for a degree at any tertiary educational institution.

Shawn Ee
For my two little bugs, Siena and Seth.

No matter how far you wander and weary you face,
May you always feel like you can return to my embrace.
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Abstract

To date, there are no comprehensive studies that have examined the concept of *attachment to substance* in a substance dependent population, and how it relates to one’s attachment relationships with others. Specifically, it is unknown how an individual’s attachment to substance may influence the therapeutic relationship with their own therapist. The current research adopted a mixed-methods approach toward exploring these under-researched areas by way of collecting psychometric data with a sample of 450 substance dependent adults undergoing treatment in an anonymous survey study, and 10 individuals from that sample were interviewed in a follow-up study. Results showed that Insecure Attachment to Substance significantly influenced the relationship between one’s Attachment-Anxiety and Preoccupied-Merger attachment to therapist, providing support for the expected mediation effects. While no effect was found between Attachment-Avoidance and any style of attachment to therapist, Attachment-Avoidance was a significant predictor of Avoidant-Fearful attachment to therapist, and a significant negative predictor of Secure attachment to therapist. Men were found to have stronger associations between Attachment-Anxiety and Avoidant-Fearful attachment to therapist, when compared to women. In Study 2, all the clients interviewed experienced a *Relational Dilemma*, summarising their intra and inter-personal difficulties characterised by their ambivalence and insecurity, in dealing with others; and patterns of substance use. Relationally, these individuals described significant struggles leading to approach and avoidance behaviours, as a function of their personal insecurities, and these difficulties were described to manifest with their therapists. Overall, the findings supported the proposed model of *Attachment to Substance*, and the view that chronic and dependent substance use is an inadequate and often futile attempt to compensate for the failure to receive adequate love and care from relationships with others. Clinical implications were discussed.
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CHAPTER 1

General Introduction

Treating addiction or substance dependence is a challenging and often daunting task, which includes macro level, socio-political ramifications accompanied by a host of primary and secondary costs of substance abuse that can impact planning and treatment service provision (D. J. Collins & Lapsley, 2008). A 2008/09 report on alcohol and other drug treatment services in Australia (H. P. Collins & Allbon, 2010) recorded 143,000 treatment episodes provided during the year. Of these, the proportion of clients treated for alcohol-related episodes as compared to other drugs, had risen four years in a row and cannabis, opioids, and amphetamines followed close behind. Nevertheless, alcohol remained the principal substance of concern with an 8% increase from the previous report in 2002/03. According to the International Narcotics Control Board (INCB), “in developed countries…the prevalence of anxiety and insomnia and the consumption of sedative hypnotics are growing”, and “notes with concern the frequent long-term use [beyond one year and sometimes indefinitely] of psychotropic substances for treating psychological reactions to social pressure without a diagnosis for a specific disorder” (INCB, 2000, p. 3). Increased abuse of pharmaceutical preparations for non-medical purposes (mainly over-the-counter and prescription analgesics containing narcotic drugs) is another notable trend: in Australia, the annual prevalence rate of abuse of such preparations among persons aged 14 years and older increased considerably, from 3.7% in 2007 to 4.2% in 2010, the second highest rate since 1995 (INCB, 2011).

In the 2007 National Survey of Mental Health and Wellbeing, the prevalence of substance use disorders in the Australian population was recorded as one in twenty Australians aged 16 - 85 years (5.1%) who had a substance use disorder in the 12 months
prior to the study (T. Slade, et al., 2009). Crucial to these figures is the impact of substance use disorders: The average number of days out of role for those with any form of substance use disorder was 3.3 days, and any drug dependence was associated with the largest number of days out of role at 6.4 days; and one in five people with alcohol dependence and with any drug dependence (21.0% and 20.6% respectively) reported significant interference in at least one of the life domains of home responsibilities, work or study, close relationships and social life (T. Slade, et al., 2009). When taking into consideration levels of psychological distress, over half (57.2%) of people with any drug dependence and one quarter (27.4%) with any drug harmful use reported high to very high levels of psychological distress (T. Slade, et al., 2009). Whereas among people with alcohol dependence, one in three (38.7%) experienced high or very high psychological distress compared to one in six (15.3%) with harmful alcohol use; and they tended to be high users of mental health services (T. Slade, et al., 2009).

According to the Global Burden of Disease Study 2015, it was found that mental and substance use disorders were leading contributors to disease burden in Australia (Ciobanu, et al., 2018). To get a sense of the associated burden of harm, mental and substance use disorders were reported to be the leading cause of non-fatal burden in Australia in 2015, explaining 24.3% of total years lived with disability, and were the second leading cause of total burden, accounting for 14.6% of total disability-adjusted life years (Ciobanu, et al., 2018). Despite several decades of national reform, the burden of mental and substance use disorders remained largely unchanged between 1990 and 2015, as epidemiological data suggests (Ciobanu, et al., 2018). To reduce this burden, effective population-level preventions strategies are required in addition to effective interventions of sufficient duration and coverage. These reported figures need to be reduced and the development of ways of understanding the complex nature of substance use and
It is recognised that there is a need to have a comprehensive meta-theory of addiction that not only integrates varied mental health models with the disease concept, but also provides guidelines for clinical practice that are compatible with existing treatment strategies (Flores, 2004). Attachment Theory (Bowlby, 1979) is viewed as a developmental framework and alternative model to the status quo in making sense of substance dependence. The theory defines the issue of addiction as both a “consequence of and solution to an individual’s incapacity to establish healthy emotional regulatory relationships” (Flores, 2004, p. 246). A review of the literature consistently highlights the association between problems in the early years of life and the development of substance use: difficulties in early attachment experiences appear to be a central component in the development of later addiction (Adams & Robinson, 2001; Firestone, 1993; Sachs, 2003). According to M. F. Schwartz and Southern (1999), early attachment difficulty with caregivers leads to overwhelming experiences for the child, and that the child is unable to adjust, thereby causing affect dysregulation and impaired self-development.

With its rich legacy and solid foundation in psychodynamic theory, attachment offers a valued theoretical perspective that assists the legitimisation of the recommendations of the abstinence-based treatment approach. Accepting attachment theory as a credible alternative explanation for the aetiology and treatment of substance dependence allows for the recognition of additional contributions from other related
perspectives, for example, the Theory of Object Relations (Bion, 1962; Klein, 1928). Besides theoretical differences, Bowlby (1988) himself insisted that attachment theory was no more than a scientifically based variant of object relations theory. Having evolved from a purely intrapsychic psychology to a relational model, the patient’s psychology is intimately connected to context, which is the psychology of the therapist, and client-therapist interaction (Flores, 2004). Thus, therapeutic or social relationships would be seen as being shaped by the projections, assumptions, hopes, wishes, and fears of all its participants (Greenson, 1967). By incorporating an exploration into the interpersonal or relational difficulties that contribute to a person’s current situation, a segue is formed, opening more innovative ways for understanding addiction and the difficulties a substance dependent individual brings to treatment.

As an overview, Chapter 2 will consist of a literature review of Substance Dependence and Attachment, followed by a conceptualisation of substance dependence as a disorder of attachment. Chapter 3 will cover the general overview of the current research, including our proposed model, and research aims. Chapters 4 and 5 contain Study 1 (A Survey of Clients’ Attachment), and Study 2 (A Client Interview Study) respectively. This is concluded by the general discussion in Chapter 6, which summarises the major findings, clinical implications, and future directions.
CHAPTER 2

Literature Review

2.1 Defining Substance Dependence

The current version of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) defines a Substance Use Disorder as:

“A cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. … Persisting beyond detoxification, particularly in individuals with severe disorders, is the exhibition of repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli.”

“Overall, the diagnosis … is based on a pathological pattern of behaviours related to use of the substance. These include overall criteria groupings of: *impaired control, social impairment, risky use, and pharmacological criteria.*” (p. 483).

In contrast to the previous edition of the DSM, Substance Use Disorder in DSM-5 combines the DSM-IV-TR (4th ed., text rev.; APA, 2000) categories of substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe. Each specific substance is addressed as a separate use disorder, but nearly all substances are diagnosed based on the same overarching criteria highlighted above. In DSM-IV-TR, the distinction between abuse and dependence was based on the concept of abuse as a mild or early phase, and dependence as the more severe manifestation.
Although the revised Substance Use Disorder constitutes a single diagnosis, the major differentiation that will determine whether something is defined as abuse or dependence is when there is an absence of dependence to the substance as well as the pronounced desire for use of the substance, and this desire overrides concerns with consequences to the individual and others (Dziegielewski, 2010).

As the current research is unconcerned by the diagnostic differences between the specifiers for physical or psychological dependence, and the DSM criteria (Potenza, 2006), the terms addiction and substance dependence will be used interchangeably to refer to an excessive, long-term use of substances that may constitute a diagnosis of Substance Use Disorder.

2.2 Past and Contemporary Models of Addiction

For better or worse, many individuals have become increasingly reliant on addictive substances to assist with managing the fears and difficulties evoked with interpersonal relationships (Flores, 2004). Unfortunately, there are those who use these substances in ways that cause prolonged harm or dreadful consequences. According to Khantzian (2004), addiction is a disorder in self-regulation and individuals who become dependent on addictive substances cannot regulate their emotions, self-care, self-esteem, and relationships. Due to “intrapsychic deficiencies related to genetic and biological substrates”, certain individuals are “more vulnerable to developing disabling dependencies and addictions to substances that many of us either learn how to use less destructively or stop using before the consequences of our use become too damaging” (Flores, 2004, p. 1). Fuelling a predisposition toward characterological issues, these individuals are potentially highly disturbed, susceptible to repetitive traumatisation, and self-destructive ways of coping with their troubles (van der Kolk, 1989). It does not take long for a therapist to get
a sense of the common narratives inherent in the subtext of these clients’ lives by observing them in individual or group psychotherapy treatment settings, which includes substance dependence issues (van der Kolk, 1989).

In the course of developing a fuller understanding of addiction through the years, researchers and clinicians saw a shift from studying specific drug use and its effects to overarching views of dependence (Flores, 2004; U.S. Department of Health and Human Services, 1980; U.S. Department of Health Education and Welfare, 1977). Despite being often considered separately in theory and research, substance dependence includes both dependence on alcohol and other drugs (Flores, 2004). Following the historical trend in psychology, the earliest psychological formulations of the cases of substance dependence were psychoanalytic in origin (Fenichel, 1945; Rado, 1926, 1933), followed by the medical model, which viewed the condition as a disease (Jellinek, 1960), and subsequently the introduction of social learning and cognitive-behavioural analyses models (Beck, Wright, Newman, & Liese, 1993; Marlatt & Gordon, 1985). The emphasis went from intrapsychic drives and conflicts to factors such as the observational learning of substance use and the effect of cognitive variables, for instance, the individual’s expectancies and attributions. Nonetheless, factors considered to contribute to the development of substance dependence generally include: genetic predisposition, the physiological makeup of the individual, the dispositional characteristics of the individual, developmental history, family background and parenting, the past and present social and physical environment of the individual, and the wider sociocultural context in which the person dwells or has dwelled (Marlatt, Baer, Donovan, & Kivlahan, 1988).

Given that there is a broad array of distinct and varied models of addiction that arose to describe the underlying mechanisms for substance dependence (for a comprehensive review, see R. West & Brown, 2013), it is beyond the scope of the current
research to detail its breadth and range. Instead, the focus of the current review will be on attachment-based models and how these might fit in the broader scheme of medical and psychological perspectives.

2.3 Disease-Concept Approach

Clinical conceptualisation in this field has become increasingly complex and fraught with controversy within the last 30 years. Amongst a plethora of factors that contribute to this complexity, of note is the application of the disease-concept treatment approach in the 1970s. According to this concept, “addiction to chemicals, whether it be to alcohol or drugs, was no longer viewed as a symptom of a more serious core issue. Rather, it was seen as a primary condition that must first be arrested if any progress in treatment is to be achieved” (Flores, 2004, p. 15). A central tenet of the Alcoholics Anonymous (AA), this meant that abstinence from all substances must be the first goal of recovery, and a principle recommended for integration into a psychotherapy format (Kemker, Kibel, & Mahler, 1993; Matano & Yalom, 1991). Unbeknownst to therapists who were in the midst of this integration, a course was steered toward a double-edged consequence: it legitimised the treatment of addiction and birthed a philosophy of treatment completely independent from traditional approaches toward psychological difficulties. Where intrapsychic conflicts and intrapersonal dynamics were usually viewed as the cause of addiction (U.S. Department of Health Education and Welfare, 1977), the subsequent acceptance of the disease concept led to a significant change in the understanding of addiction and its treatment: depression, anxiety, and character pathology are viewed as symptoms and not the cause of addiction (Flores, 2004).

2.4 Learning Theory Model
Notwithstanding, many have rejected the disease concept as simplistic, and have questioned the AA’s basic assumptions. There were those who challenged that the reasons why an individual initially uses drugs are primarily psychological and sociological, rather than pharmacological (Peele, 1989; Ray, 1983). Vast amounts of contradictory evidence contest the basic assumptions and beliefs of the disease-concept-oriented treatment modalities. From a learning theory perspective, many of these researchers (Kishline, 1994; Marlatt, Larimer, Baer, & Quigley, 1993; Sobell & Sobell, 1973) have recommended controlled drinking and Moderation Management as alternatives to abstinence, presenting evidence that alcoholics can learn how to drink non-alcoholically. On the other hand, there is evidence suggesting that prolonged periods of substance use can produce physiological and neurobiological alterations in the brain, which not only fuels the addictive process (Heyman, 1995), but more recently was shown to leave certain vulnerable individuals unable to use substances non-addictively (Leshner, 2001).

2.5 Addiction: A cause and result of mental illness

Many individuals experience periods of alcohol and drug experimentation where they misuse, abuse, or excessively use substances. However, not everyone becomes dependent. According to Flores (2001) and Khantzian (2001), certain persons, because of intrapsychic or developmental deficiencies often closely related to their genetic and biological underpinnings, either are more vulnerable to developing a substance abuse disorder or are at greater risk of exacerbating pre-existing co-occurring conditions if substances are used excessively. Predictably, this subset of substance users typically present for treatment suffering from co-occurring conditions that if gone unrecognised, and consequently untreated, would severely diminish their chances of successful treatment. It is thus essential that the therapist be prepared to assess and effectively identify any accompanying conditions while working with this population, since all Axis I and II
conditions are overly represented here (W. R. Miller & Brown, 1997). A report published by the Centre for Substance Abuse Treatment (1994), extensively reviewed the primary relationships between substance abuse and psychiatric symptoms, and concluded that “there is no single combination of dual disorders; in fact, there is great variability among them…Patients with mental disorders have an increased risk for substance abuse disorders, and patients with substance abuse disorders have an increased risk for mental disorders” (p. 4). While symptom comorbidity is a well-established phenomenon, it is not unusual for individuals who are dually diagnosed to receive inadequate treatment for either addiction or mental health related issues based on their primary diagnoses. Flores (2004) listed some difficulties in the early stages of treatment such as receiving specialised treatment between different settings often with little coordination, and based on therapies which were not always complementary.

The result is an inadvertent split between approaching addiction and mental health treatment, based on fundamental differences in aetiology and a somewhat disparate and rigid treatment sphere. Without being over reductionist, this flux is ironically reflected in not only the confused state of mind in the substance dependent patient but also the potentially ungrounded help. Today, as it had been so aptly described back then (Rotgers, Keller, & Morgenstern, 1996), the substance dependence treatment field is still in transition, driven largely by a paradox. That which stems from two observations clinicians and researchers make routinely: the traditional substance abuse treatments worked for many clients, yet for many other clients, traditional treatments appear to have little, if any, long-term benefit (Flores, 2004). Clearly, there are many factors to be considered in the treatment process but perhaps more research is needed beyond the formulaic that takes us back to reassessing current addictions psychotherapy practices.
This next chapter will embark upon introducing and reviewing attachment theory and its developments, followed by formulating the substance dependence process within the attachment framework.

2.6 Attachment Theory

Attachment is defined as an affectional bond to another person and healthy human beings continue to rely on attachment relationships in times of danger, vulnerability or illness (Bowlby, 1988). Attachment theory puts the search for security above all other psychological motivators, and posits the attachment bond as the starting point for survival, a precondition for all meaningful human interactions. According to Bowlby (1982), human infants are born with a repertoire of behaviours (attachment behaviours) designed by evolution to ensure proximity to supportive others (attachment figures), who are likely to provide protection from physical and psychological threats, promote safe and healthy exploration of the environment, and help the infant learn to regulate emotions effectively.

In defining attachment relationships, what differentiates these attachment relationships from other close relationships is the extent that a relationship partner accomplishes three important functions (e.g., Ainsworth, 1991; Hazan & Shaver, 1994; Hazan & Zeifman, 1994). First, the attachment figure should be viewed as a target to maintain proximity in times of distress, and unwanted separation from this person should elicit distress, protest, and efforts to achieve reunion. Second, the use of the attachment figure as a “secure base” from which to pursue non-attachment-related goals in a safe environment and to sustain exploration, risk taking, and self-expansion. Third, the attachment figure should be viewed as a real or potential “safe haven”, because he or she provides comfort, support, protection, and security in times of need. In other words, interactions with attachment figures are dissimilar to other forms of social interaction.
This system is assumed to govern the choice, activation, and termination of proximity-seeking behaviours aimed at attaining protection and support from significant others in times of need (Obegi & Berant, 2008). This protection and support is valued because it allows a person to restore emotional balance and return to effective behaviour in the wider social and physical environment (Mikulincer & Shaver, 2016).

During infancy, primary caregivers (usually one or both parents, but also surrogates, grandparents, and older siblings) are likely to occupy the role of attachment figure. Ainsworth (1973) reported that infants tend to seek proximity to their primary caregiver when tired, ill or distressed, and Heinicke and Westheimer (1966) found that infants tend to be soothed in the presence of their primary caregivers. These proximity seeking behaviours are organised by an adaptive behavioural system (the attachment behavioural system), which emerged over time because it increased the likelihood of survival and reproduction in a species whose offspring are born with very immature abilities to acquire food, move about their environment, or defend themselves (Bowlby, 1969, 1982). In addition, the attachment system is organised and regulated based on caregiver responsiveness and sensitivity to distress signals, and the infant learns what to expect and modifies their behaviour accordingly (Hazan & Shaver, 1994; Levy & Blatt, 1999). In contrast, experiences of distress may become associated with negative outcome if the parent is rejecting or inconsistently available. These expectations form the basis of “internal working models” (IWMs) of self and others (Bowlby, 1988).

2.7 Adult Attachment

Most of the research examining individual difference in attachment-system functioning in adults has focused on ‘attachment styles’. These are defined as patterns of expectations, needs, emotions, and social behaviour that result from a particular history of
attachment experiences, usually beginning in relationships with parents (Mikulincer & Shaver, 2016). These styles reflect a person’s most chronically accessible IWMs, and reflects the underlying organising action of a particular attachment strategy (i.e., primary or secondary, hyperactivating or detactivating). Beginning with the three infant attachment styles defined identified by Ainsworth et al. (1978), namely Secure, Avoidant, or Anxious; the development of self-report measures derived two dimensions of insecurity, attachment-related avoidance, and attachment-related anxiety (Mikulincer & Shaver, 2016).

Attachment-related avoidance is concerned with discomfort with closeness and discomfort with depending on relationship partners, preference for emotional distance and self-reliance, and using deactivating strategies to deal with insecurity and distress (Mikulincer & Shaver, 2016). In contrast, attachment-related anxiety is concerned with a strong desire for closeness and protection, intense worries about partner availability and one’s own value to the partner, and use of hyperactivating strategies to deal with insecurity and distress (Mikulincer & Shaver, 2016).

A multitude of studies have shown substantial evidence for the continuity of attachment styles from infancy throughout the school years, and into adolescence (e.g., N. L. Collins & Read, 1990; Florian & Mikulincer, 1997; Fraley & Shaver, 1998; Main, Kaplan, & Cassidy, 1985; Sroufe, Fox, & Pancake, 1983; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000; Waters, Weinfield, & Hamilton, 2000). These studies, in part, provide the impetus for subsequent theoretical development and research to conceptualise and study attachment in adulthood.

More recently, Fraley (2002), Fraley (2007) and Fraley, Vicary, Brumbaugh, and Roisman (2011) found that patterns of attachment stability are best accounted for by a prototype model – a model assuming that there is a stable factor underlying temporary variations in attachment. This view assumes that working models are updated and changed
as individuals encounter new events, but suggests that the representations developed in infancy remain unchanged and continue to shape interpersonal dynamics throughout the life span (Owens, et al., 1995; Sroufe, Egeland, & Kreutzer, 1990). This implies that early representations are preserved over the course of development and reactivated in the context of new interactions. As such, these prototypes can contribute to a constant source of variability to attachment dynamics over the lifespan, increasing the likelihood that attachment patterns in adulthood will reflect those observed in childhood. The implication of these findings provides strong support that an individual’s attachment can change over time but the internal working model established in childhood still influences the attachment in adulthood.

Several other studies (e.g., Green & Campbell, 2000; Mikulincer, Hirschberger, Nachmias, & Gillath, 2001; Mikulincer & Shaver, 2001; Mikulincer, Shaver, Gillath, & Nitzberg, 2005) have shown that a variety of experimental techniques designed to activate mental representations of attachment figures (e.g., visualisation of the faces of attachment figures) infuse a person with positive affect; reduce hostility to out-group members; facilitate empathy, compassion, and altruistic helping; and sustain relaxed and creative forms of exploration. In terms of clinically useful findings, they also reduce the harshness of hurt feelings among anxious individuals and open more avoidant individuals to such feelings that were suppressed (P. Shaver, Mikulincer, Lavy, & Cassidy, 2009).

2.8 Substance Dependence as an Attachment Disorder

There has been a growing interest in the relationship between attachment and psychopathology in the last decade (Flores, 2001, 2004; Mikulincer & Shaver, 2016). However, there is little research demonstrating empirically the links between adult attachment and substance dependence. Schindler and Bröning (2015) reviewed the
empirical evidence on attachment and adolescent substance use and found only 10 studies on adolescent substance use disorders and another 13 studies on adult substance use disorders. An unpublished study (Carse, 1998) proposed a model of substance dependence which viewed substance-dependent individuals as having severe disturbance of attachment organisation, and secondary to this, impairment of mood and of functioning in close interpersonal relationships. Of significance, it was also proposed that the substance provides attachment-related security and comfort for such individuals (Carse, 1998). 60 substance-dependent individuals in six residential rehabilitation centres in Australia were interviewed about their experience of substance use and compared with 32 non-substance-dependent participants on substance use, attachment, mood and the experience of close relationship. Interestingly, it was found that all components of the proposed model of substance dependence were supported: a sizeable proportion of the substance-dependent individuals had a conscious relationship with the substance indicative of an attachment relationship; or sought and received from the substance the kind of security and other benefits usually associated with attachment relationships (Carse, 1998). Likewise, despite the comprehensive and ground-breaking conceptualisation of Carse’s (1998) research and Flores’ view of addiction as an attachment disorder, there is still a paucity of empirical evidence in support of this model and its associated theories.

A growing body of research has established that traumatic early-childhood experiences and insecure attachments are both independent and interrelated risk factors for developing substance abuse disorders (Fletcher, Nutton, & Brend, 2015). Research that considered the history of individuals affected by substance dependence, highlights deprivation of developmental needs, early trauma, neglect, lack of physical and emotional closeness and problems in the family system (Bell, Montoya, & Atkinson, 1997; DaVania, 2006; De Rick & Vanheule, 2007; Firestone, 1993; Gaiton, 2004; Gold, 1999; Golden &
Stermac, 2000; Grosenick & Hatmaker, 2000; Sicher, 1998; Walant, 1997; Woollcott, 1981). Chafetz (1959) found that substance dependent individuals grew up with a lack of a warm, giving, meaningful relationship with a mother figure during early years of development and experienced significant amounts of rejection (Andersson & Eisemann, 2003; Hofler & Kooyman, 1996). In addition, insecure attachment to parents or peers is associated with higher levels of alcohol consumption, cigarette smoking, and drug abuse in community samples of adolescents and young adults (Andres, Castanier, & Le Scanff, 2014; Bailey & Hubbard, 1990; Danielsson, Rolemsjö, & Tengström, 2011; DeFronzo & Pawlak, 1993; Foshee & Bauman, 1994; Lee & Bell, 2003; Massey, Compton, & Kaslow, 2014; Reis, Curtis, & Reid, 2012; van der Vorst, Engels, Meeus, & Dekovic, 2006; Walsh, 1992). This finding has been replicated in a nationally representative U.S. sample (L. A. Crawford & Novak, 2008), samples of juvenile delinquents (Elgar, Knight, Worrall, & Sherman, 2003), and prospective studies of adolescents and young adults (Branstetter, Furman, & Cottrell, 2009; Burge, et al., 1997; Cavendish, Nielsen, & Montague, 2012; Labrie & Sessoms, 2012; Tyler, Stone, & Bersani, 2006; Zhai, Kirisci, Tarter, & Ridenour, 2014). Specifically, insecure attachment in relationships with parents and peers predicted heightened substance use one to three years later (Mikulincer & Shaver, 2016). It is clear that disrupted emotional bonding and inconsistent parental responsiveness does not allow for provision of a secure base, which leaves these individuals vulnerable to seeking comfort and security through substance use, as opposed to seeking unreliable others. For these individuals who had experienced little sense of comfort or security, the effects of drugs or alcohol may be far more gratifying than any attachment experiences they may have had. However, many of these studies made conclusions based on retrospective data, instead of ascertaining the attachment experiences directly from their participants.
Not only does the literature demonstrate that insecurely attached children are at a
greater risk to developing emotional and behavioural problems (Cicchetti, Toth, & Lynch,
1995; Sroufe, 1986), adults who experience intimate social bonds tend to be happier and
healthier compared to those who lack such attachments (e.g., DeLongis, Folkman, &
Lazarus, 1988; Leary, 1990). A child or adult who feels threatened and inadequately
protected or supported has a difficult time directing attention to free play, curious
investigation of objects and environments, and affiliative relationships with peers (Obegi
& Berant, 2008). Prolonged periods of this sort of interference disrupt the development of
self-efficacy, self-esteem, and positive, trusting social attitudes (Powell, Cooper, Hoffman,
& Marvin, 2013). Attachment research over the years have suggested an association
between insecure adult attachment and psychological distress, which include low self-
esteeem (N. L. Collins & Read, 1990; Gamble & Roberts, 2005; Griffin & Bartholomew,
1994; Roberts, Gotlib, & Kassel, 1996), negative emotional traits (Magai, Distel, & Liker,
1995), eating disorders (Cole-Detke & Kobak, 1996), depressive symptomatology (Kobak,
Sudler, & Gamble, 1991; Roberts, et al., 1996), and anxiety (Warren, Huston, Egeland, &
Sroufe, 1997). More recently, many researchers have also reported on the relationship
between different adult attachment types and psychopathology (Blatt & Levy, 2003; T. N.
Crawford, et al., 2006; D. Martin, Gillath, Deboeck, Lang, & Kerr, 2017; McGuire,
Gillath, Jackson, & Ingram, 2018; Shorey & Snyder, 2006). For example, individuals
assessed with “fearful” avoidant attachment tend toward avoidant and schizoid personality
disorders and an introjective/ self-critical type of depression (Blatt & Levy, 2003; Levy &
Blatt, 1999). See also Gillath, Karantzas, and Fraley (2016; ch. 11) for a review.

Research on adult attachment showed that individuals with a secure attachment
style tend to seek social support to cope with emotional stress whereas individuals with an
insecure attachment style tend to seek other means such as use of alcohol or drugs as a
coping mechanism for emotional self-regulation (Flores, 2004; Thorberg & Lyvers, 2006). Research has consistently reported that substance dependent individuals often display insecure patterns of attachment (Ball & Legow, 1996; Berman, Kallmen, Barredal, & Lindqvist, 2008; Doumas, Blasey, & Mitchell, 2006; Fletcher, et al., 2015; Flores, 2004; Frank, 2001; Kohn, 2004; Lander, Howsare, & Byrne, 2013; Lapidus, 2005; Markus, 2003; McNally, Palfai, Levine, & Moore, 2003; Molnar, 2004; Mottola, 1984; Schindler & Bröning, 2015; Schindler, et al., 2005; Short, 2001; Sicher, 1998; Stapleton, 2004; Thorberg & Lyvers, 2006; Wedekind, et al., 2013; Zapf, 2007) and these individuals tend to experience higher levels of anxiety and have greater difficulty regulating their emotions than those with secure attachment (Doumas, et al., 2006; Flores, 2004; Schindler & Bröning, 2015; Schindler, et al., 2005). Research has also revealed some of the motives associated with insecure individual’s proneness to substance abuse. In studies assessing motives for drinking, anxiously attached individuals reported using alcohol to cope with anxiety, tension, and distress (Brennan & Shaver, 1995; Magai, 1999; McNally, et al., 2003; Molnar, Sadava, De Courville, & Perrier, 2010). Avoidant individuals, on the other hand, were more likely to say they drink to avoid emotional dependence (Brennan & Shaver, 1995), or to enhance positive mood or self-esteem (Magai, 1999; Molnar, et al., 2010). There has also been evidence concerning the role of attachment strategies in mediating the association between insecure attachment and deviant behaviour – anxiously attached individual’s deviant behaviour was mainly explained by intensified feelings of depression and hostility, whereas avoidantly attached individual’s deviant behaviour was better explained by deactivating strategies (defined below) that inhibited involvement in close relationships (Cooper, Shaver, & Collins, 1998).

According to Newell (2005), less attachment anxiety was found among substance-dependent individuals who had consistent and warm caregiving from their father whereas
those who perceived their mother as being intrusive showed high anxiety and avoidance. Consistent with insecurely attached children who are more likely to sacrifice exploration for the sake of security (Flores, 2004), substance dependent individuals are more likely to perceive treatment as unhelpful and opt to leave instead of trying to make sense of their internal process and building capacity for self-awareness (Berman, et al., 2008).

Further research examining specific attachment organisations found that fearful and preoccupied attachment styles were overrepresented in a drug and alcohol sample (Doumas, et al., 2006): fearful and preoccupied clients in the study reported more interpersonal problems, and higher levels of anxiety and depression than clients with a secure or dismissing style. Furthermore, these findings were consistent with McNally, et al. (2003) who found that clients with a negative view of self have more difficulty regulating affect in relationships and tend to use substances as a coping strategy. Other studies have reported higher prevalence of avoidant attachment among chemically dependent individuals (Frank, 2001; Gardner, 1995; Schindler & Bröning, 2015). While preoccupied, avoidant and fearful attachment styles were found to be prevalent among substance dependent individuals, fearful attachment has been consistently identified in all studies exploring their attachment styles. This supports the view that substance dependent individuals’ negative working model of self and others influences their ability to derive satisfaction from interpersonal relationships, and thus more likely to turn to external objects (defined below) for comfort.

The following section discusses the possible alternative sources of security when individuals’ supportive others fail to provide.

2.9 Attachment Objects
Originally derived from Freud’s drive theory, the term “object” continues to be used frequently, universally and flexibly throughout psychoanalytic literature that over time, the meaning of object has lost its specificity (Greenberg & Mitchell, 1983). From an attachment perspective, the emphasis is to understand the complex transformation of external objects to internalised object representation, in this case, the formation of internal working models (IWMs) of self and others. An attachment object may take the form of a person, but may just as well have a wide range of boundless and malleable attributes, describing something physical and concrete, but may also be something intangible.

Aligned with the Winnicottian concept of the transitional object as the first treasured possession (Stevenson, 1954; Winnicott, 1953), it is generally agreed that the infant’s first object is most likely its mother but may be supplemented by attachments to a handful of other specific persons (Ainsworth, 1969). Defined as “a symbol of the mother that is intermediate between internal and external reality for the infant” (Passman, 1987, p. 825), the use of transitional objects is considered normal and beneficial to healthy development (e.g., Busch, 1974; Litt, 1981; Newson, Newson, & Mahalski, 1982). Rudhe and Ekecrantz (1974) described this as an enduring “emotional dependence on a special object, which has a soothing and/or comforting effect primarily at bedtime and times of anxiety, illness, etc.” (p. 382), and some researchers have concluded that the absence of such attachments may predict later psychopathology (Horton, Louy, & Coppolillo, 1974; Lobel, 1981). Given attachment theory’s emphasis on a relational model, it posits that close interpersonal relationships provide people with psychological security across the lifespan. Over the course of development, people broaden their source of security from their parents to a network of close others, including friends and romantic partners (Mikulincer & Shaver, 2016). However, there are those who have experienced painful, rejecting, and shaming relationships, which form the origins of their self-regulating deficits.
Attachment to Substance (Flores, 2004). It is conceivable that such individuals, in turn, have tremendous difficulty seeking others to obtain what they need or have never received.

Substance dependence from this perspective is hypothesised as the result of unmet developmental needs, which leave certain individuals with an injured, fragmented self, vulnerable to struggles with regulating affect, and in many cases, unable to identify what it is they feel (Stasiewicz, et al., 2012). According to Flores (2004), these individuals are unable to draw on their own internal resources as there are none, and they remain in constant need (or "object hunger", p. 83) of self-regulating resources provided externally. Deprivation of attachment needs and thus object hunger, leaves these individuals with unrealistic and intolerable affect that are disturbing to self and others (Flores, 2004). Consequently, their strong and overpowering needs for human responsiveness may be experienced as insatiable, and compound their feelings of shame and be frightened by their own neediness. People whose attachment figures consistently reject or dismiss them in times of need may learn that relying on others is not an effective way to manage distress. Recent research shows that when people perceive that close others are unreliable, they may seek alternative, non-social sources of security, such as: security blankets (Passman, 1987); an omnipotent god (Granqvist, 2006; Kirkpatrick, 2005); and obsessive-compulsive hoarding of inanimate objects (Frost, Hartl, Christian, & Williams, 1995; Grisham, et al., 2009; Nedelisky & Steele, 2009). Indirect evidence that object attachment serve a compensatory function comes from studies showing that individuals continue to derive psychological security from objects well into adulthood (Bachar, Canetti, Galilee-Weisstub, Kaplan-DeNour, & Shalev, 1998; Erkolahti & Nyström, 2009), and such object attachment is positively associated with a lack of close interpersonal attachment (Nedelisky & Steele, 2009). Hence, the same can be said about how substance dependent individuals may use their substances to meet their insatiable hunger for self-regulation, to
quell the desperate need to gratify those feelings when their attachment system is experienced as being under threat.

Building on this work, Keefer, Landau, Rothschild, and Sullivan (2012) proposed that attachment to material objects can similarly serve to compensate for the threat to attachment security posed by close others’ perceived unreliability. According to Keefer, et al. (2012), unlike other potential sources of security, objects are perceived as exceptionally reliable, and can be completely controlled, summoned when needed and discarded when not. This sort of responsiveness, although lacking care and compassion that individuals typically seek from a human caregiver, may be attractive to people confronted with the unreliability of close others (Keefer, et al., 2012). They found that object attachment compensates for the perception that close others are unreliable, rather than consistently rejecting (Keefer, et al., 2012). When under threat, increased separation anxiety and motivation to reunite with the belonging was found, regardless of the belonging’s perceived importance for facilitating relationships (Keefer, et al., 2012). These findings support Carse’s (1998) findings that substances provide an attachment relationship giving security and comfort. This underlies the importance of how these objects keep the individual from feeling overwhelmed by a sense of loneliness, separateness, and alienation (Khantzian, 2001). However, for such individuals, attachments to external objects (e.g., a cold and critical mother, drugs, alcohol, etc.) in the external world are difficult to relinquish until internalised object (i.e., experience of others) and self-representations (IWMs) are worked through or modified (Flores, 2004).

2.10 Attachment to Substance

Bowlby (1969) viewed that the attachment process is constantly active, and the inanimate object is a substitute sought out due to the caregiver’s absence. According to
him, “Instead of the breast, non-nutritive sucking is directed to a … blanket or cuddly toy” (Bowlby, 1969, p. 312). However, caution must be drawn at the presumption that an individual quickly seeks such substitutions for the primary caregiver. It is when there are initial failures in caretaking that it is possible for an individual’s attachment behaviour to be directed towards an inanimate object and none towards a person, as observed in the issue of substance dependence. Having formulated substance dependence, as a disorder of unmet attachment needs in an earlier section, the current research reiterates the argument made by others (e.g., Connors, Carroll, C., Longabaugh, & Donovan, 1997; Wildmon-White, 2002; Williams, 1998) that insecure attachment styles interfere with the ability to derive satisfaction from interpersonal relationships. When a substance dependent individual’s attachment system is threatened by a sense of insecurity, patterns of attachment behaviours are set into motion based on one’s IWM of self and others. It follows that if these attachment emotional needs are chronically unmet, it may raise the likelihood of seeking other sources of security (Carse, 1998; Keefer, et al., 2012). Therefore, substance dependent individuals are more likely to self-medicate and regulate their emotions through the use of substances (B. Johnson, 2003; Orford, 2001; Southwick & Satel, 1990).

Building on the early theoretical formulations and observations of the addictive process (i.e., Kohut, 1977), Khantzian (2001) proposed the self-medication hypothesis which provided an explanation of why substance abusers have a propensity toward certain addictions. He hypothesised that it is not pleasure that they are seeking, but that they are attempting to regulate their emotional selves and escape, even momentarily, from the constant feelings of deprivation, shame, and inadequacy that dominate their lives (Flores, 2004). Consistent with the construct of attachment to substance and attachment-based formulation on substance dependence argued above, Khantzian hypothesised that
attachment to substance of choice, and explored how this specific form of attachment may interact with their attachment with others. Nevertheless, the literature reviewed here are crucial and serve as a platform for further investigation as this area of inquiry is very much under-researched. There are few published studies that address these issues sufficiently, much less attempt to demonstrate empirically these theoretical assumptions (e.g., Carse, 1998). The current research will be seeking to explore and clarify these attachment assumptions, and provide an in-depth investigation into how substance use is experienced in relation to individuals’ interpersonal relationships. To improve on the quality of research and possibly yield some important findings, the current studies will be adopting a mixed-methodological approach which is anticipated to be able to cover depth and scope, compared to the available literature thus far. Argued to provide
crucial information for the field of attachment and substance dependence, the next chapter will present an overview of the current research.
CHAPTER 3

General Overview of the Current Research

Research has shown that damaging experiences with early attachment figures can result in insecure attachment, leading to a heightened risk of developing psychopathology in adult life (Keefer, et al., 2012). More specifically, attachment representations show predictive associations with a wide-range of pathological behaviour including: personality disorders, mood disturbance, and psychopathy (van IJzendoorn & Bakermans-Kranenburg, 1996). Furthermore, both clinical reflections and empirical studies support the hypothesis that early attachment disorganisation is causally linked to a group of adult disorders consequent to attachment-related childhood traumas (van IJzendoorn & Bakermans-Kranenburg, 1996). Intimate long-lasting relationships are an integral part of human nature and the inability to establish long-lasting gratifying relationships is directly related to the quality of early attachment experiences (Flores, 2004).

Attachment theory differentiates between distinct patterns of attachment styles, which imply different types of emotion-regulation and coping towards distress, and significant research supports the relationship between insecure attachment styles and substance use as both an emotional regulation and coping strategy (Liotti, 2004). Individuals use mental representations that include the incorporated traits of security-providing attachment figures for self-soothing or soothing by actual others for regulating distress. However, for individuals who have experienced damaging experiences with their attachment figures, that ability to regulate their distress and emotions in a functional way may not be present. Hence, the vulnerability of the individual is the consequence of developmental failures and early environmental deprivation leading to ineffective attachment styles (e.g., Belsky, 2002; Magai, 1999). Difficulty overcoming ineffective
attachment styles (Flores, 2001) can leave certain individuals vulnerable to addictive compulsions as compensatory behaviour for their attachment deficiencies.

While it is understood that substance dependent individuals may have damaging interpersonal experiences and ineffective attachment styles, it was found that such individuals who developed a stronger therapeutic alliance (or relationship) with their therapists achieved greater reductions in distress during treatment (Urbanoski, Kelly, Hoeppner, & Slaymaker, 2012). Furthermore, the alliance influenced during-treatment changes in key process variables (i.e., psychological distress, motivation, self-efficacy, coping skills, and commitment), underscoring its integral role in psychotherapeutic interventions (Urbanoski, et al., 2012). It had been established that the nature of the therapeutic relationship between client and therapist is a significant factor in promoting therapeutic change, and many authors have described that relationship as an attachment relationship (Bowlby, 1988; L. Collins, 2007; Daniel, 2006; Epstein, 1995; Holmes, 2010; Parish, 1999; Parish & Eagle, 2003; Pistole, 1989). The therapeutic relationship is said to contain many features, which activate an adult client’s ingrained attachment expectations and behaviours (IWM's of self and others; Bowlby, 1988). Akin to the attachment behaviours displayed by infants in times of stress, people tend to seek therapy when faced with difficult situations that they cannot handle on their own. Similarly, it would be important to understand how these IWM patterns are activated and experienced in the relationships substance dependent individuals’ have with their therapists.

The current research sets out to extend and bolster the initial research in the areas of attachment and substance dependence, and derive findings that could assist with developing a more coherent and organised model to possibly explain its complex phenomena from an attachment point of view. Findings may then assist with providing a more in-depth understanding of substance use and its implications to other relationships
(including attachment relationships with their therapists), and developing more focused approaches for the treatment of substance use dependence. In this next section, the proposed model of attachment to substance will be introduced and how it is conceptualised.

3.1 The Proposed Model

3.1.1 Attachment to Parents/ Primary Caregiver

As introduced and reviewed, individuals’ attachment to their primary caregiver forms the bedrock of internal working models of self and others, and serves as a template for subsequent interpersonal interactions. As part of this study, we seek to measure this construct by using an established scale of global attachment based on our participants’ early experiences. To date, there is no completely satisfactory measure of attachment in adults at this stage. Therefore, to establish an individual’s attachment to their primary caregiver, the Experiences in Close Relationships Scale (ECR; Brennan, Clark, & Shaver, 1998) was adopted.

The ECR is a 36-item self-report scale made up of two 18-item subscales, to assess dimensions of Attachment Anxiety and Attachment Avoidance, in the measurement of attachment style. Clients respond to each item on a 7-point scale ranging from strongly disagree (1) to strongly agree (7). The items on the attachment anxiety factor are reminiscent of Ainsworth et al.’s coding scales (Ainsworth, et al., 1978) describing anxiously attached infants, emphasising both fear of abandonment and anger about separations. Conversely, items on the attachment avoidance factor emphasise lack of closeness and emotional suppression. This measure has been used in hundreds of studies since 1998, always with high reliability (the alpha coefficients are always near or above .90, and test-retest coefficients range between .50 and .75, depending on the time
span and the nature of the sample). The ECR has been translated into many other languages, always producing more than adequate reliability coefficients and good evidence of construct validity (Mikulincer & Shaver, 2016).

In a comprehensive review of attachment measures, Mikulincer and Shaver (2016) considered the ECR a benchmark whenever they evaluated other measures and other studies. Consistent with recommendations for use (Mikulincer & Shaver, 2016), the wording of the ECR instructions were altered slightly to apply to one’s general or global “attachment style” in various kinds of close relationships. Specifically, participants were instructed that the ECR statements concern “how you generally feel in close relationships (e.g., with romantic partners, close friends, or family members)”.

3.1.2 Attachment to Therapist

The concept of a therapist being an attachment figure had been explored by many (e.g., L. Collins, 2007; Farber, Lippert, & Nevas, 1995; Mackie, 1981; Mallinckrodt, Gantt, & Coble, 1995; Parish, 1999). Research on clients’ help-seeking preferences provides ample evidence for the stronger and wiser elements and the proximity seeking function in psychotherapy (Vogel & Wei, 2005). Therapist as a safe haven is evident in a study of clients who reported a significantly greater sense of relief in sessions and support from their counsellor after experiencing a critical incident that strengthened the relationship (Janzen, Fitzpatrick, & Drapeau, 2008). Fostering an adult client’s sense of safe haven is particularly important for clients who have experienced severe childhood trauma (Kinsler, Courtois, & Frankel, 2009), and many clients experience separation anxiety as the end of psychotherapy approaches (Joyce, Piper, Ogrodniczuk, & Klein, 2007). Perhaps the strongest focus of recent research interest has been on the secure base element of the psychotherapy relationship (Farber & Metzger, 2009). Stronger attachment
to the therapist was found with increased duration of therapy and frequency of sessions (Parish, 1999). Parish and Eagle (2003) also showed that “clients in long-term psychotherapy sought proximity to their therapist, turned to them in times of distress, evoked a mental representation of them in their absence and relied on them as a secure base” (p. 280). In two studies, clients’ secure attachment to their therapist was associated with greater depth of exploration in the middle phase of time-limited psychotherapy (Mallinckrodt, Porter, & Kivlighan, 2005; Romano, Fitzpatrick, & Janzen, 2008).

As introduced above, infants’ and childrens’ expectations of whether their caregivers are emotionally available and responsive serve as foundations for their working models of self and others, and these original prototypes influence subsequent behaviour and representations in new relationships (Bowlby, 1973, 1988). These can then be generalised across recurrent interactions with an attachment figure and eventually be generalised across relationships via transference processes (Andersen & Glassman, 1996). Transference is defined as “the experiencing of feelings, drives, attitudes, fantasies and defenses toward a person in the present, which are inappropriate to that person and are a repetition, a displacement of reactions originating in regard to significant people of early childhood” (Greenson, 1967, p. 156). These patterns of relating are essentially repeated patterns of enactments of what the individual has been “taught” overtime to respond to and has eventually, begun to expect in subsequent interactions with others. In the same manner, therapists tend to fulfill the primary function of attachment that is, providing comfort, security and safety. Thus, the therapeutic relationship can be understood as the therapist serving as an attachment figure, a “secure base” that enables exploration (Bowlby, 1988, 2006; Holmes, 2010). Following the lead by Bowlby (1988), other contemporary writers have argued the parallel in the psychotherapy relationship (e.g.,
Flores, 2004; Holmes, 2010; Obegi & Berant, 2008), and a small but emerging body of empirical evidence supports this position (Brumbaugh & Fraley, 2006, 2007).

Given that clients are likely to respond to their therapists in ways that are consistent with their lifelong patterns of defense, affect regulation and security operations (A. Slade, 1999), clients’ attachment to their therapist has particular relevance in the work with substance dependent individuals, as part of the goal of therapy is for the therapist to become a new object of attachment in order to assist with their shift from being attached to substances to getting their needs met in relationships (Flores, 2004; Walant, 1997).

The Client Attachment to Therapist Scale (CATS; Mallinckrodt, et al., 1995) will be used to measure the quality of the substance dependent individual’s attachment to their therapist. The CATS is a 36-item self-report measure of clients’ perceptions of their relationships with their therapist from an attachment theory perspective. Clients respond to each item on a 6-point scale ranging from strongly disagree (1) to strongly agree (6). The CATS has three subscales: (a) Secure (14 items), (b) Preoccupied-Merger (10 items), and (c) Avoidant-Fearful (12 items). The wording on the instructions and on some items, was altered slightly to refer to a client’s “therapist” rather than “counsellor” so as to prevent confusion when completing the questionnaire.

Consistent with Mallinckrodt, et al. (1995), the interpretations of the three subscales are as follows: (a) Secure, experiencing the therapist as responsive, sensitive, understanding, and emotionally available; feeling hopeful and comforted by the therapist; and feeling encouraged to explore frightening or troubling clinical material (e.g., “My therapist is sensitive to my needs”); (b) Preoccupied-Merger, longing for more contact and to be “at one” with the therapist, wishing to expand the relationship beyond the boundaries of therapy, and preoccupation with the therapist and the therapist’s other clients (e.g., “I
wish my therapist could be with me on a daily basis”); (c) Avoidant-Fearful, suspicion that
the therapist is disapproving, dishonest, and likely to be rejecting if displeased; reluctance
to make personal disclosures in therapy; and feeling threatened, shameful, and humiliated
in the sessions (e.g., “Talking over my problems with my therapist makes me feel ashamed
or foolish”).

Test-retest reliability coefficients were reported by Mallinckrodt, et al. (1995) as .84 for the Secure subscale, .86 for the Preoccupied-Merger subscale, and .72 for the Avoidant-Fearful subscale. Mallinckrodt, et al. (1995) found internal consistency
coefficient alphas of .64, .81, and .63 respectively. However, in a subsequent study
(Woodhouse, Schlosser, Crook, Ligiéro, & Gelso, 2003), higher alpha values were
reported: .78, .84 and .70, respectively.

3.1.3 Attachment to Substance as a Mediator

As the above literature helps to illustrate, by understanding one’s attachment
patterns, people can become more knowledgeable about possible sources of their
insecurities, subsequent reactions to difficult emotional experiences, and interpersonal
patterns of relating. With this understanding, people can learn to adopt different strategies
to manage their dependency needs and more effectively use the therapeutic relationship
toward meeting their goals. However, substance dependent individuals would have to
challenge themselves to trust and ultimately learn to depend on their therapists in the
process of treatment to have any chance of experiencing the benefits of meeting their
attachment needs (as opposed to constantly relying on their substances). Given that
attachment difficulties are formulated to be the core of their interpersonal struggles, it
follows that an understanding is needed about how their substance use influences the
therapeutic relationship – a relationship that is purported to be experienced as a safe space for examining interpersonal issues and learning to relate to a novel person.

Unfortunately, there are no published studies beyond the associations of the client-therapist attachment in the context of substance dependence treatment that would indicate the extent to which a substance dependent individual’s attachment to substance serve as mediators between attachment formed in childhood (i.e., attachment anxiety and attachment avoidance) and attachment to their therapist. Hence, the present research sets off to pioneer an investigation into this area, which is identified as a gap in the current available literature.

Thus, in the present research, we examine the mediation effects of attachment to substance on the known association between attachment patterns formed in childhood, and attachment to therapist. A model schematic below (refer to Figure 1) depicts the purported relationship between these three constructs. Here, attachment formed toward parents/caregivers serves as a precursor for subsequent patterns of relating with others. However, given the theoretical assumption that these individuals have attachment difficulties based on their IWMs of self and others, they may also have certain patterns of attachment to their therapists. When the hypothesised attachment to substance is introduced, this new variable is proposed to have an impact on the use of the therapeutic relationship, since there is already an attachment relationship with the substance. Hence, the attachment to substance variable is placed between attachment to parents/caregivers and attachment to therapist, as conceptualised.

There is still little known about how one’s attachment to substance can impact this complex and dynamic relationship, except that it can possibly hinder treatment. For
therapists working with such individuals, the implications for treatment are likely immense.

Figure 1. Schematic of the proposed model.

3.2 Attachment to Substance of Choice Questionnaire

To capture one’s attachment to substance, there is a need to develop a new measure such that a conscious report of how one relates to their substances may provide a standardised protocol that is easy to administer for the purposes of investigating this new concept. Also, simply administering an attachment scale for humans may not be relevant for many clients and is likely to introduce construct validity issues. Given that there is no established measure to specifically assess an individual’s attachment to their preferred substance, the Attachment to Substance of Choice Questionnaire (ASCQ) was developed as part of this study by rewording the Reciprocal Attachment Questionnaire (RAQ; M. L. West & Sheldon-Keller, 1992, 1994) for assessing an individual’s attachment to their substance of choice, rather than an attachment to a particular person or primary caregiver.
The 15-item version of the RAQ (M. L. West & Sheldon-Keller, 1994) assesses five dimensions of attachment in adults, namely: Availability and Responsiveness; Feared Loss; Proximity Seeking; Separation Protest; and Use of the Attachment Figure. Participants endorse each item on a 5-point Likert-type scale ranging from 1 (Strongly disagree) to 5 (Strongly agree).

In no particular order, these dimensions described by M. L. West and Sheldon-Keller (1994) are apt to measuring attachment to substance:

(1) Feared Loss assesses the ability to sustain confidence in the future of the attachment relationship.
(2) Proximity Seeking refers to the tendency to reduce distance from the attachment figure in times of stress.
(3) Separation Protest assesses the degree to which physical separation (actual or anticipated) is perceived as threatening to the attachment relationship and, therefore, results in reactions to separation.
(4) Availability refers to the extent to which the attachment figure is perceived as reliably accessible.
(5) Use of the Attachment Figure assesses the extent to which the individual asks for the attachment figure’s availability and responsiveness.

Summation scores for the five scales are produced and each scale consists of three items with scores varying from 3 to 15. High scores indicate more problems regarding the dimension being measured. For example, high scores on Availability indicate low perceived available responsiveness of the attachment figure. The items are given in Table 1, grouped according to each RAQ dimension.
While there is a plethora of attachment measures out in the field, most attachment questionnaires reviewed at the time were not validated for use with clinical populations. Not only has the RAQ been used in both clinical and normative samples, it is particularly oriented towards identifying the disturbed attachment patterns described by Bowlby (1973). It was previously adapted for use in a study that assessed attachment to inanimate objects in adults (Nedelisky & Steele, 2009), which increased the confidence in its usability in novel applications, akin to the proposed attachment to substance paradigm. Adhering closely to attachment theory, the RAQ attempts to elicit a specific attachment figure, and subscales directly measure attachment behaviours such as Separation Protest—a dimension that may easily be applied to refer to one’s substance. Overall, the RAQ conceptual dimensions appeared to fit well with the variable of interest (i.e., attachment to substance), as a good choice of questionnaire needed to have subscales that capture participant responses with breadth and was face valid. Consistent with the ECR and CATS, the RAQ conceptualises security and insecurity as falling along a spectrum as opposed to within discrete categories, and was reported to fit well in the two-dimensional space mapped by the authors of the ECR (Mikulincer & Shaver, 2016). Hence, the RAQ was selected as an appropriate measure for modification.
Table 1

**Reciprocal Attachment Questionnaire (RAQ) Scale Items**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feared Loss</td>
<td>I have a terrible fear that my relationship with my attachment figure will end.</td>
</tr>
<tr>
<td></td>
<td>I’m afraid that I will lose my attachment figure’s love.</td>
</tr>
<tr>
<td></td>
<td>*I’m confident that my attachment figure will always love me.</td>
</tr>
<tr>
<td>Separation Protest</td>
<td>*I don’t object when my attachment figure goes away for a few days.</td>
</tr>
<tr>
<td></td>
<td>I resent it when my attachment figure spends time away from me.</td>
</tr>
<tr>
<td></td>
<td>I feel abandoned when my attachment figure is away for a few days.</td>
</tr>
<tr>
<td>Proximity Seeking</td>
<td>I have to have my attachment figure with me when I’m upset.</td>
</tr>
<tr>
<td></td>
<td>I feel lost if I am upset and my attachment figure is not around.</td>
</tr>
<tr>
<td></td>
<td>When I am anxious, I desperately need to be close to my attachment figure.</td>
</tr>
<tr>
<td>Low Use of the Attachment Figure</td>
<td>*I turn to my attachment figure for many things including comfort and reassurance.</td>
</tr>
<tr>
<td></td>
<td>*I talk things over with my attachment figure.</td>
</tr>
<tr>
<td></td>
<td>Things have to be really bad for me to ask my attachment figure for help.</td>
</tr>
<tr>
<td>Availability of the Attachment Figure</td>
<td>*I am confident that my attachment figure will try to understand my feelings.</td>
</tr>
<tr>
<td></td>
<td>I worry that my attachment figure will let me down.</td>
</tr>
<tr>
<td></td>
<td>*When I’m upset, I am confident my attachment figure will be there to listen to me.</td>
</tr>
</tbody>
</table>

* reverse scored

Taken from M. L. West, Rose, Spreng, Verhoef, and Bergman (1999).

Psychometric properties of the complete 35-item version of the RAQ, include adequate construct validity as confirmed by factor analytic studies, good internal consistency and test-retest reliabilities (over a four-month period) for each of the subscales: *Feared Loss* ($\alpha = 0.83$, test-retest = 0.81); *Proximity Seeking* ($\alpha = 0.71$, test-retest = 0.82); *Separation Protest* ($\alpha = 0.78$, test-retest = 0.76); availability ($\alpha = 0.85$, test-retest = 0.68); and *Use of the Attachment Figure* ($\alpha = 0.74$, test-retest = 0.77). These statistics are based on a sample that included 136 non-patients and 110 psychiatric patients (M. L. West & Sheldon-Keller, 1992, 1994). In a more recent study on non-suicidal self-injury in a sample of college students (Heath, Toste, Nedeccheva, & Charlebois, 2008), the researchers found reasonable internal consistency reliability for the 15-item RAQ ($\alpha = .76$).
A separate, yet associated use of the RAQ had been applied in the context of assessing attachment to inanimate objects in adults (Nedelisky & Steele, 2009). Similar in concept to the current study, the original RAQ was adapted to examine the hypothesis that Obsessive-Compulsive Disorder individuals who hoard, have an atypical emotional attachment to the inanimate objects that they pathologically accumulate. The researchers (Nedelisky & Steele, 2009) concluded that though exploratory and limited in sample size (30 participants), their study found good internal consistency (α = .89) in their adapted RAQ and all of the subscales related to the current study had adequate to good reliability (α ranging from 0.73 to 0.85).

Being an instrument modelled after the RAQ, the ASCQ comprises similar subscales that are listed below. For a brief description of the subscales of the ASCQ, see Table 2 below, and a more detailed description of the ASCQ will be presented in the Method section.

Table 2

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Item content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feared Loss</td>
<td>Assesses the ability to sustain confidence in the future of the attachment relationship with the substance.</td>
</tr>
<tr>
<td>Separation Protest</td>
<td>Assesses the degree to which physical separation (actual or anticipated) is perceived as threatening to the attachment relationship with the substance and, therefore, results in reactions to separation.</td>
</tr>
<tr>
<td>Proximity Seeking</td>
<td>Refers to the tendency to reduce distance from the substance of choice in times of stress.</td>
</tr>
<tr>
<td>Low Use of the Substance</td>
<td>Assesses the extent to which the individual seeks the soothing and security-inducing effects (physical and emotional) of their substance of choice.</td>
</tr>
<tr>
<td>Availability of the Substance</td>
<td>Refers to the extent to which the substance of choice is perceived as reliable and accessible.</td>
</tr>
</tbody>
</table>
3.3 Research Aims

Following the attachment and addictions research discussed in the literature review, the current research aims to examine the construct of attachment to substance of choice in the context of the psychotherapeutic relationship. Broadly, the aims of the research include:

1. To adapt an existing adult attachment questionnaire for use in assessing substance-dependent individuals’ attachment to their substance of choice (or preferred substance used).
2. To propose a model of attachment to substance that impacts the therapeutic relationship.
3. To examine the attachment styles of substance-dependent individuals as related to their substance of choice.
4. To examine the relationship dynamics between substance-dependent individuals and their therapists as a result of their:
   a. Childhood/early attachment styles
   b. Attachment to their substance of choice
5. To examine the crucial factors in the client-therapist attachment relationship for the treatment of substance dependence.

Given that these research aims required both broad and detailed examination of several attachment concepts and phenomena, a robust and comprehensive approach is necessary to derive a more thorough understanding of the proposed model. To meet these aims adequately, a mixed-methodological approach was adopted to take advantage of the benefits of both quantitative and qualitative methods. In this way, different aspects of the
research problem can be investigated enabling a detailed and comprehensive inquiry (Hansen, 2006).

The current research will comprise of two studies: a quantitative survey study of clients’ attachment, and a qualitative interview study with clients about their experience in therapy with their therapists. It was anticipated that the results from the first study could only derive broader findings due to quantitative methodological limitations, as it does not examine the specific reasons clients struggled with their interpersonal issues. From a clinical perspective, a direct enquiry with the client sample may provide a good source of unfiltered information given it would be from their point-of-view (Horvath, 2000; Horvath, Del Re, Flückiger, & Symonds, 2011; Viklund, 2013). Hence, by utilising a methodology that assists with deriving themes inherent in the clients’ relational repertoire, it can reveal processes that are unable to be captured in quantitative methodology. Following which, the results from these different methods will be discussed in relation to each other in order to produce new insights.

The first study was designed to be broad and encompassed clients’ views via self-report questionnaires, about their Global Attachment (Attachment to Parents/ Caregivers), Attachment to Therapist, and a newly introduced concept of Attachment to Substance. 450 substance-dependent individuals that was representative of a sample of inpatients and outpatients in a private hospital addictions treatment milieu was examined. The study presented a hypothesised model and developed a new attachment scale which assessed substance-dependent individuals’ attachment to substance. Thereafter, the mediational model of attachment to substance was tested and an examination of individuals’ attachment to substance of choice as a mediating variable in the therapeutic relationship was explored. The findings here were intended to be generalisable to the substance-
dependent population and served to provide useful insights into other aspects worthy of in-depth exploration in the second study.

The second study was designed to be specific and provided an in-depth, qualitative exploration into the specific views of substance-dependent clients who were involved in psychotherapeutic treatment with their therapist. Built on the findings of the first study, a smaller sample of 10 clients was interviewed for their subjective experiences of their own therapy and their therapists. Their views derived qualitative themes from that was utilised to supplement and inform the findings from the first study. Taken together, the findings from both studies will be discussed and implications to treatment will be suggested.
CHAPTER 4

Study 1: A Survey of Clients’ Attachment

4.1 Introduction

Forming an alliance in psychotherapy with a substance dependent individual is a challenging task and in certain therapeutic contexts, viewed as a contraindication for suitability (e.g., psychodynamic psychotherapy; Bateman, Brown, & Pedder, 2010). Yet, these individuals often present to treatment with some of the most complex issues and relational difficulties. There seems to be agreement that substance dependent individuals must learn to replace addiction with human relationships if they are to maintain sobriety (Berke, 1991; Flores, 2004). However, high rates of treatment dropout in drug and alcohol rehabilitation remain a concern (Cournoyer, Brochu, Landry, & Bergeron, 2007; Flores, 2004), as well as the difficulties therapists face in the engagement and retention of their substance dependent clients in psychotherapy (Meier, Barrowclough, & Donmall, 2005). It had been shown that the development of alliance with substance dependent individuals is a dynamic non-linear relationship that develops over time and forms in stages (Berke, 1991): research provided support that clients who form weaker alliances are more likely to leave treatment prematurely (Meier, Donmall, McElduff, Barrowclough, & Heller, 2006) and stronger alliances predict positive outcomes in psychotherapy with substance dependent individuals (Barber, et al., 2001; Connors, et al., 1997; Gaiton, 2004; Liszka-Chaloner, 2004; Moos, 2003; Pantalon, Chawarski, Falcioni, Pakes, & Schottenfeld, 2004). Despite the findings emphasising the importance of forming strong working alliances, little is understood about how interpersonal dynamics in psychotherapy treatment may impact the alliance itself.
Generally, the literature is mounting in the area of attachment styles and their influence on both process and outcome in psychotherapy (Cyranowski, et al., 2002; Fonagy, et al., 1996; Meyer & Pilkonis, 2001). Studies show that clients who tend to have high levels of attachment anxiety and avoidance displayed greater severity of problems related to substance dependence (Brummett, 2007; Molnar, 2004) and did not fare as well in treatment (Justitz, 2002). As expected, clients with dismissing states of mind were associated with less help seeking, less self-disclosure, and poorer treatment use (Dozier, 1990). More specifically, client attachment patterns were found to be related to the development of alliance in therapy (Eames & Roth, 2000; Kivlghan, Patton, & Foote, 1998; Mallinckrodt, 1991; Mallinckrodt, et al., 1995; Satterfield & Lyddon, 1995), and substance dependent individuals with insecure patterns of attachment were found to form poorer alliances (Liszka-Chaloner, 2004). This research on attachment styles in therapy infers that there is value in elucidating the attachment patterns in treatment as it may influence how clients relate to their therapists. Of interest are the attachment styles substance dependent clients bring to their therapy appointments given their relational issues. So far, there are many quantitative studies that show a correlation between insecure attachment style and substance use, but there is little research that have attempted to demonstrate the way attachment patterns influence the treatment of substance dependent individuals. Such research may provide fresh insight for therapists in addictions work with a focus on psychotherapeutic process and outcome.

It has been found that attachment security provides the strongest individual predictor of working alliance (Bair, 2007). Clients with more successful relationship histories, secure attachment style and better social support find it easier to establish a successful alliance with their therapists (Freeman, 2001; Logan, 2000; Meier, Donmall, Barrowclough, McElduff, & Heller, 2005), and showed greater improvement in presenting
Attachment to Substance 54

symptoms (Meyer, Pilkonis, Proietti, Heape, & Egan, 2001; G. A. Miller, 1995). Secure attachment to a therapist provides a corrective emotional experience through which a client eventually comes to rely more on security-based strategies to regulate affect, and develops more effective social competencies to form satisfying attachments with others (Mallinckrodt, 2001). However, for substance dependent individuals to form a good enough working alliance and therapeutic relationship with their therapists, they would have to be willing to experience affect-regulation and soothing from others in an optimal environment (Flores, 2001, 2004). An optimal environment would allow for the re-establishment of ruptured bonds in an atmosphere of responsiveness by the therapist, and offer opportunities for repair (Beebe, 1993). Hence, this suggests that these individuals’ ability to form a close attachment with their therapist was a necessary prerequisite for a strong working alliance. Otherwise, their denial of the need for others would continue to be fulfilled by their substances, thereby impacting the quality of the attachment relationship with their therapists (Walant, 1997). Before interventions can be designed to target the specific areas of this complex interplay of interpersonal attachment and substance dependency, a more in-depth understanding of these processes must be achieved.

Although previous research has suggested a link between attachment styles with substance abuse, emotional distress, and interpersonal problems in adults (e.g., Davidson & Ireland, 2009; Doumas, et al., 2006; Molnar, et al., 2010; Thorberg & Lyvers, 2010), none had conceptualised substance dependence as an Attachment to Substance. As reviewed, attachment theory is typically used to understand the struggles within interpersonal relationships (Mikulincer & Shaver, 2016), and viewing one’s substance as a relational entity that may provide attachment security might at first appear to be absurd. However, it has been found that people have sought alternative, non-social sources of security that may include blankets (Passman, 1987), god (Granqvist, 2006; Kirkpatrick,
2005), and other inanimate objects (Frost, et al., 1995; Grisham, et al., 2009; Nedelisky & Steele, 2009). This study proposes that attachment theory may offer an alternative view of substance dependent individuals’ struggles with their patterns of substance use. Hence, an attachment to substance may also characterise familiar attributes that refer to maladaptive relations to an alcohol or other drug (Flores, 2004). Patterns of attachment anxiety or avoidance may be conceptualised as approach or avoidant patterns of substance use, and these individuals may have peculiar attachment to substance based on their own patterns of attachment in childhood. It then follows that these maladaptive attachment patterns may be present in therapy and as this study suggests, may influence the quality of attachment with a therapist. There are no studies to date that had examined substance use in this regard, and its impact on an attachment to therapist.

The current study argues for a better understanding of these attachment processes as it inherently impacts clinical practice, as clinicians and therapists might have to be careful and sensitive regarding how they address and engage their substance dependent clients. Despite some experimental and correlational research to differentiate the variations in attachment described by Mikulincer, Shaver, and Pereg (2003) in the general population, little is known about how substance dependent clients might exhibit these strategies in the psychotherapy relationship. In addition, virtually no research exists that includes attachment as the theorised precursor, except two recent studies that examined mediational models of adult attachment and depressive symptoms on populations of undergraduates. Cantazaro and Wei (2010) found that the relation between attachment anxiety and depressive symptoms was fully mediated by dependence and self-criticism, whereas the relation between attachment avoidance and depressive symptoms was partially mediated by dependence and self-esteem. They found that men with high levels of attachment avoidance are more likely than women to be self-critical.
In the other study by Wei, Mallinckrodt, Larson, and Zakalik (2005), attachment working models of self and others were examined to see how adults’ preferences for internal vs. external sources of reassurance were governed, leading to depressive symptoms. It was found that both capacity for self-reinforcement and need for reassurance from others partially mediated the link between attachment anxiety and depression. In contrast, the capacity for self-reinforcement fully mediated the link between attachment avoidance and depression (Wei, Mallinckrodt, et al., 2005). While these findings provide crucial information in the study of depression, they do not address the depressive presentation commonly seen in the substance dependent population. However, findings from these forms of studies could contribute to a better understanding of how specific patterns of adult attachment lead to vulnerabilities for types of maladaptive functioning like substance dependence, and its impact on client attachment to therapist.

Despite the primary presenting issues as substance dependence, these individuals may be unlikely to list improving their interpersonal relationships among their goals for therapy. However, as research in attachment and psychotherapy suggests, key features of these problems lie with maladaptive interpersonal patterns significantly contributing to an individual’s predicament, and that adult attachment theory offers a useful framework for case conceptualisation and treatment of these maladaptive patterns (Mallinckrodt, Daly, & Wang, 2009). As reviewed above, therapists can expect clients to predominantly employ one or a mix of the secondary strategies, corresponding to their individual attachment styles, with a different ingrained pattern of attachment, affect regulation style and potential vulnerability to a different set of interpersonal difficulties. While secure clients rely predominantly on security-based strategies, substance dependent individuals are viewed to engage in one or two possible secondary strategies: those who anticipate that proximity seeking, may result in at least some measure of felt security are likely to engage in a hyperactivating secondary attachment strategy; whereas those who believe that proximity
seeking is useless and likely to lead to further emotional injury engage in a *deactivating* secondary attachment strategy (Mallinckrodt, et al., 2009).

Anxious individuals relying on hyperactivating strategies have negative beliefs about their ability to cope with distress and expect that others will be inconsistently responsible and available (Mikulincer, et al., 2003). Besides tending to score relatively high on self-report measures of anxious attachment, these anxiously attached individuals are associated with rumination and exaggerated appraisal of perceived threat, intense reactions to stressful events, and pervasive fears of abandonment (Mikulincer & Florian, 1998). Research conducted on undergraduates report that the positive association between anxious attachment and self-reported symptoms of distress is mediated by a low capacity for self-reinforcement and a high need for reassurance from others (Wei, Mallinckrodt, et al., 2005), emotional reactivity (Wei, Vogel, Ku, & Zakalik, 2005), alexithymia, and the perception of low self-efficacy in social relationships (Mallinckrodt & Wei, 2005). More recently, it was found that the relation between attachment anxiety and depressive symptoms was fully mediated by dependence and self-criticism (Cantazaro & Wei, 2010).

In contrast, avoidant individuals relying on deactivating strategies tend to inflate their self-esteem defensively in the face of attachment threats and to avoid interactions that might involve intimacy or dependency (Mikulincer, et al., 2003). When threat to felt security is perceived, their secondary strategy involves both conscious and unconscious efforts to suppress attachment related thoughts and feelings in an effort to avoid heightened distress, translating to relatively high scores on self-report measures of avoidant attachment. Research conducted on undergraduates have found that the association between attachment avoidance and self-reported symptoms of distress is mediated by the tendency to suppress emotional experience (Wei, Vogel, et al., 2005). Similar to the self-reports of individuals scoring high on attachment anxiety, avoidant individuals’ self-reports of distress tend to be mediated by alexithymia and the perception of low self-
efficacy in social relationships (Mallinckrodt & Wei, 2005). However, it was found that
dependence and self-criticism only partially mediated the relation between attachment
avoidance and depressive symptoms (Cantazaro & Wei, 2010). Given the tendencies for
anxious or avoidant clients to employ these problematic and ineffective attachment
strategies to cope with their attachment insecurities, there is a need to examine these
patterns of attachment in detail.

To address the gap in the literature, the present study will initiate the first attempt
to explore mediators between attachment formed in childhood as a precursor, and
attachment to therapist. Using a similar method of exploration (e.g., Cantazaro & Wei,
2010; Wei, Mallinckrodt, et al., 2005), the current study sought to examine a mediational
model of attachment to substance and how it impacts attachment with therapists. Unlike
many studies, this investigation may elucidate the impact of attachment to substance, and
its relation to attachment to others, including attachment to therapists. The proposed
model illustrates that based on individuals’ global attachment organisations formed in
childhood; these patterns predict subsequent displays of relating toward others (i.e.,
attachment objects). Because of unmet attachment needs, these individuals turn towards
substances to fulfil those needs. It is theorised that these individuals have certain patterns
of dependence on these substances, which impacts their intra- and interpersonal
functioning. However, the substance dependent individual may not seek use of the
therapist upon entering psychotherapy given recurrent experiences with interpersonal
relationships. This largely impacts the formation of a strong attachment bond and
therapeutic alliance crucial for psychotherapy work. As argued above, the substance
serves as an alternative source of security and assists with hyperactivating or deactivating
the attachment system when that felt security is under threat. By investigating how the
substance dependent individual’s attachment to substance may influence their attachment
toward their therapists, we can perhaps understand more about how to intervene when therapists are faced with such clients.

There are six hypotheses in the present study (Figure 2 provides a graphical summary of these predictions):

1. Attachment anxiety will be positively correlated with attachment to substance;
2. Attachment anxiety will be negatively correlated with secure attachment to therapist, but positively correlated to preoccupied-merger attachment to therapist;
3. Attachment to substance will be a significant mediator of the link between attachment anxiety and preoccupied-merger attachment to therapist;
4. Attachment avoidance will be positively correlated with attachment to substance;
5. Attachment avoidance will be negatively correlated with secure attachment to therapist, but positively correlated to avoidant-fearful attachment to therapist;
6. Attachment to substance will be a significant mediator of the link between attachment avoidance and avoidant-fearful attachment to therapist.

In addition, it is expected that some gender differences would be found on attachment to substance, and attachment to therapist. However, the study of gender differences in the field of addiction is complex, and multi-faceted, that covers areas beyond the scope of the current research – including physiological, psychological and sociocultural differences (Horihan, 2014). Furthermore, to our knowledge, there has been no specific gender effects shown on attachment to substance and attachment to therapist, as conceptualised in the current study. Nevertheless, drawing on the empirical literature above, it is conceivable that these men and women would be subject to the psychological impact of gender-role expectations, and type/severity of abuse (i.e., physical, sexual and emotional/neglect) in their developmental years, which form their fundamental interpersonal orientations (Horowitz, Rosenberg, & Bartholomew, 1993). Specifically, in
a comprehensive review by Horihan (2014), women are more vulnerable than men to sexual abuse, reportedly 70% of such individuals were sexually abused by age 16, and women are at further risk for trauma compared to men. Whilst we may reasonably anticipate that female clients would be more anxiously attached than male clients to their substance and therapist, and male clients would be found to be more avoidantly attached than their female counterparts, the current study adopts a more explorative position to see if there were any uncharacteristic gender differences.

![Hypothetical Model](image)

*Figure 2. Hypothetical Model*
4.2 Methodology

4.2.1 Participants

The participants \((N = 450)\) in this study consisted of both inpatient and outpatient, male and female substance (alcohol and other drug) dependent individuals from clinics that support a private hospital located in the Perth metropolitan region. Appropriate ethics approval from the University Human Research Ethics Committee was obtained for this study. Participant recruitment was carried out via two clinics at the hospital’s locale: a specialist addictions clinic, and a psychological therapy practice who also gave approval. Regarding sample representation, clients or patients attending these two clinics may be on a mental healthcare plan (government funded) or be full-fee paying patients. Hence, the profile of participants accessed is made up of individuals assumed to be from low to high socio-economic statuses based on their level of education, employment and source of family income in childhood (See Table 3). Of the two clinics, there was more involvement from the specialist addictions clinic due to a comparatively higher patient throughput. Many of the patients at this clinic undergo drug replacement therapy and may receive some counselling from an addictions specialist or prescribing doctor, while at the psychological therapy practice, clients typically see a psychologist for fifty-minute psychotherapy sessions. Psychological treatment mainly consisted of Cognitive-Behavioural Therapy, and Mindfulness-Based Cognitive Therapy by postgraduate-trained psychologists. Depending on the nature and severity of their presenting issues, clients may undergo short to long-term treatment.

Approaching and enquiring with potential participants who were awaiting their appointments was the main mode of recruitment, while there were other participants who chose to take study materials at the respective clinics. To reduce the effect, as well as
perception of biased participant selection, all patients and clients who entered the clinics were approached when the researcher was present. Of those approached, 355 participated (overall response rate = 78.9%), while the rest (95 participants) were considered as having chosen to discontinue participation given that their surveys were not submitted. As it was unnecessary for participants to be identified in this study, an anonymous research survey was used whereby the submission of a survey pack was counted as consent given to participate (See Appendix A).

Frequency and descriptive statistics ascertained that the sample clinical population assessed was large and diverse. The demographic profile of the participants is presented in Table 3, Table 4 presents family history of dependence issues, Table 5 shows participants by history of substance use and substance of choice, and Table 6 describes participants by current treatment-related information.
### Table 3

**Number and percentage of participants by demographic variables (N = 355)**

<table>
<thead>
<tr>
<th>Variables</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age:</strong> mean (SD)</td>
<td>38.2 (9.69)</td>
</tr>
<tr>
<td>Range (years)</td>
<td>18 – 76</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>198 (55.8)</td>
</tr>
<tr>
<td>Female</td>
<td>155 (43.7)</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>2 (.6)</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>177 (49.9)</td>
</tr>
<tr>
<td>Married</td>
<td>35 (9.9)</td>
</tr>
<tr>
<td>Divorced</td>
<td>19 (5.4)</td>
</tr>
<tr>
<td>Widowed</td>
<td>11 (3.1)</td>
</tr>
<tr>
<td>De facto</td>
<td>75 (21.1)</td>
</tr>
<tr>
<td>Separated</td>
<td>30 (8.5)</td>
</tr>
<tr>
<td>Others</td>
<td>5 (1.4)</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>3 (.8)</td>
</tr>
<tr>
<td><strong>Romantic relationship status</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>175 (49.3)</td>
</tr>
<tr>
<td>Length of relationship: mean in years (SD)</td>
<td>7.72 (7.17)</td>
</tr>
<tr>
<td>No</td>
<td>178 (50.1)</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>2 (.6)</td>
</tr>
<tr>
<td><strong>Parent</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>194 (54.6)</td>
</tr>
<tr>
<td>Living together with children</td>
<td>101 (52.1)</td>
</tr>
<tr>
<td>Living apart from children</td>
<td>81 (41.8)</td>
</tr>
<tr>
<td>Shared situation</td>
<td>4 (2.1)</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>8 (4.1)</td>
</tr>
<tr>
<td>No</td>
<td>146 (41.1)</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>15 (4.2)</td>
</tr>
<tr>
<td><strong>Highest level of education completed</strong></td>
<td></td>
</tr>
<tr>
<td>Primary (Year 1 – 7)</td>
<td>6 (1.7)</td>
</tr>
<tr>
<td>High School (Year 8 – 12)</td>
<td>166 (46.8)</td>
</tr>
<tr>
<td>TAFE (Vocational Training)</td>
<td>97 (27.3)</td>
</tr>
<tr>
<td>University</td>
<td>65 (18.3)</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>21 (5.9)</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
</tr>
<tr>
<td>Currently employed</td>
<td>162 (45.6)</td>
</tr>
<tr>
<td>Currently unemployed</td>
<td>180 (50.7)</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>13 (3.7)</td>
</tr>
<tr>
<td>Years employed since school: mean in years (SD)</td>
<td>14.1 (9.8)</td>
</tr>
<tr>
<td>Years unemployed since school: mean in years (SD)</td>
<td>7.64 (6.16)</td>
</tr>
<tr>
<td><strong>Main source of household income in childhood</strong></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>177 (49.9)</td>
</tr>
<tr>
<td>Mother</td>
<td>71 (20.0)</td>
</tr>
<tr>
<td>Both parents</td>
<td>72 (20.3)</td>
</tr>
<tr>
<td>Sibling(s)</td>
<td>3 (.8)</td>
</tr>
<tr>
<td>Father and siblings</td>
<td>1 (.3)</td>
</tr>
<tr>
<td>Mother and siblings</td>
<td>3 (.8)</td>
</tr>
<tr>
<td>Yourself</td>
<td>9 (2.5)</td>
</tr>
<tr>
<td>Others</td>
<td>7 (2.0)</td>
</tr>
<tr>
<td>All the above</td>
<td>1 (.3)</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>11 (3.1)</td>
</tr>
</tbody>
</table>

*Note.* Percentage figures contained within parentheses unless otherwise stated.
### Table 4
Number and percentage of participants by family history of dependence issues (N = 355)

<table>
<thead>
<tr>
<th></th>
<th>Both parents</th>
<th>Father</th>
<th>Mother</th>
<th>Other family member (e.g., uncle, sibling)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>18 (31.6)</td>
<td>82 (18.2)</td>
<td>46 (13.0)</td>
<td>13 (3.7)</td>
</tr>
<tr>
<td>Drug</td>
<td>2 (3.5)</td>
<td>6 (1.3)</td>
<td>15 (4.2)</td>
<td>6 (1.7)</td>
</tr>
<tr>
<td>Compulsive gambling</td>
<td>1 (1.8)</td>
<td>9 (2.0)</td>
<td>4 (1.1)</td>
<td>2 (0.6)</td>
</tr>
<tr>
<td>Alcohol and drug</td>
<td>3 (5.3)</td>
<td>14 (3.1)</td>
<td>14 (3.9)</td>
<td>7 (2.0)</td>
</tr>
<tr>
<td>Drug and compulsive gambling</td>
<td>1 (1.8)</td>
<td>1 (0.2)</td>
<td>4 (1.1)</td>
<td>2 (0.6)</td>
</tr>
<tr>
<td>Alcohol and compulsive gambling</td>
<td>1 (1.8)</td>
<td>10 (2.2)</td>
<td>3 (0.8)</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Alcohol, Drug and Compulsive Gambling</td>
<td>0 (0.0)</td>
<td>7 (1.6)</td>
<td>6 (1.7)</td>
<td>3 (0.8)</td>
</tr>
<tr>
<td>At least one issue of dependence</td>
<td>57 (16.1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependence issues in only one parent</td>
<td>108 (30.4)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Frequency (Percentage)</th>
<th>Mean duration in years (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>18 (31.6)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>2 (3.5)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Cannabis</td>
<td>0 (0.0)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0 (0.0)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>0 (0.0)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Opiates</td>
<td>4 (1.1)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Alcohol/spirits</td>
<td>6 (1.7)</td>
<td>17.64 (12.07)</td>
</tr>
</tbody>
</table>

### Table 5
Number and percentage of participants by history of substance use and substance of choice (N = 355)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency (Percentage)</th>
<th>Mean duration in years (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of substances used</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only form of substance used</td>
<td>13 (3.7)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>2 (0.6)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>0 (0.0)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Cannabis</td>
<td>0 (0.0)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0 (0.0)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>0 (0.0)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Opiates</td>
<td>4 (1.1)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Sedatives</td>
<td>1 (0.3)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Solvents</td>
<td>0 (0.0)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Alcohol/spirits</td>
<td>6 (1.7)</td>
<td>17.64 (12.07)</td>
</tr>
<tr>
<td>Preferred substance + other(s)</td>
<td>335 (94.4)</td>
<td>14.78 (8.67)</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>299 (85.9)</td>
<td>14.78 (8.67)</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>240 (69.0)</td>
<td>14.78 (8.67)</td>
</tr>
<tr>
<td>Cannabis</td>
<td>305 (87.6)</td>
<td>14.78 (8.67)</td>
</tr>
<tr>
<td>Cocaine</td>
<td>220 (63.2)</td>
<td>14.78 (8.67)</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>242 (69.5)</td>
<td>14.78 (8.67)</td>
</tr>
<tr>
<td>Opiates</td>
<td>309 (88.8)</td>
<td>14.78 (8.67)</td>
</tr>
<tr>
<td>Sedatives</td>
<td>281 (80.7)</td>
<td>14.78 (8.67)</td>
</tr>
<tr>
<td>Solvents</td>
<td>55 (15.8)</td>
<td>14.78 (8.67)</td>
</tr>
<tr>
<td>Alcohol/spirits</td>
<td>283 (81.3)</td>
<td>14.78 (8.67)</td>
</tr>
<tr>
<td>Missing</td>
<td>7 (2.0)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>355 (100.0)</td>
<td></td>
</tr>
</tbody>
</table>

Substance of choice

| Stimulants                        | 36 (10.1)             | 11.12 (6.76)               |
| Amphetamines                      | 35 (9.9)              | 10.92 (6.75)               |
| Cocaine                           | 1 (0.3)               | 18 (na)                    |
| Depressants                        | 293 (82.5)            | 15.21 (8.97)               |
| Cannabis                          | 20 (5.6)              | 16.71 (10.72)              |
| Opiates                            | 235 (66.2)            | 14.73 (8.53)               |
| Sedatives                         | 6 (1.7)               | 11.67 (7.0)                |
| Alcohol                           | 32 (9.0)              | 18.38 (10.62)              |
| Mixed (Stimulants/Depressants)    | 14 (3.9)              | 19.44 (5.96)               |
| Unmentioned                        | 12 (3.4)              | 0 (0.0)                    |

Note. Percentage figures contained within parentheses.
4.2.2 Materials

The following section describes each component of the survey pack that was provided to each participant. The survey is made up of the demographics section, as well as the questionnaires described below.

**Demographics.** This section is designed to capture each participant’s demographic details, which include: substance use history; substance of choice; education and employment history; mental health history; relevant family and interpersonal relationship details; information about their current and treatment history. Additionally, a non-compulsory subsection was included to assess the presence and nature of abuse in the participant’s life. Given the sensitive nature of disclosing this information, participants were reminded verbally and in print that the survey was anonymous and that any disclosure was entirely unidentifiable.

**Severity of Dependence Scale (SDS; Gossop, et al., 1995).** The SDS is a five-item, 16-point scale for measuring the psychological components of substance dependence, specifically related to impaired control over and preoccupation, and anxiety toward substance taking. This scale was included in the study to provide an assessment of the

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Table 6
*Number and percentage of participants by current treatment-related information (N = 355)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number and Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean number of treatment sessions (SD)</td>
<td>44.87 (120.16)</td>
</tr>
<tr>
<td>Mean duration of therapy for substance issues in years (SD)</td>
<td>6.03 (5.84)</td>
</tr>
<tr>
<td>Motivation for seeking treatment</td>
<td></td>
</tr>
<tr>
<td>“I want to get better”</td>
<td>238 (67)</td>
</tr>
<tr>
<td>“Someone asked me to seek help”</td>
<td>8 (2.3)</td>
</tr>
<tr>
<td>Under legal obligation</td>
<td>5 (1.4)</td>
</tr>
<tr>
<td>Other reasons</td>
<td>31 (8.7)</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>73 (20.6)</td>
</tr>
<tr>
<td>Total</td>
<td>355 (100)</td>
</tr>
</tbody>
</table>

*Note.* Percentage figures contained within parentheses unless otherwise stated.
degree of dependence one experiences with their substance and assist with clarification of the findings. It has been validated across a range of drug using groups, including heroin, cannabis, cocaine, amphetamine and benzodiazepine users (de las Cuevas, Sanz, de la Fuente, Padilla, & Berenguer, 2000; Gossop, et al., 1995; G. Martin, Copeland, Gates, & Gilmour, 2006). Although originally designed as a measure of dependency for illicit drug classes, the SDS has since been demonstrated to be a valid and reliable measure of alcohol dependence (Ferri, Marsden, de Araujo, Laranjeira, & Gossop, 2000; Gossop, Marsden, & Stewart, 2002).

Studies among heroin, amphetamine and cocaine users have shown the SDS to be a reliable measure of psychological dependence, and it has been found to have good internal consistency (Cronbach’s alpha ranging from .80 to .90) and good test-retest reliability (.89) over a one-day interval in a sample of heroin users (Gossop, Best, Marsden, & Strang, 1997; Gossop, et al., 1995). In addition, the construct validity of the SDS has been supported by significant correlations with behavioural indices of dependence including dose, frequency and duration of use (Darke, Ross, & Hall, 1996).

Although higher scores on the SDS indicate more problematic use, and lower scores, less problematic use, cut-off scores have been established in various studies in Australia. Besides being shown to have high diagnostic utility, a score of greater than 4 on the scale is indicative of problematic amphetamine use (Topp & Mattick, 1997); an optimal cut-off of 3 or more for cannabis dependence (Swift, Copeland, & Hall, 1998); scores greater than or equal to 3 as indicative of benzodiazepine dependence, and greater than 4 for heroin (Ross & Darke, 1997); optimal discrimination between the presence and absence of a DSM-IV diagnosis of cocaine dependence at a score of 3 or more (Kaye & Darke, 2002); and an SDS score of 3 or above as optimal for characterising alcohol
dependence (Lawrinson, Copeland, Gerber, & Gilmour, 2007). See Appendix A, under “2. Substance of Choice, (i) to (v)”, for SDS items.

The five items of the SDS were reworded by replacing the word “drug” with “preferred substance” so that the scale would be applicable to both alcohol and drugs. The SDS was incorporated into the demographics section following questions about a participant’s substance of choice. Totalling each of the five item scores derived an SDS total score. Higher SDS total scores indicate more severe substance dependence.

Attachment to Primary Caregiver

Experiences in Close Relationships Scale (ECR; Brennan, et al., 1998). The ECR, as introduced above, was selected to measure the participants’ self-reported attachment to their primary caregiver established in childhood. Coefficient alphas were attained from the study: Attachment Anxiety ($\alpha = .92$) and Attachment Avoidance ($\alpha = .89$). Higher scores on Attachment Anxiety reflect greater anxiety, while higher scores on Attachment Avoidance reflect greater avoidance. Given the likelihood of a high prevalence of severe forms of attachment patterns in the current clinical sample, high scores on both the anxiety and avoidance dimensions can theoretically be interpreted as an adequate index of fearful avoidance attachment (See Appendix A for the ECR).

Attachment to Therapist

Client Attachment to Therapist Scale (CATS; Mallinckrodt, et al., 1995). Also introduced above, the CATS was used to access each participant’s conscious patterns of relating toward their own therapists. Coefficient alphas were attained from the study: Secure ($\alpha = .88$), Preoccupied-Merger ($\alpha = .86$), and Avoidant-Fearful ($\alpha = .88$). Higher scores indicate more Secure, Preoccupied-Merger, and Avoidant-Fearful attachments to their therapists (See Appendix A for the CATS).
Attachment to Substance

Attachment to Substance of Choice Questionnaire (ASCQ). Developed as part of the current study, the ASCQ’s (modified Reciprocal Attachment Questionnaire [RAQ]; M. L. West & Sheldon-Keller, 1994) readability and use with the substance dependent population was previously clarified by running an informal pilot-test of the questionnaire with a small group of patients attending the specialist addictions clinic, as well as clinic staff. The ASCQ was also put through a Readability Consensus Calculator consisting of eight readability formulas, which scored a Grade Level: Three, classified as “easy to read”, and suitable for readers aged eight to nine years old. Prior to adopting the RAQ as the foundation for the ASCQ, appropriate permission was given by its author, Dr Malcolm West.

Instructions in the RAQ were re-worded to be appropriate for assessing one’s attachment to substance with the substance dependent population. Participants were instructed to think of “how you feel about the relationship you have with your preferred substance”, as opposed to “attachment figure”, which would be more meaningful in the context of what substance the participant had in mind. Individual items were also modified to be relevant to the theme of its subscale and consistent with the above instructions. For example, Item 7 in the ASCQ was revised from, “When I’m upset, I am confident my attachment figure will be there to listen to me” to “When I’m upset, I am confident my substance of choice will soothe me.” In addition, an item in the RAQ had to be totally replaced to preserve relevance. “I talk things over with my attachment figure”, was replaced with Item 10, “The relationship with my substance of choice is my only source of security.”
By incorporating the feedback received from the pilot, the resultant questionnaire is a brief, 15-item ASCQ, which fits on a single page. The order of the items is identical to the RAQ when the items are arranged in ascending order. Reverse worded items are marked with an “*”. A summary of its scale items can be found in Table 7.

Table 7
ASCQ Scale Items

<table>
<thead>
<tr>
<th>Scale</th>
<th>Item No.</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feared Loss</td>
<td>9</td>
<td>I have a terrible fear that I will have to get rid of my substance of choice for good.</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>I’m afraid that I will lose access to my substance of choice.</td>
</tr>
<tr>
<td></td>
<td>*13</td>
<td>I’m confident that use of my substance of choice will always make me feel like I’m loved and accepted.</td>
</tr>
<tr>
<td>Separation Protest</td>
<td>*2</td>
<td>I don’t object when I cannot get access to my substance of choice for a few days.</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>I feel uncomfortable going away and leaving my substance of choice behind for a few days.</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>I feel vulnerable when I am away from my substance of choice for a few days.</td>
</tr>
<tr>
<td>Proximity Seeking</td>
<td>6</td>
<td>I have to have my substance of choice when I’m upset.</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>I feel lost if I’m upset and my substance of choice is not around.</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>When I am anxious, I desperately need to have my substance of choice close to help me feel better.</td>
</tr>
<tr>
<td>Minimal Use of the Substance</td>
<td>*1</td>
<td>I turn to my substance of choice for many things, including comfort and reassurance.</td>
</tr>
<tr>
<td></td>
<td>*10</td>
<td>The relationship with my substance is my only source of security.</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Things have to be really good for me to not seek my substance of choice.</td>
</tr>
<tr>
<td>Availability of the Substance</td>
<td>*3</td>
<td>I’m confident that my substance of choice will give me a feeling like I’m being understood.</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>I worry that turning to my substance of choice will let me down.</td>
</tr>
<tr>
<td></td>
<td>*7</td>
<td>When I’m upset, I am confident my attachment figure will soothe me.</td>
</tr>
</tbody>
</table>

* reverse scored

**Intended Population.** The ASCQ has been adapted from the RAQ as a self-report measure for male and female adults aged 18 onwards, in the evaluation of the substance dependent individual’s attachment to their substance of choice. Currently, there is no
ceiling for age appropriateness as the development of the ASCQ is exploratory in nature. It has been designed for specific use with adults in the clinical population, with current substance dependence difficulties. These individuals need not meet the full criteria for substance dependence diagnoses, and the questionnaire does not target specific minorities or ethnic groups.

**Characteristics of the ASCQ.** The items of the ASCQ are contained on one side of an A4-sized sheet, preceded with instructions to indicate how much they agree with each statement. The ASCQ maintained the 5-point Likert scale of the RAQ, providing an ample range of response choice, from “1” for *strongly disagree*, to “5” for *strongly agree*. Each statement describes a certain feeling a participant has about the relationship with their preferred substance and the participant can directly mark a response indicating their level of agreement by circling one answer after each statement. The ASCQ by itself requires approximately 10 – 15 minutes to complete for most participants (See Appendix A for the ASCQ).

**ASCQ Scoring.** To obtain subscale scores, responses of reverse-worded items are first converted and subsequently, the mean of all 15 items is computed. To convert the reverse-worded items, a score of 1 is changed to 5, a score of 2 is changed to 4, a score of 4 is changed to 2, and a score of 5 is changed to 1. To obtain subscale scores, the responses of the reverse-worded items are first converted and the mean of the items making up that scale is then computed.

**Operationalisation of ASCQ Constructs.** Like the RAQ, high scores on each subscale indicate more difficulties with each construct dimension (i.e., Feared Loss, Separation Protest, Proximity Seeking, Minimal Use of the Substance, and Availability of the Substance). For example, high scores on *Availability* indicate low perceived reliability
of the substance of choice to be accessible and able to provide its attachment security-enhancing effects. That is, the substance dependent individual would perceive their substance of choice as being unreliable and inadequately responsive to his/her needs. Low scores on each subscale, on the other hand, suggests relatively less problems regarding the dimension being measured. This means that low scores on say, Availability, can be interpreted as the substance dependent individual perceiving the substance of choice as being highly reliable and accessible.

4.2.3 Procedure

Survey Administration. The two clinics were provided with copies of the Participant Information Sheet (See Appendix B) and the anonymous survey pack. Potential participants were either approached by the researcher or asked by the respective clinic managers/receptionists to participate. In addition, individuals were informed that they were free to take a copy of the information sheet and ask questions to their satisfaction before considering participation in the study.

Each potential participant was given a brief verbal explanation of the background and purpose of the study, confidentiality/anonymity issues, and what the survey assesses. The survey was then administered in an informal setting in the clinic reception area while participants waited for their appointments. Although the testing environment was not optimal in that the clinic can be noisy and crowded on some days, efforts were made to preserve confidentiality and privacy. Participants were handed clipboards and pens, and asked if they would like to sit in a quiet corner where they would not be disturbed. To minimise selection bias and inadvertent exclusion, every patient/client who attended the clinics were approached. Although exposure to the content of the survey pack should not cause undue distress, participants were informed that participation was voluntary and they
could approach the person in-charge for debriefing or they could decide to withdraw from the study.

Participants were each given an anonymous survey pack and were told by the respective clinic receptionists to read the Information Sheet, and explained that submission of the survey was deemed as having given their consent. Next, participants were instructed not to discuss any of their answers with others while completing the pack. They were told to read instructions and individual items carefully, and circle the most appropriate and immediate response per their experiences. Participants were reminded not to spend a great deal of time thinking about their answers. Before they began working on the pack, participants were told that survey submission involved insertion of the completed survey into a secure box.

In an extraordinary circumstance, whereby one participant had reading difficulties, but expressed interest to participate in the research, permission was sought from the individual to read out the items and record down her responses so as not to exclude interested respondents. This was carried out in an outdoor courtyard where no one could hear her responses or identify her as a participant. To prevent duplicate entries, participants were told not to participate in the study if they had already done so. Per feedback from the respective clinic staff, there were no significant issues reported from participants regarding the survey administration process.

4.2.4 Data Preparation

Data Coding and Entry. Each individual survey was assigned a unique Participant Number and labelled on the top right-hand corner. The Participant Number was designed as a running number beginning from 1001, followed by 1002, 1003, so on and so forth. This ensured that each survey could easily be recorded in a database, and hastened the
process of data entry and subsequent access to individual cases. Survey data were entered into a central SPSS database daily. Demographic information and item responses were entered into textboxes and translated into list-box options (where available) using the SPSS Value Labels function ready for a mouse-click selection. Following this, data entry responses were verified with the corresponding survey as an initial screen for data entry errors.

_Data Checking Protocol and Preparation._ To ensure that data was correctly entered, a crosscheck protocol was established. Every 10th survey in the SPSS database was singled out for crosschecking with the corresponding survey. Incorrectly entered surveys had their Participant Numbers noted and nature of the error recorded, then a backcheck and forward-check of three surveys either side of the erroneous entry was carried out. Updated database files were also crosschecked weekly. Prior to data analysis, the entire dataset was screened to locate missing values. In totality, minimal errors in the dataset were found (error rate < 1%).

_Missing and Disruptive Responses._ There were instances where not all of the items of the survey pack were completed. Furthermore, each component of the questionnaire suite (e.g., ASCQ, ECR or CATS) had several missing or disruptive responses. Each survey pack was then examined for unanswered items and tallied. If the non-responses totalled more than 50% of the total number of items for a single questionnaire component (e.g., ECR: > 18 items), and the ASCQ was deemed inadequately complete, then the entire survey pack was considered invalid. Examined questionnaire components with obvious item response patterns, or single or central response tendencies were considered invalid as well. Using these criteria for data exclusion, 34 participants (9.6% of the total sample) were omitted from ASCQ factor analyses, while 141 participants (31.3% of the total
sample) were omitted from subsequent path analyses as they were unable to adequately complete all three questionnaires.

4.2.5 Analytical Strategy

Statistical analyses were conducted using IBM Statistical Package for the Social Sciences (SPSS) Statistics Version 21.0 for the Macintosh and IBM SPSS Analysis of Moment Structures (AMOS) Version 20.0 for Windows. A Confirmatory Factor Analysis (CFA) was run to clarify the number of factors for the ASCQ, and the resulting ASCQ model was analysed by structural equation modelling to investigate mediation effects. Preliminary analyses conducted are presented below.

4.2.5.1 CFA Data Screen

Handling Missing Data. The ASCQ dataset was screened for missing data. Figure 3 displays the composition of suitable cases for statistical analysis. Before accepting the current sample as being adequate for analysis (N = 321), appropriate management of missing data, examination of outliers and the sample distribution must take place. SPSS MVA (Missing Values Analysis) was used to highlight patterns of missing values, as well as to assist in deciding how to manage them in the dataset. Summaries of estimated means and standard deviations were plausible, and extreme cases expected.

Given that there were no variables with 5% or more missing values, there is no systematic relationship between missingness and any of the variables. Missing patterns were unremarkable in that patterns with less than 5% cases (16 or fewer) are not displayed. In addition, Little’s MCAR (Missing Completely At Random) test of whether the data are missing completely at random is statistically nonsignificant (p = .37), indicating that the probability that the pattern of missing diverges from randomness is greater than chance, so MCAR may be inferred (Tabachnick & Fidell, 2007).
Considering the random distribution of missing values and the remaining sample size \( (N = 321) \), estimating missing values is preferred over deletion to preserve the naturalness of the sample distribution for outlier detection (Tabachnick & Fidell, 2007). Following EM imputation from the MVA, a comparison of variable means and standard deviations of the original data to those same values after data estimation using EM procedures, shown no noticeable differences. A case-by-case inspection of the ASCQ dataset did not reveal any cases that may not be from the intended population.

**Managing Outliers.** By running box plots, a total of 14 potential univariate outliers were identified and retained on the basis that their standardised scores \( (z\text{ scores}) \) were not more than 3.29 \( (p < .001, \text{ two-tailed test}) \) and they were too few to have a significant impact on subsequent analysis (4.5% of the sample). Finally, six multivariate outliers were identified through Mahalanobis distances with \( p < .001, \chi^2 (15) = 37.697, \) and the decision was made to retain them when the final CFA showed no obvious decline in model fit, on inclusion of these cases. Additionally, upon individual examination, these cases were considered a legitimate part of the sample. Given that the ASCQ dataset had undergone intensive data checking procedures to eliminate extreme cases prior to data screening, the remaining number of cases \( (N = 321) \) is considered adequate to achieve the reliable measurement of correlation coefficients (Tabachnick & Fidell, 2007).

**Normality and Linearity Assumptions.** Based on graphical comparisons of \( z \) scores and descriptive statistics of skewness and kurtoses, there were some deviations from normality that were considered insufficient to make a substantive difference in the analysis. As substance abuse populations tend to be nonnormally distributed (Tabachnick & Fidell, 2007), some skewness and kurtoses in the sample are expected. Therefore, transformation is considered unnecessary as it might affect the naturalness of the data and
may threaten interpretation. Presenting a good sample size (> 300), the resulting dataset was thus considered suitable for analysis.

4.2.5.2 **SEM Data Screen and Preparation**

*Missing Data.* As reflected in Figure 3, 214 (47.6% of the entire sample) participants remained after measures were applied to prevent data contamination for this section of the analysis. SPSS MVA was used to examine the path analysis sample. Of this sample, 162 (75.7%) did not have any missing values while 52 (24.3%) cases were incomplete, specifically: groups of 45 cases (< 27% missing), and 7 cases (between 27 – 34% missing) were acceptable and within expectation. As anticipated, separate variance t-tests revealed six variables (namely, Items 24, 25, 26, 29, 34, and 35 of the CATS) near the end of the questionnaire suite that contained more than 5% missing responses. Given that Little’s MCAR test was statistically significant ($p = .04$), and that all six items were statistically nonsignificant (> .05) as indicated by the separate variance t-tests, MAR (missing at random, or ignorable nonresponse) can be inferred (Tabachnick & Fidell, 2007). Given that scores are MAR and there were no observably remarkable configurations of missing values, use of the EM imputation algorithm is permitted and considered appropriate for SEM (Tabachnick & Fidell, 2007).

*Outlier Detection.* The entire dataset (i.e., ASCQ, ECR and CATS) was screened for both univariate and multivariate outliers. Eight potential univariate outliers were identified by means of inspecting box plots, one of which had a $z$ score of 3.46 (> 3), and another happened to also be a multivariate outlier, was found with Mahalanobis distance, $p < .001$, $\chi^2 (7) = 24.322$. All eight outliers were retained in the sample given that including them in the path analyses yielded similar results in the final model.
Figure 3. Prisma Flow Diagram depicts number of participants approached, participated, discontinued, and the final statistical sample.

**Normality Assumptions.** Anticipating problems with skewness and kurtosis with item distributions in our substance use population, item parcelling was adopted to assist with normal distribution (Little, Cunningham, & Shahar, 2002). Item parcels were used to create latent variables of attachment to cancel out random and systematic error by aggregating across these errors (Cantazaro & Wei, 2010). Acceptable skew and kurtotic values of the generated item parcels are presented below in Table 8. In addition, correcting for standard error and fit statistic bias that occurs in structural equation modelling applications due to non-normal data (Enders, 2005), the Bollen-Stine bootstrap \( p \) function (where a non-significant \( p \) is desirable) was used to adjust for non-normality when testing for model fit; therefore, transformations were unnecessary.

**Latent Variables.** Latent attachment variables in the present study were created with multiple measured variables (i.e., indicators) for each construct to remove measurement error. Exploratory factor analysis was first conducted for the subscales of
the ECR, ASCQ, and CATS by using the maximum-likelihood method with a single factor extraction. The magnitude of the factor loadings was rank-ordered from highest to lowest. To equalise the loadings for each parcel on its respective factor, the highest- and lowest-ranking items were successively assigned as pairs into each parcel. Therefore, a total of three parcels were created for each latent variable in the model. This procedure was chosen over other methods of parcelling as it should result in item parcels that reflect the underlying construct to an equal degree (Russell, Kahn, Spoth, & Altmaier, 1998).
Table 8
*Skew and kurtotic values of the measured variables (N = 214)*

<table>
<thead>
<tr>
<th>Measure and Variable</th>
<th>Skewness (C. R.)</th>
<th>Kurtosis (C. R.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ECR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attachment Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parcel 1 (ecrAnx1)</td>
<td>.03 (.17)</td>
<td>-.26 (-.76)</td>
</tr>
<tr>
<td>Parcel 2 (ecrAnx2)</td>
<td>.03 (.17)</td>
<td>-.35 (-1.1)</td>
</tr>
<tr>
<td>Parcel 3 (ecrAnx3)</td>
<td>.11 (.68)</td>
<td>-.55 (-1.64)</td>
</tr>
<tr>
<td>Attachment Avoidance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parcel 1 (ecrAvd1)</td>
<td>.14 (.83)</td>
<td>.01 (.02)</td>
</tr>
<tr>
<td>Parcel 2 (ecrAvd2)</td>
<td>.07 (.41)</td>
<td>-1.17 (-.5)</td>
</tr>
<tr>
<td>Parcel 3 (ecrAvd3)</td>
<td>.02 (.09)</td>
<td>.03 (.09)</td>
</tr>
<tr>
<td><strong>ASCQ</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insecure Attachment to Substance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parcel 1 (ascqSub1)</td>
<td>-.2 (-1.21)</td>
<td>-.68 (-2.03)</td>
</tr>
<tr>
<td>Parcel 2 (ascqSub2)</td>
<td>.1 (.6)</td>
<td>-.07 (-.21)</td>
</tr>
<tr>
<td>Parcel 3 (ascqSub3)</td>
<td>-.28 (-1.67)</td>
<td>-.42 (-1.26)</td>
</tr>
<tr>
<td><strong>CATS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parcel 1 (catsSec1)</td>
<td>-.59 (-3.54)</td>
<td>.06 (.17)</td>
</tr>
<tr>
<td>Parcel 2 (catsSec2)</td>
<td>-.35 (-2.3)</td>
<td>-.21 (-.62)</td>
</tr>
<tr>
<td>Parcel 3 (catsSec3)</td>
<td>-.42 (-2.5)</td>
<td>-.19 (-.57)</td>
</tr>
<tr>
<td>Preoccupied-Merger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parcel 1 (catsPreM1)</td>
<td>.71 (4.26)</td>
<td>.09 (.28)</td>
</tr>
<tr>
<td>Parcel 2 (catsPreM2)</td>
<td>.67 (4.03)</td>
<td>-.19 (-.57)</td>
</tr>
<tr>
<td>Parcel 3 (catsPreM3)</td>
<td>1.3 (7.74)</td>
<td>1.26 (3.75)</td>
</tr>
<tr>
<td>Avoidant-Fearful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parcel 1 (catsAvdF1)</td>
<td>.74 (4.43)</td>
<td>-.04 (-.11)</td>
</tr>
<tr>
<td>Parcel 2 (catsAvdF2)</td>
<td>.52 (3.11)</td>
<td>-.48 (-1.43)</td>
</tr>
<tr>
<td>Parcel 3 (catsAvdF3)</td>
<td>.52 (3.08)</td>
<td>-.71 (-2.13)</td>
</tr>
</tbody>
</table>

*Note.* C. R. = Critical Ratio.

Key: **ecrAnx 1, 2, 3** = three parcels from the Anxiety subscale of the Experiences in Close Relationships Scale; **ecrAvd 1, 2, 3** = three parcels from the Avoidance subscale of the Experiences in Close Relationships Scale; **ascqSub 1, 2, 3** = three parcels from the Insecure Attachment to Substance subscale of the Attachment to Substance of Choice Questionnaire; **catsSec 1, 2, 3** = three parcels from the Secure subscale of the Client Attachment to Therapist Scale; **catsPreM 1, 2, 3** = three parcels from the Preoccupied-Merger subscale of the Client Attachment to Therapist Scale; **catsAvdF 1, 2, 3** = three parcels from the Avoidant-Fearful subscale of the Client Attachment to Therapist Scale.
4.3 Results

4.3.1 Overview of the Findings

The findings are presented in two sections: (1) Confirmatory Factor Analysis (CFA) of the ASCQ, followed by (2) Testing Mediation Effects in the hypothesised model.

It was found that the ASCQ fit well as a single factor model in measuring attachment to substance of choice in the substance dependence population. Furthermore, the ASCQ was found to strongly correlate with the SDS, adding support to its validity.

Of most interest is that Insecure Attachment to Substance was found to be a significant partial mediator between Attachment Anxiety and Preoccupied-Merger attachment to therapist, thereby providing support for the expected mediation effects. However, this effect was not found for Attachment Avoidance and any style of attachment to therapist. Nevertheless, Attachment Avoidance was a significant predictor of Avoidant-Fearful attachment to therapist and was also a significant negative predictor of Secure attachment to therapist.

Thus, hypotheses (1), (2), (3), and (5) were supported, but (4) and (6) were unsupported. Still, several predictions were found providing support for the hypothesised model:

(i) Attachment Anxiety was a significant predictor of Insecure Attachment to Substance.

(ii) Insecure Attachment to Substance was a significant predictor of Preoccupied-Merger attachment to therapist.

(iii) Attachment Anxiety was a significant predictor of Preoccupied-Merger attachment to therapist.
(iv) *Attachment Avoidance* was a significant negative predictor of *Secure* attachment to therapist.

(v) *Attachment Avoidance* was a significant predictor of *Avoidant-Fearful* attachment to therapist.

Gender comparisons revealed that women differed significantly to men, in that: men had stronger associations between *Attachment Anxiety* and *Avoidant-Fearful* attachment to therapist, compared to women in the sample.

4.3.2 Confirmatory Factor Analysis (CFA) of the ASCQ

An initial CFA was conducted on the ASCQ defining the five-factor model described above, using three fit indices to assess the goodness-of-fit for the model: the root-mean-square error approximation (RMSEA; .06 or less), the Tucker-Lewis Index (TLI; .95 or greater), and the comparative fit index (CFI; .95 or greater). The analysis revealed a significant chi-square estimate ($\chi^2 = 277.067, df = 80, p < .0001$) with unsatisfactory goodness-of-fit statistics (RMSEA = .09; TLI = .85; CFI = .90), indicating poor model fit. Given that the predicted model does not fit the data, Cattell’s (1966) scree test was performed on the dataset, confirming the presence of one prominent factor. Based on this finding, another CFA was run to confirm the presence of the single factor and an item analysis was conducted.

Following an item analysis, three items (namely, *ascq2*, *ascq3*, and *ascq4*) were found to have low parameter values (< .5). On inspection of the three items, *ascq2*: “*I don’t object when I cannot get access to my substance of choice for a few days*”, appeared to be potentially confusing due to the double negative in the statement. On the other hand, *ascq3* and *ascq4*, “*I’m confident that my substance of choice will give me a feeling like I’m being understood*” and “*I worry that turning to my substance of choice will let me down*”
respectively, read as items that can be interpreted quite literally compared to the other items, and may sound meaningless to the respondent. Thus, these ambiguous items were removed. The resulting model achieved a significant chi-square estimate ($\chi^2 = 159.778, df = 50, p < .0001$) with adequate goodness-of-fit statistics (RMSEA = .08; TLI = .90; CFI = .94), demonstrating good model fit. Figure 4 presents the path diagram of the final 12-item ASCQ single-factor model.

![Figure 4. Path diagram of the 12-item ASCQ presented with standardised parameter estimates.](image)

Examining the 12-item ASCQ scale reliability/ item homogeneity derived a low (.44) Cronbach’s alpha. Given the brevity of the ASCQ and the assumption of a single factor solution (or unidimensional model; Gorsuch, 1983), a review of the psychometrics is needed to make sense of the alpha as recommended by (Boyle, 1991; Tavakol & Dennick, 2011). The 12-item factor loadings confirmed that acceptable values (.56 to .81) were representing the scale, the single factor accounted for 49.47% of the variance, and
exhibited low to moderate (.23 to .70) item inter-correlations in order to maximise the breadth of measurement of the given factor (Boyle, 1991). Having satisfactorily reviewed its factor and itemetric structure, the ASCQ “could readily have treatment utility without internal consistency…, and high internal consistency should not necessarily be expected” (Hayes, Nelson, & Jarrett, 1987, p. 972). Likewise, B. P. Allen and Potkay (1983), Lachar and Wirt (1981), and McDonald (1981) have all shown, either high or low item homogeneity can be associated with either high or low reliability, despite classical internal consistency opinion. Furthermore, it was asserted that especially in the assessment of non-ability areas (e.g., attachment, motivation, personality and mood states), low to moderate item homogeneity is actually preferred if one is to ensure a broad coverage of the particular constructs being measured (Boyle, 1991). Hence, the alpha was accepted.

The analysis yielded a single factor, labelled Insecure Attachment to Substance. Having departed from the novel, five-factor scales of the ASCQ (shared with the 15-item RAQ), the interpretation of the single scale included a systematic review of each item to examine for consistencies and assist with careful description. Additionally, the ASCQ was found to be strongly correlated with the SDS, \( r(50) = .43, p < .01 \). Hence, the following scale definition is a reasonably accurate reflection of the underlying construct measured. For a description of the derived factor scale from the analysis, see Table 9 below.

<table>
<thead>
<tr>
<th>Scores</th>
<th>Item content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher scores</td>
<td>Extent to which perceived separation evokes protest and promotes proximity seeking to the substance.</td>
</tr>
<tr>
<td>Lower scores</td>
<td>Extent to which perceived separation and inaccessibility does not evoke protest but indifference toward the substance.</td>
</tr>
</tbody>
</table>
4.3.3 Testing Mediation Effects

4.3.3.1 Measurement Model

A two-step process for the analysis of structural equation models was adopted (Anderson & Gerbing, 1988): (a) conducting a CFA to determine whether a measurement model has an acceptable fit to the data, and then (b) conducting an analysis for the structural model to test the mediation hypothesis. Three fit indices were used to assess the goodness-of-fit for the model: the comparative fit index (CFI; .95 or greater), the root-mean-square error approximation (RMSEA; .06 or less), and the standardised root-mean-square residual (SRMR; .08 or less).

The test of the measurement model resulted in a good fit to the data ($N = 214; \chi^2 = 267.72, df = 120, p < .0001$, Bollen-Stine bootstrap $p = .0001$; CFI = .95, RMSEA = .08 (90% confidence interval [CI]: .06, .09), SRMR = .06). All the factor loadings were statistically significant ($p < .001$, see Table 10). This implies that all observed variables were operationalised adequately through their respective indicators. The expected correlations among the independent latent variables (i.e., Attachment Anxiety and Attachment Avoidance), the mediating latent variable (i.e., Insecure Attachment to Substance), and dependent latent variables (i.e., Secure, Preoccupied-Merger, and Avoidant-Fearful) were statistically significant ($p < .001$, see Table 11). Therefore, the latent variables in the measurement model were used to test the structural model.
Table 10

Factor Loadings for the Measurement Model (N = 214)

<table>
<thead>
<tr>
<th>Measure and Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unstandardised Factor Loadings</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td><strong>ECR</strong></td>
</tr>
<tr>
<td>Attachment Anxiety</td>
</tr>
<tr>
<td>Parcel 1 (ecrAnx1)</td>
</tr>
<tr>
<td>Parcel 2 (ecrAnx2)</td>
</tr>
<tr>
<td>Parcel 3 (ecrAnx3)</td>
</tr>
<tr>
<td>Attachment Avoidance</td>
</tr>
<tr>
<td>Parcel 1 (ecrAvd1)</td>
</tr>
<tr>
<td>Parcel 2 (ecrAvd2)</td>
</tr>
<tr>
<td>Parcel 3 (ecrAvd3)</td>
</tr>
<tr>
<td><strong>ASCQ</strong></td>
</tr>
<tr>
<td>Insecure Attachment to Substance</td>
</tr>
<tr>
<td>Parcel 1 (ascqSub1)</td>
</tr>
<tr>
<td>Parcel 2 (ascqSub2)</td>
</tr>
<tr>
<td>Parcel 3 (ascqSub3)</td>
</tr>
<tr>
<td><strong>CATS</strong></td>
</tr>
<tr>
<td>Secure</td>
</tr>
<tr>
<td>Parcel 1 (catsSec1)</td>
</tr>
<tr>
<td>Parcel 2 (catsSec2)</td>
</tr>
<tr>
<td>Parcel 3 (catsSec3)</td>
</tr>
<tr>
<td>Preoccupied-Merger</td>
</tr>
<tr>
<td>Parcel 1 (catsPreM1)</td>
</tr>
<tr>
<td>Parcel 2 (catsPreM2)</td>
</tr>
<tr>
<td>Parcel 3 (catsPreM3)</td>
</tr>
<tr>
<td>Avoidant-Fearful</td>
</tr>
<tr>
<td>Parcel 1 (catsAvdF1)</td>
</tr>
<tr>
<td>Parcel 2 (catsAvdF2)</td>
</tr>
<tr>
<td>Parcel 3 (catsAvdF3)</td>
</tr>
</tbody>
</table>

Note. C. R. = Critical Ratio.

Key: *ecrAnx 1, 2, 3* = three parcels from the Anxiety subscale of the Experiences in Close Relationships Scale; *ecrAvd 1, 2, 3* = three parcels from the Avoidance subscale of the Experiences in Close Relationships Scale; *ascqSub 1, 2, 3* = three parcels from the Insecure Attachment to Substance subscale of the Attachment to Substance of Choice Questionnaire; *catsSec 1, 2, 3* = three parcels from the Secure subscale of the Client Attachment to Therapist Scale; *catsPreM 1, 2, 3* = three parcels from the Preoccupied-Merger subscale of the Client Attachment to Therapist Scale; *catsAvdF 1, 2, 3* = three parcels from the Avoidant-Fearful subscale of the Client Attachment to Therapist Scale.

**p < .001.
Table 11  
**Correlations Among Latent Variables for the Measurement Model (N = 214)**

<table>
<thead>
<tr>
<th>Latent Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attachment Anxiety</td>
<td>4.06 (1.22)</td>
<td>.92</td>
<td>.24**</td>
<td>.43**</td>
<td>-.08**</td>
<td>.41**</td>
</tr>
<tr>
<td>2. Attachment Avoidance</td>
<td>3.88 (1.09)</td>
<td>.89</td>
<td>.21**</td>
<td>-.20**</td>
<td>.15**</td>
<td>.28**</td>
</tr>
<tr>
<td>3. Insecure Attachment to Substance</td>
<td>3.05 (0.47)</td>
<td>.44</td>
<td>-.11**</td>
<td>.37**</td>
<td>.16**</td>
<td></td>
</tr>
<tr>
<td>4. Secure</td>
<td>4.18 (0.98)</td>
<td></td>
<td>.88</td>
<td>-.19**</td>
<td>-.80**</td>
<td></td>
</tr>
<tr>
<td>5. Preoccupied-Merger</td>
<td>2.38 (1.04)</td>
<td></td>
<td></td>
<td>.86</td>
<td>.49**</td>
<td></td>
</tr>
<tr>
<td>6. Avoidant-Fearful</td>
<td>2.46 (1.03)</td>
<td></td>
<td></td>
<td></td>
<td>.88</td>
<td></td>
</tr>
</tbody>
</table>

**Note.** Means presented with standard deviations in parentheses, and Cronbach alphas in bold.  
**p < .001 (two-tailed).**

4.3.3.2 **Structural Model**

The hypothesised model presented below in the path diagram with item parcels defining each latent variable (refer to Figure 5) is a saturated model (i.e., examining all the possible paths); hence, as expected, the fit indices are identical to those reported in the above measurement model. Observed variable reliabilities ranged from .76 to .96. A summary of the path coefficients is displayed in Table 12.
Table 12
Path coefficients for the Structural Model (N = 214)

<table>
<thead>
<tr>
<th>Path Coefficients</th>
<th>Unstandardised Estimates</th>
<th>Standardised Estimates</th>
<th>SE</th>
<th>C.R.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ecrAnx → ascqSub</td>
<td>.29</td>
<td>.40</td>
<td>***</td>
<td>.05</td>
</tr>
<tr>
<td>ecrAvd → ascqSub</td>
<td>.09</td>
<td>.11</td>
<td>.06</td>
<td>1.53</td>
</tr>
<tr>
<td>ascqSub → catsSec</td>
<td>-.07</td>
<td>-.07</td>
<td>.09</td>
<td>-.79</td>
</tr>
<tr>
<td>ascqSub → catsPreM</td>
<td>.28</td>
<td>.24</td>
<td>**</td>
<td>.09</td>
</tr>
<tr>
<td>ascqSub → catsAvdF</td>
<td>.07</td>
<td>.06</td>
<td>.09</td>
<td>.69</td>
</tr>
<tr>
<td>ecrAvd → catsSec</td>
<td>-.17</td>
<td>-.19</td>
<td>*</td>
<td>.07</td>
</tr>
<tr>
<td>ecrAvd → catsPreM</td>
<td>.03</td>
<td>.03</td>
<td>.07</td>
<td>.41</td>
</tr>
<tr>
<td>ecrAvd → catsAvdF</td>
<td>.22</td>
<td>.23</td>
<td>**</td>
<td>.07</td>
</tr>
<tr>
<td>ecrAnx → catsSec</td>
<td>-.003</td>
<td>-.004</td>
<td>.07</td>
<td>-.04</td>
</tr>
<tr>
<td>ecrAnx → catsPreM</td>
<td>.26</td>
<td>.30</td>
<td>***</td>
<td>.07</td>
</tr>
<tr>
<td>ecrAnx → catsAvdF</td>
<td>.12</td>
<td>.14</td>
<td>.07</td>
<td>1.73</td>
</tr>
</tbody>
</table>

Note. ecrAnx = Attachment Anxiety; ecrAvd = Attachment Avoidance; ascqSub = Insecure Attachment to Substance; catsSec = Secure; catsPreM = Preoccupied-Merger; catsAvdF = Avoidant-Fearful.

*** p < .001 (two-tailed).
**  p < .01   (two-tailed).
  p < .05   (two-tailed).
Figure 5. Hypothesised model with standardised path coefficients and item parcels. Significant paths in parentheses. **Key:** ecrAnx 1, 2, 3 = three parcels from the Anxiety subscale of the Experiences in Close Relationships Scale; ecrArd 1, 2, 3 = three parcels from the Avoidance subscale of the Experiences in Close Relationships Scale; ascqSub 1, 2, 3 = three parcels from the Insecure Attachment to Substance subscale of the Attachment to Substance of Choice Questionnaire; catsSec 1, 2, 3 = three parcels from the Secure subscale of
Using the causal steps approach (Baron & Kenny, 1986) for demonstrating mediation, the results suggest a possible mediation between clients’ Attachment Anxiety (ecrAnx) and Preoccupied-Merger attachment to therapist (catsPreM) through Insecure Attachment to Substance (ascqSub). To examine whether mediation occurred, a subset of the hypothesised model was extracted and tested: ecrAnx (independent variable), ascqSub (mediator), and catsPreM (dependent variable). The steps are presented in Figure 6 below. In addition, the bootstrap method for testing the level of significance for indirect effects (e.g., Mallinckrodt, Abraham, Wei, & Russell, 2006; Shrout & Bolger, 2002) was used to supplement the causal steps in deriving the 95% confidence interval (CI) for a total of 2,000 bootstrap samples.

**Figure 6.** Standardised coefficients for the relationship between Attachment Anxiety (ecrAnx) and Preoccupied-Merger (catsPreM; $R^2 = .82$) by Insecure Attachment to Substance (ascqSub; $R^2 = .85$). The standardised coefficient between Attachment Anxiety and Preoccupied-Merger controlling for Insecure Attachment to Substance is in parentheses.

**p < .001; * p < .01

Prior to examining mediation, the conditions (a), (b), and (c) were met: Attachment Anxiety was a significant predictor of Insecure Attachment to Substance (a) and of Preoccupied-Merger attachment to therapist (c), and Insecure Attachment to Substance was a significant predictor of Preoccupied-Merger attachment to therapist (b). As expected, ascqSub was found to partially mediate the relationship between ecrAnx and catsPreM. The
indirect effect of Attachment Anxiety on Preoccupied-Merger through Insecure Attachment to Substance (95% CI [.04, .20], $\beta = .43 \quad 24 = .10$, $p < .05$) was significant. Based on the significant path coefficients and mediation found, hypotheses (1), (2) and (3) were supported.

Even though mediation could not be found between Attachment Avoidance and any style of attachment to therapist through Insecure Attachment to Substance, Attachment Avoidance was a significant predictor of Avoidant-Fearful attachment to therapist and was also a significant negative predictor of Secure attachment to therapist.

4.3.3.3 Gender Comparisons

Means and standard deviations for male and female participants were first compared. Findings showed that equal variances should be assumed over all variables (Levene’s Test of Equality of Variances; > .05). An independent samples t-test for Equality of Means conducted revealed that two variables, Secure Attachment to Therapist (catsSecure) and Avoidant Fearful Attachment to Therapist (catsAvdFearful), had means that differed significantly ($p < .05$) between males and females.

The final model (as hypothesised) was used to examine the invariance of path coefficients for structural paths by conducting a multiple-group comparison analysis for women ($n = 95$) and men ($n = 119$). The two models were compared, one in which the path coefficients were allowed to vary, and one in which the path coefficients were constrained to be equal for women and men. The chi-square difference test was used to determine whether these two were equivalent. The results indicated a significant difference, $\Delta \chi^2 (23, N = 214) = 40.71, p = .01$, between these two models, implying that the path coefficients were significantly different for women and men. Thus, examination of specific paths was conducted by way of pairwise parameter comparisons to look at differences for women and men. The results showed only the path coefficient from Attachment Anxiety to Avoidant-Fearful attachment to therapist was significantly different, C.R. = -2.54, $p < .05$, for women
and men. Specifically, the association between Attachment Anxiety and Avoidant-Fearful attachment to therapist was stronger for men ($\beta = .27, p < .01$) than for women ($\beta = -.12, p > .05$).

4.4 Discussion

The purpose of the current study was to introduce a model of attachment to substance and explore its impact on the therapeutic relationship for substance dependent individuals, by way of examining concurrent predictors or associations. Specifically, an attempt was made to conceptualise an individual’s attachment to their substance of choice based on how they viewed their own patterns of substance use. Additionally, attachment was explored dimensionally along several continua, to assess global attachment based on experiences with parents/primary caregivers and attachment toward their therapist. To date, research has not empirically tested the assumptions as conceptualised in the model proposed. Implications for practice, as well as limitations and directions for future research are discussed below.

The ASCQ was found to be a useful tool in the measurement of attachment to substance of choice in a drug and alcohol dependent, clinical population. Having examined the factor structure of the ASCQ, it was found that contrary to the five-factor model originally proposed that underlies the 15-item RAQ (M. L. West & Sheldon-Keller, 1994), the attachment to substance construct was confirmed to fit best as a single-factor model, namely Insecure Attachment to Substance. The final version of the ASCQ consisted of twelve items and was shown to correlate highly with the SDS. By including the ASCQ within the proposed model, the following hypotheses were supported by the data:

1) Attachment anxiety will be positively correlated with attachment to substance.

2) Attachment anxiety will be negatively correlated with secure attachment to therapist, but positively correlated to preoccupied-merger attachment to therapist.
3) Attachment to substance will be a significant mediator of the link between attachment anxiety and preoccupied-merger attachment to therapist.

5) Attachment avoidance will be negatively correlated with secure attachment to therapist, but positively correlated to avoidant-fearful attachment to therapist.

Whilst the other hypotheses based on the global avoidant attachment dimension were unsupported:

4) Attachment avoidance will be positively correlated with attachment to substance.

6) Attachment to substance will be a significant mediator of the link between attachment avoidance and avoidant-fearful attachment to therapist.

First, prior to establishing mediation, the current findings support the predictions that: attachment anxiety will be positively correlated with attachment to substance; and that attachment anxiety will be negatively correlated with secure attachment to therapist, but positively correlated to preoccupied-merger attachment to therapist. These findings show that, consistent with our expectations of the continuity of attachment patterns throughout the lifespan, Attachment Anxiety predicted strong positive associations with an Insecure Attachment to Substance, and it followed that Insecure Attachment to Substance predicted Preoccupied-Merger attachment to therapist. The typical anxious individual (non-substance dependent) would seek the use of an object in times of need, normally an attachment figure: significant other or therapist (Mikulincer & Shaver, 2016). However, in this case, the anxious substance dependent individual would perceive to a large extent that separation from the substance evokes protest and promotes proximity seeking to the object. The results in Figure 6 indicated that an insecure attachment to substance influenced the therapeutic relationship – it predicted [to a lesser extent] Preoccupied-Merger attachment to therapist, than when it was controlled for.
Providing support for the self-medication hypothesis (Khantzian, 2001, 2004),
Insecure Attachment to Substance appeared to augment the anxious individuals’
hyperactivating strategies by upregulating their attachment system. This can be interpreted as
intensifying proximity seeking, use and dependence on the substance of choice to satisfy their
attachment needs (i.e., extent to which perceived separation evokes protest and promotes
proximity seeking toward the object). Unfortunately, as the findings suggest, it also means
that the anxious individual is likely to receive the soothing, affect regulatory effects of the
substance, and exhibit less preoccupied-merger attachment responses to their therapist.
However, it is unclear how effective these substances can truly soothe and regulate the affect
that anxious substance dependent individuals experience, given their intense need to receive
and merge with their attachment objects. This may in turn, lead to unintended over-dosing
given their zeal to be soothed by the unpredictable effects of a drug or alcohol substance.
While incomparable with an authentic, secure relationship with the therapist (who may
provide supportiveness and consistent responding), the client’s dependence on the substance
may inhibit any attempts at seeking security with the therapist.

Without the presence of an insecure attachment to substance, Mallinckrodt (2010)
described that typical anxious individuals who attempt a hyperactivating strategy can manifest
their insecurities in psychotherapy by: (i) regarding the therapist as far stronger and wiser, (ii)
seeking very close proximity through increased meeting times and an accelerated pace of
emotional self-disclosure, (iii) developing a sometimes frantic dependency on the therapist,
(iv) desperately seeking a secure base, but experiencing such a chronically high level of
anxiety that any sense of felt security is fleeting, and (v) uncontrollable panic when the
therapist seems unavailable, coupled with a powerful dread in anticipation of the planned
termination of the therapy. However, the current finding suggests that anxious clients’ hunger
for attention, care and affect regulation, may be intensified to the extent where it might be
simply easier to satiate their attachment needs by using, instead of employing magnified
hyperactivating strategies toward their therapist (Mallinckrodt, 2010). From this perspective, an unsuspecting therapist may observe the anxious client as cooperative, calm/aloof, and possibly emotionally distant, given that the client is meeting their insecure needs elsewhere (i.e., by using their substance). At worst, the anxious substance dependent individual may also be interpreted as being relatively securely attached to the therapist, and showing progress in therapy.

The current results generally support the expected mediation effects by demonstrating *Insecure Attachment to Substance* as a significant mediator between *Attachment Anxiety* and *Preoccupied-Merger* attachment to therapist. The results support the prediction that attachment to substance would mediate the association between attachment anxiety and preoccupied-merger attachment to therapist. Given that partial mediation was found, this means that an anxious individual’s insecure attachment to their substance of choice cannot completely account for the direct effect (i.e., Attachment Anxiety $\rightarrow$ Preoccupied-Merger to therapist). Nevertheless, this indicates that an anxious substance dependent individual’s insecure attachment to substance can account to a significant degree to which he/she might seek security with the substance as opposed to the therapist. In other words, the quality of the therapeutic relationship can be influenced by the presence of an insecure attachment to substance of choice, particularly for highly anxious clients. Not only does being dependent on a substance pose a threat to the establishment and use of the therapeutic attachment relationship, anxious clients’ desire for merger and consensus may lead to the use of hyperactivating strategies with their therapists. Clients like these may agree readily with their therapists about the goals and tasks of therapy, while ambivalently deviating toward their substance to meet their insecure needs.

Third, the results did not support the prediction that *Insecure Attachment to Substance* would mediate the association between *Attachment Avoidance* and *Avoidant-Fearful* attachment to therapist. Compared to anxious individuals, avoidant individuals in the present
study were not shown to significantly predict an insecure attachment to substance. Nevertheless, complementary results were found that indicated that Attachment Avoidance significantly predicted a negative association with Secure attachment to therapist, while significantly predicting a positive association with Avoidant-Fearful attachment to therapist. Consistent with findings of anxious individuals in the current study, individuals’ attachment anxiety and avoidance significantly predicted attachment to therapist, thereby bolstering support for the hypothesised model.

Being unable to demonstrate any form of mediation through Insecure Attachment to Substance for avoidant individuals in the current study is a finding of theoretical and clinical interest. Given avoidant individuals’ tendencies to suppress attachment-related thoughts and feelings in an effort to avoid heightened distress (Mallinckrodt, et al., 2009), it gave support to findings from studies that showed the association between attachment-related avoidance and self-reported symptoms of distress being mediated by the tendency to suppress emotional experience (Wei, Vogel, et al., 2005). The current findings contribute to empirical support for the existing literature on avoidant attachment defences. For example, experimental research had suggested that avoidant individuals are actually able to reduce physiological arousal when they suppress thoughts of attachment, rather than merely masking distress or denying it in self-reports (Fraley & Shaver, 1997). The avoidant individuals’ self-reported insecure attachment to substance in the current study may reflect their predominant attitudes against their own vulnerabilities regarding substance dependence. This may in turn, mask any heightened insecure attachment towards their substances for a conscious or unconscious fear of revealing their coping and self-esteem inadequacies (Mallinckrodt, et al., 2009). However, recent experimental research suggests that the capacity to suppress thoughts about a previous painful separation tends to break down when cognitive resources are otherwise taxed, resulting in a rebound of suppressed thoughts about separation and heightened access to negative self-evaluations (Mikulincer, Dolev, & Shaver, 2004). This may explain the finding
that Attachment Avoidance significantly predicts a negative association with Secure attachment to therapist, while Attachment Anxiety did not show a significant negative association to Secure Attachment to therapist.

To make sense of this discrepancy, it was possible that the avoidant individuals may inflate their self-esteem defensively in the face of attachment threats and avoid interactions that might involve intimacy or dependency (Mikulincer, et al., 2003). These self-reliant individuals tend to be unlikely candidates to volunteer participation in a process where one must engage in meaningful conversation likely to involve emotional laden issues (in an intimate psychotherapy context or a research study). In a bid to avoid these interactions that may bring about issues that are linked to problematic patterns of interpersonal relating in the first place, these might prove to be too exposing for avoidant individuals. This view is supported by the findings in the work of Mallinckrodt (2010) where typical avoidant individuals who attempt a deactivating strategy can manifest their insecurities in psychotherapy by: (i) refusing to acknowledge that the therapist may be “stronger and wise” and questioning the therapist’s expertise; (ii) rejecting proximity by missing sessions and keeping the conversation at a superficial level; refusing to allow the relationship to function as a (iii) safe haven or (iv) secure base by acting compulsively independent or self-reliant; and (v) refusing to allow the therapist to become significant enough to prompt grief or anxiety at the prospect that the relationship will end. In contrast to avoidant individuals who deactivate their attachment system and distance themselves in their therapy, anxious individuals crave attention and closeness, aspects of which may not be deemed as unsafe when displayed in therapy (Mallinckrodt, 2010). Besides, for anxious individuals, their expectation that others will be inconsistently responsive and available might be sufficient for them to allow themselves to be superficially engaged in therapy despite being soothed by their substances.

Lastly, gender comparisons found that men and women differed significantly in their levels of Secure, as well as Avoidant Fearful Attachment to Therapist. This finding bolsters
the view that given one’s dependence on their substance for attachment security, it may inhibit or disturb one’s capacity to securely attach to one’s therapist (Carse, 1998). Conceptually, Secure and Avoidant Fearful attachment to Therapist are both opposite quadrants/extremes of the attachment dimension (Mallinckrodt, 1991; Mallinckrodt, et al., 1995; Mallinckrodt, et al., 2005; Mikulincer & Shaver, 2016), possibly suggesting a fearful state of relating with their therapist. This may mean that the male or female client may not truly be “secure” with their therapist, but be displaying features of an avoidant-fearful individual – that is, difficulties using a coherent secondary attachment strategy.

Specifically, men had stronger associations between attachment anxiety and avoidant-fearful attachment to therapist, when compared to women. While there is no prior research to account for this differentiation in substance dependent individuals, it was possible that substance dependent men who were anxiously attached, depended on using substances to address their emotional issues much more than requesting and receiving support from others for assistance. This is consistent with the view that specific attachment insecurities may interfere with the integration of traditional masculine and feminine gender roles (Mikulincer & Shaver, 2016). The current finding supports previous studies that found men’s insecure attachments to parents, as well as ratings of anxiety or avoidance in close relationships, were associated with stronger conflicts regarding the “feminine” trait of emotional expressiveness (Blazina & Watkins, 2000; DeFranc & Mahalik, 2002; Mahalik, Aldarondo, Gilbert-Gokhale, & Shore, 2005; J. P. Schwartz, Waldo, & Higgins, 2004). This suggests that attachment insecurities can influence men to overidentify with traditional, rigid masculine ideologies (e.g., to fear appearing feminine). It follows that if these anxious men were shamed and received harsh earlier experiences, they may relate to their therapist in avoidant-fearful ways. Consistent with needing to appear more masculine and thus, less expressive, Mallinckrodt, et al. (1995) found that these avoidant-fearful attachment strategies took the form of distrust of the therapist, feeling unsafe or patronised, and a strong reluctance to self-disclose or become
more intimate in therapy. Nevertheless, more research is needed in the investigation of
gender on attachment and its relation to the attachment dynamics in psychotherapy.

4.5 Limitations

Taken together, the findings provide support for the hypothesised model, and suggest
some critical implications for clinical practice. However, there exist some limitations in this
study that require mention.

Firstly, the attainment of participants’ attachment patterns in all three constructs
(namely, attachment to parents/caregivers, attachment to substance, and attachment to
therapist) was measured by way of self-report questionnaires. There is a controversial debate
over the nature of assessing attachment in adult attachment research since the 1980s.
Comprehensively reviewed by Bartholomew and Shaver (1998), the assessment of attachment
grew from two distinct streams of adult attachment research – one focused on parenting, and
the other on romantic relationships – derived from different disciplinary subcultures. Besides
conceptual origins, there lies the issue that interview and self-report measures have
fundamental differences in targeted relationships (parent-child vs. adult-adult relationships),
method (intensively coded interview transcripts vs. brief self-reports), and analytic focus
(structural properties of coherence, believability, and vagueness of a person’s narrative of
attachment experiences vs. content of a person’s perceptions, feelings, and self-observed
behaviour).

Self-report measures are viewed as being unable to probe the psychodynamic depths
probed by measures such as the Adult Attachment Interview (AAI). Jacobvitz, Curran, and
Moller (2002) detailed that the AAI classification coding system assesses adults’ unconscious
processes for regulating emotion, while self-report measures tap adults’ conscious appraisals
of themselves in particular contexts. Besides its potential for biases by social desirability
concerns and other motivational and cognitive tendencies (P. R. Shaver & Mikulincer, 2004),
these researchers have inferred that due to conscious, deliberate answers to explicit questions or statements, they are probably limited to conscious mental processes. However, P. R. Shaver and Mikulincer (2002) showed that when self-report measures were used in conjunction with other kinds of measures, a great deal can be revealed about implicit, unconscious processes.

Secondly, it is unclear how much time is needed for a client under normal circumstances to develop attachment with their therapist, let alone clients with substance dependence. The participants in the current study were assessed at a particular point in time regardless of their stage of treatment, which means that some clients would have had the time to build more robust attachment relationships with their therapists compared to others, dysfunctional or not. Clients who agreed to participate may also have differed from those who declined, suggesting the possibility of self-selection. Alternatively, participants may also exhibit avoidant and unmotivated attitudes common in this population, or worse, appear to be securely attached to their therapists when in fact, they have avoidant-fearful attachment to the therapist (as found in this study). While stage of treatment may yield some interesting findings if successfully accounted for, this variable remains difficult to control since it is also dependent on the therapist’s skill in the appropriate manipulation of therapeutic distance to cater to the needs of their insecure clients’ attachment system proclivities. Given the prototypical model of attachment across the lifespan, it is also possible that these ingrained attachment patterns established from childhood might have little variability even if more time is given to develop a “secure” attachment with their therapist (Fraley, 2002, 2007; Fraley & Brumbaugh, 2004).

Thirdly, the current study did not take into account or explore any other potential mediators that may influence the substance dependent individuals’ attachment to their therapist. Given that there is always the possibility of additional mediation, shedding light on a new indirect effect can be of theoretical and practical importance regardless of the size of
the effect, and whether or not it meets the standard criteria for full mediation (Rucker, Preacher, Tormala, & Petty, 2011). Although this may be so, exploration of mediation should still be guided by theory. For example, dysfunctional relationships were highlighted as a potential mediator between women’s substance misuse and offending (Kreis, Gillings, Svanberg, & Schwannauer, 2016) – the study developed a model of the interconnection between family disconnection, dysfunctional intimate partner relationships, loss of children, and substance misuse and drug-related offending, within the context of complex trauma, insecure attachment, and shame. On a separate note, other potential mediators may provide further insights into gender comparison discrepancies. Nevertheless, this is a possible area for subsequent research that is beyond the scope of the current study.

Next, the present study did not take into consideration the notion of therapists’ own attachment styles. Studies have provided support that attachment related dynamics are present even in the first therapeutic encounter and that these dynamics are a function of client attachment, therapist attachment, and the unique combination of client and therapist attachment patterns (Daniel, 2006; Flores, 2004; Meyer & Pilkonis, 2001). Although clients’ and therapists’ internal working models of attachment may affect a number of aspects of the therapeutic process including the nature of the clients’ symptom reporting, capacity to make use of treatment, quality of alliance, treatment outcome, and in particular, transference and countertransference (Dozier, Cue, & Barnett, 1994; Fonagy, et al., 1996; Stuart & Noyes, 2006; Tyrrell, Dozier, Teague, & Fallot, 1999), the present study intentionally left the therapists’ own attachment styles out of the model to focus on aspects of the clients’ attachment toward particular attachment objects. Adding an additional layer of complexity at this stage may render it difficult to interpret the exploratory findings. These limitations though valid, constitute areas of investigation beyond the scope of the current quantitative study, and had to be excluded such that it lays the foundation for the second, more in-depth qualitative study.
Lastly, there were several methodological issues that are worth pointing out for the purposes of facilitating further studies. Given that this study utilised a cross-sectional design, data was collected at a single point in time to examine the relationship between the hypothesised variable, and other latent variables. Although rigorous efforts were made toward choosing a representative sample and ensuring a sufficiently large sample size, there is always concern of potential bias in cross-sectional studies (Tabachnick & Fidell, 2007). One such issue is the possibility of non-response, which can result in bias of the measures of outcome when the characteristics of non-responders differ from responders (Tabachnick & Fidell, 2007). This type of study is also limited in its ability to draw valid conclusions about any association or possible causality because of the presence of risk factors and outcomes that are measured simultaneously (Tabachnick & Fidell, 2007). However, given the current study’s exploratory nature, the benefits were that data on all variables only needed to be collected once, there was no need for long period of follow-up, and the cross-sectional methodology assisted with generating hypotheses for this new area of study (Hennekens & Buring, 1987).

Given that there is marked variation in the sample (which includes treatment duration as a source of variability), there were initial concerns about sampling error. However, given that others (e.g., Alaghemandan, et al., 2015) have also found a significantly high prevalence of personality problems related to their substance dependence as a potential source of variation, wide sample characteristics (including nature/severity and different treatment needs/lengths) are to be expected of addictions samples (Tabachnick & Fidell, 2007). Besides, efforts were made to minimise the potential for bias or human error in the study procedures. Hence, to preserve the naturalness of the sample, the variation of the sample was considered acceptable.

In addition, this study did not control for potential confounders in the data such as age or background SES (Tabachnick & Fidell, 2007). Although a goal was to preserve the
sample’s characteristics and its ecological validity, the study had assumed that these potential confounds were unrelated. It is therefore worthwhile to interpret the data with caution. Nevertheless, it is suggested that future research take into consideration factors that may contribute to significant sample variations, to add validity and robustness to their study design. Lastly, the ASCQ scale may require refinement, given its low correlation with its latent variables under study. One possible source of error may be the alteration of the original RAQ item, “I talk things over with my attachment figure” to “The relationship with my substance of choice is my only source of security”. This scale needs further development to improve its internal consistency and be validated in other studies that captures participant’s responses at various time points, especially if this tool is to be used in future studies or for clinical purposes.

4.6 Conclusion

This study represents a sizeable first attempt at investigating the impact of how substance dependent individuals’ attachment to substance impacts their attachment to therapist. The findings yielded strong evidence to suggest the importance of considering attachment dynamics in the treatment of substance dependence, as well as utilising an attachment framework to understand and address the underlying issues in treatment. It also provides support for considering other ways of connecting with these clients apart from what is currently considered evidence-based. Given that this study examined concurrent predictors, future research may like to focus on uncovering the prospective predictors of attachment to substance. Lastly, there is some preliminary evidence that the ASCQ may be a valid and useful tool to assess one’s attachment to substance, however further research is needed to test its validity and general psychometric properties. This study is considered to have opened an area worth further investigation.
CHAPTER 5

Study 2: A Client Interview Study

5.1 Introduction

The assumption that existing mental representations are carried forward from one relationship to the next is a central tenet of attachment theory. Over the course of the lifespan, relationships are developed with a variety of significant others. Bowlby (1969) introduced the concept of Internal Working Models (IWM) to describe cognitive and emotional representations of self and others that operate automatically and unconsciously to monitor attachment-related experiences on an ongoing basis, and forms the basis for subsequent behaviour. According to adult attachment theory (Bowlby, 1973; Fraley & Shaver, 2000; Hazan & Shaver, 1987, 1994), previous relationship patterns can re-emerge because the IWMs (i.e., attachment representations) people hold of past relationships are highly accessible and are used to guide interpersonal behaviour in novel circumstances. These working models, or mental representations of relationships, influence individuals’ ongoing social experiences. In fact, this process is understood to partially explain the continuity of attachment patterns across time and context (N. L. Collins, 1996; Fraley, 2002; Fraley & Brumbaugh, 2004).

A concept that parallels this dynamic is that of transference, defined as the process by which existing mental representations of significant others resurface to influence new social interactions (Andersen & Cole, 1990). Transference processes influence emotional, motivational, and behavioural reactions to strangers (Andersen & Glassman, 1996). However, when traumatic stressors are experienced, such as interpersonal violence and exploitation, it can have a highly negative impact on one’s capacity to develop and maintain relationships. It has been shown that attachment-specific feelings, defences, and expectations (i.e., attachment styles) can be transferred from one relationship to another (Brumbaugh &
Fraley, 2006), and these effects are compounded when the sources of distress (i.e., violence, neglect, or abuse) come from significant others or caregivers (Hildyard & Wolfe, 2002; Holt, Buckley, & Whelan, 2008). The developmental sequelae for individuals who experienced severe cumulative interpersonal transgressions comprise alterations in relations with others, including the ability to connect with other people in ways that foster relational security and stability (Pearlman & Courtois, 2005). Such alterations may impede the formation of healthy relationships (i.e., social support and supportive relationships) that have been found to buffer and ameliorate the ill effects of instability and chaos along with additional abuse, victimisation and loss (Bowlby, 1969; Wortman, Battle, & Lemkau, 1997). Despite growing evidence of these processes and theory that purport to explain its dynamic phenomena, and further, a developed methodological paradigm for investigating transference in the past two decades (Andersen & Baum, 1994; Andersen & Berk, 2000; Hinkley & Andersen, 1996), there is little empirical evidence to suggest that these interpersonal processes are existent in psychotherapeutic work with complex presentations.

Specifically, the psychotherapeutic treatment of the substance dependent population presents itself a flurry of complex and often treatment-resistant issues. From a clinical point of view, developmental difficulties observed in persons with drug and alcohol dependence have to do with the individual’s sense of self, ability to identify and modulate emotions, alterations in consciousness and self-awareness, difficulty maintaining personal safety, somatic and medical concerns (Pearlman & Courtois, 2005). To be proficient in managing these various aspects of functioning, this study takes the position that it is critical for the development of healthy attachment from childhood, as it lays the foundation for subsequent patterns of relating (Fraley, 2002; Fraley & Brumbaugh, 2004). Such a secure attachment is based on responsiveness and availability of the caregiver, offering protection from over-stimulation and threat, teaching social interaction and other life skills (Mikulincer & Shaver, 2016). This enables both physiological and psychological development and regulation,
paving the way for a secure base from which the child explores the world, and to which he/she returns for refuge when overwhelmed or threatened in some way (Bowlby, 1969). On the other hand, negative experiences and disruptions of these affectional and secure bonds through loss, separation, threat of separation, misattunement, violence, abuse, or neglect, can lead to psychological difficulties such as anxiety, depression, anger and emotional detachment, resulting in relational and social struggles (Pearlman & Courtois, 2005). In addition, the cumulative effects of developmental trauma reveal major cognitive distortions about self, their worth in relationships, and the motivations of others (Pearlman, 2003). These beliefs are reinforced when relationships in adulthood reiterate the dissatisfactions, abandonment, and abuse of the past (Basham & Miehls, 2004; S. Johnson, 2002). Given the high likelihood of such difficulties, substance use and dependence appear to be more conceivable, presenting a viable alternative to futile attempts at depending on others for comfort and sustenance (Flores, 2001, 2004; Khantzian, 2004; Walant, 1997).

Since postulated by Bowlby (1988) that the psychotherapy relationship incorporates important features of attachment and that the therapist may serve as a secure base for clients to explore the internal terrain of their own emotional and interpersonal functioning, a growing number of empirical studies have applied attachment theory to gain an enriched understanding of psychotherapy processes. Drawing primarily from the concept of transference, several authors have speculated that key features of a client’s adult attachment pattern influence the type of attachment formed with their therapist (Fonagy, Gergely, Jurist, & Target, 2002; Mallinckrodt, 2000; Sable, 1997; A. Slade, 1999; Szajnberg & Crittenden, 1997). Others have found that secure attachment to therapist was associated with greater session depth and smoothness, and insecure adult attachment was associated with insecure therapeutic attachment (Mallinckrodt, et al., 2005). Therefore, it follows that substance dependent individuals will inevitably carry on their IWMs, and complex personal and interpersonal
struggles when in psychotherapy, and in turn, influence their relational experiences with the therapist.

Despite the growing body of evidence suggesting that clients’ adult attachment style may have an important influence on the psychotherapy relationship (for reviews, see Mallinckrodt, 2000; Meyer, et al., 2001; Meyer & Pilkonis, 2001), the American Psychological Association Division 29 Task Force on psychotherapy relationships concluded that evidence is as yet “insufficient to make a clear judgement” about whether customising the therapy relationship to account for client attachment style could make a positive contribution to treatment outcomes (Norcross & Hill, 2004, p. 23). This could prove problematic for the uninformed therapist or a therapy focused on purely relinquishing substance use for these clients, as the lack of sufficient “evidence” for attachment dynamics could signal therapists to ignore these critical relational patterns present in the consulting room. Nevertheless, Norcross and Hill (2004) encouraged researchers to utilise methodologies capable of examining the complex associations among patient qualities, clinician behaviours, and therapy outcome; as well as to avoid a therapist-centric view of the therapeutic relationship. It was recommended to study both client and therapist contributions to the relationship and the ways in which those contributions combine to impact treatment (Norcross & Hill, 2004). Besides, it makes conceptual sense that studies on attachment be conducted by observing individuals in interpersonal circumstances.

These developmental underpinnings in childhood must be understood and addressed in the context of the therapeutic relationship for healing to extend beyond resolution of traditional psychiatric symptoms and skill deficits. An appreciation of the subtle but critical nuances of substance use must be studied. To do so, it is vital to incorporate the subjective views and experiences of substance dependent individuals who were involved in psychotherapy. With a focus on relational patterns, the psychotherapy milieu may provide a suitable and active point of reference for clients, as there is precious client self-reported
information on the client-therapist relationship to tap into (Daly & Mallinckrodt, 2009; Horvath, 2000; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Mallinckrodt, 2000; Mallinckrodt, et al., 2009; Mallinckrodt, et al., 1995; Mallinckrodt, et al., 2005). From a relational perspective, an emphasis is placed on exploring the dynamics present between the substance dependent client and their therapist. Through close examination of being with one’s therapist, and one’s experience of the therapeutic relationship, much may be learnt about a client’s patterns of relating with significant others.

It has been established that both anxious and avoidant forms of insecure attachment can encourage substance use, and the defensive functions of substance abuse have been extensively documented in psychological research (e.g., Hull, Young, & Jouriles, 1986; U.S. Department of Health Education and Welfare, 1977). For example, attachment-anxious individuals who have issues with emotional control, can use substances to calm or anaesthetise their distress and block the uncontrollable spread of anxious ruminations and memories (Mikulincer & Shaver, 2016). It was found that these anxiously attached individuals’ common motives for using alcohol was to cope with anxiety, tension, and distress (Brennan & Shaver, 1995; Magai, 1999; McNally, et al., 2003). On the other hand, avoidantly attached individuals who tend to detach themselves from psychological distress, can use substances as a means of avoiding painful affect, and self-awareness (Mikulincer & Shaver, 2016). These individuals were more likely to avoid emotional dependence (Brennan & Shaver, 1995), or to enhance positive mood (Magai, 1999). With these propensities to cope with emotionally difficult issues by way of substance use, it may seem that there be no need for these individuals to rely on other people for help in times of need. However, herein lies the question; how do substance dependent individuals, with their own IWM’s, deal with a psychotherapy situation. By examining what is experienced by these clients when using substances or relating to others, a clearer appreciation of these complex relationships may be understood.
The current study adopted a qualitative methodology with aims to pursue an exploration of the relational patterns substance dependent clients in psychotherapy have toward their interpersonal relationships and substance use, and how these patterns/dynamics work at depth. Given that this study is an initial attempt to make an exploratory investigation into attachment dynamics within the psychotherapy relationship of the substance dependent client, Bowlby’s (1969) concept of IWM’s of self and others is proposed as a guide to structure the general areas of inquiry. Since these attachment representations (i.e., IWM’s) were argued to be stable over the lifetime and function to guide interpersonal behaviour (Brumbaugh & Fraley, 2006, 2007; Fraley, 2002; Fraley, et al., 2011), it would be reasonable to examine substance dependent individuals’ internal representation of self, as well as that of others (Bartholomew, 1990). Conceptually, “others” in the context of the current study, would be operationally defined as including significant others (such as parents/caregivers), as well as one’s own therapist.

It would be interesting to clarify if these substance dependent clients differ in the ways they relate to others as opposed to their therapist. By examining this concept empirically, it can assist to elucidate how an individuals’ attachment organisation might impact the therapeutic relationship in the process of treatment. Whilst there has been theoretical disagreement about what transference encompasses (Høglend, 2004), perhaps attachment may supplement other concepts such as the therapeutic alliance as a way to account for the client’s reaction to the therapist (Ehrenreich, 1989). If indeed there is transference or an enactment of an earlier relationship or a new experience, a close look at each client’s personal issues and context could assist with developing new insights about the psychotherapy process. As most research into attachment and therapy outcomes do not address this, especially since there is the added factor of substance dependence, the current research is well-placed to explore these given its use of a mixed-methodological design.
In addition, the current study is particularly interested in how these clients utilise their substances, in relation to these relationships with others. Therefore, the core research questions in the current study encompass (1) how substance dependent clients view themselves, as opposed to others (i.e., primary caregivers/significant others, therapist), and (2) how these relationships impact their substance use. Also, to understand (3) how these individuals experience the psychotherapy process, (4) how their interpersonal patterns of relating was played out with their therapists, and (5) how to address these attachment-related issues in psychotherapy.

5.2 Methodology

5.2.1 Participants

Clients. Ten clients (6 women and 4 men; 10 White Caucasian Australians) were recruited through their therapists from a private psychology practice in the Perth metropolitan area. Clients ranged in age from 18 to 60 years ($M = 33.30, SD = 14.37$), had been in therapy with their therapists from 3 to 240 months (20 years; $M = 52, SD = 76.78$), had had between 6 to 800 sessions ($M = 132.10, SD = 242.54$) with their therapists, and had no planned termination in sight. These figures were specific to their current therapist, and does not include previous therapists these clients may have seen. In addition, clients were seeing their current therapist on average once a week, and anticipated to be doing so for at least another six months. These clients were selected by their therapists based on four criteria: (1) must be substance dependent; (2) been seen for at least five sessions; (3) next available client to be seen on their schedule; (4) who agreed to complete a questionnaire package and participate in a follow-up interview about their relational experiences. Clients identified their presenting problems, in addition to substance use, as the following: anxiety and/or depression ($n = 7$), and “others” ($n = 3$). Refer to Table 13 for client demographics and history of substance use.
**Therapists.** Five therapists (2 female and 3 male therapists) were recruited from the psychology practice to invite two of their own individual clients. As described by the participating clients, these therapists ranged in age from their 30’s to 60’s, and were identified as “experienced therapists”. These therapists were White Caucasian Australians who received postgraduate training in psychology (2 counselling psychologists and 3 clinical psychologists) and specialised in the treatment of substance dependence issues. Refer to Appendix C for Participant Information Sheets for clients and therapists, and Appendix D for Interview Consent Forms.

**Transcriber and auditors.** A 45-year-old White Caucasian Australian woman was hired for her secretarial services in the transcription of the interview audiotapes. Two clinical psychology postgraduate students were involved in a pilot interview for validating and revising the interview questions for flow and relevance prior to the study proper. Another clinical psychology postgraduate student who acted as an auditor was involved in reading the qualitative nodes and themes for clarification. The results of each set of analyses were reviewed by the principal research supervisor at periodic stages of the analysis.
Table 13.
Client demographics and history of substance use

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Marital/Relationship Status</th>
<th>Highest Education Attained</th>
<th>Substance of Choice (Length of use)</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>F</td>
<td>Single (Not dating)</td>
<td>University</td>
<td>Methamphetamines &amp; Benzodiazepines (11 yrs)</td>
</tr>
<tr>
<td>46</td>
<td>F</td>
<td>Married (15 yrs)</td>
<td>University</td>
<td>Alcohol (30 yrs)</td>
</tr>
<tr>
<td>60</td>
<td>F</td>
<td>Widowed (Not dating)</td>
<td>University</td>
<td>Alcohol (40 yrs)</td>
</tr>
<tr>
<td>46</td>
<td>F</td>
<td>Single (Not dating)</td>
<td>TAFE</td>
<td>Alcohol (20 yrs)</td>
</tr>
<tr>
<td>39</td>
<td>M</td>
<td>Single (Dating 15 yrs)</td>
<td>University</td>
<td>Methamphetamines (20 yrs)</td>
</tr>
<tr>
<td>47</td>
<td>M</td>
<td>De Facto (15 years)</td>
<td>High School</td>
<td>Amphetamines &amp; Heroin (25 yrs)</td>
</tr>
<tr>
<td>22</td>
<td>F</td>
<td>Single (Dating 3 mths)</td>
<td>University</td>
<td>Amphetamines &amp; Cannabis (1.5 yrs)</td>
</tr>
<tr>
<td>18</td>
<td>F</td>
<td>Single (Dating 2 mths)</td>
<td>High School</td>
<td>Methamphetamines &amp; Cannabis (4 yrs)</td>
</tr>
<tr>
<td>25</td>
<td>M</td>
<td>Single (Dating 4 yrs)</td>
<td>TAFE</td>
<td>Alcohol (8 yrs)</td>
</tr>
<tr>
<td>50</td>
<td>M</td>
<td>Single (Not dating)</td>
<td>TAFE</td>
<td>Heroin (18 yrs)</td>
</tr>
</tbody>
</table>

Note. Clients were labelled with a letter (i.e., A or B) following a number which indicated their therapist.

5.2.2 Measures & Procedures

As introduced in Study 1, an identical questionnaire pack consisting of the demographic form and set of questionnaires (i.e., SDS, ASCQ, ECR and CATS) were used.

A semi-structured interview consisted of a series of questions asking participants to describe their subjective views of themselves, in relation to their patterns of substance use, relationships with significant others, as well as relationship with their therapist. Based on the style of the Adult Attachment Interview (Main, et al., 1985), the interview protocol was designed to encourage participating clients to gradually get sufficiently comfortable to share in their thoughts and feelings about their sense of self and others. The entire interview was estimated to take at least 30 minutes, depending on what came up in discussion (Refer to Appendix E for the Interview Protocol).
Care was taken to word the protocol appropriately so that questions asked were sensitive but assisted to evoke an open-ended, emotional response to the topics in question. The interview questions were designed to aid as a starting point, giving both researcher and participants a chance to further points of discussion that may have arisen after some clarification. It also provided the opportunity for both interviewer and participants to explore what, if any, other thoughts and reactions that had been stimulated by the ensuing discussion. The interview protocol was piloted by two clinicians who had previously practiced in the psychology practice.

Recruiting clients. Five therapists who worked at the psychology practice were recruited by face-to-face contact and asked to invite their clients to participate. Therapists were informed that the study sought to investigate the relationships their clients had toward significant others and patterns of their substance use, but to reduce bias they were not told specifically that the study would examine clients’ relationships toward their therapists. Each therapist was given an information sheet, which explained the nature of the research, its purpose and possible risks. After assuring confidentiality and agreeing to audio recordings of the interviews, therapists signed an informed consent for their involvement.

Each of the five therapists who agreed to assist passed on the researcher’s contact information to at least two of their adult clients (at least 18 years old). Consistent with research on the working alliance and therapeutic outcome conducted by Horvath (2015), therapists were instructed to select clients who had attended at least five individual sessions with them to have sufficiently built some form of therapeutic relationship. Satisfying criteria of being substance dependent and being the next scheduled client seen, these clients needed to be seen at least once a week, and had no planned termination in sight. Clients who contacted the researcher and agreed to completing a questionnaire package and participating in a follow-up interview were invited to a meeting with the researcher. Clients were provided with specific information about the nature of the study and assuring confidentiality, all participants
gave informed consent. Finally, therapists and clients were both instructed not to discuss the questionnaire or aspects of the study with each other if the interview was scheduled for a later date. Depending on clients’ availabilities, the questionnaire pack was either completed on the same day or on a separate the day with the interview.

**Interviewing.** The researcher completed interviews with 10 clients using the interview protocol. During the interviews, the researcher made field notes on the interview, noting how long the interview took, the interviewer’s sense of participants’ mood, and their overall behavioural and affective responses. This assisted with providing crucial contextual information that are omitted in audiotaped interviews. At the end of the interview, the clients’ responses were verified with them for accuracy and for any need of clarification. None of the clients opted to receive and amend their interview transcripts. The interview concluded with a short debriefing paragraph in case clients felt any distress or discomfort following the interview. Clients were encouraged to speak about these difficulties with their therapists if this was necessary. The average length of the interviews was 63.5 minutes ($SD = 14.14$).

**Transcripts.** The interviews were transcribed verbatim for all verbal utterances and significant non-verbal behaviours (e.g., long pauses) for each participant. All identifying information was removed from the transcripts and each participant was assigned a code number. Each interview transcript was reviewed and compared with their source audiotapes for accuracy, and finally, softcopies of the transcripts were sent to the principal research supervisor for verification and acted as another data back-up.

**Managing biases.** Care was taken to explore the potential expectations and biases by responding to each interview question as they expected participants to respond. This included care against asking leading questions, and being mindful of phrasing questions more neutrally (e.g., “Would you consider this easy or difficult?”). In addition, a reflexive journal was kept that detailed the development of the research, data collection, analysis and the ensuing results.
This included experiences, feelings about the interviews, and field notes taken during the client interviews. Adding honest consideration to the researcher’s role in the study and the way the study was conducted over time (Hansen, 2006), ongoing reflexivity assisted with questioning the researcher’s assumptions and interpretations (and of research participants).

5.2.3 Analytic Approach to Interviews

The data was analysed using thematic analysis (Braun & Clarke, 2006). The authors set out clear guidelines using thematic analysis as a method for identifying, analysing and reporting patterns (themes) within data. This method was selected on the basis that the objective was not about theory development, nor was it the intention to tie the methodology to a pre-existing theoretical framework. Given its exploratory nature, the current study did not set out to prove or disprove hypotheses or to test a theory. Rather, it sought to generate phenomenological data from which an understanding might be developed. However, it is understood that the researcher cannot free himself from theoretical and epistemological commitments, and that data are not coded in an epistemological vacuum (Braun & Clarke, 2006). Hence, the current study adopted an inductive data-driven approach toward identifying themes at the latent level beyond the semantic content of the data (Braun & Clarke, 2006). Consistent with the phenomenological tradition, the focus was to identify or examine the underlying ideas, assumptions, and conceptualisations that enable the clients’ individual accounts.

The process of analysis began when participant clients were recruited. Reflexive considerations were paid to how these clients were selected by their therapists, apart from meeting participant criterion. While we could never be certain about the therapists’ client selection decision making process, it is understandable that their priority is the treatment of their clients and ensuring that therapy proceeds as per normal practice. As such, it is reasonable to assume that therapists were unlikely to refer clinically unstable clients, and
clients who had major struggles with interpersonal interaction were likely to reject study participation anyway.

Transcribed interviews were analysed using QSR NVivo Version 10.0.641.0 (64-bit) for Windows, allowing an audit trail. Throughout the data collection process, transcripts were read and reread to sufficiently immerse oneself with the data, taking in the possible meanings and patterns. Field notes were compared with their clients’ corresponding transcripts, which functioned as primes to assist with recalling the researcher’s experience with the client. Notes and ideas for coding were made throughout the entire phase of analysis. Initial codes were generated and matched with data extracts that demonstrated that code.

During this phase, as many potential themes and patterns were coded inclusively, in order to preserve sufficient context (Bryman, 2001). Extracts that contained different themes were retained so as to keep data patterns (e.g., potential inconsistencies or contradictions) and possible relationships between them (Braun & Clarke, 2006). Potential themes were identified and different codes were sorted into these themes, which were subsequently collated. Once organised, relationships between codes and themes were considered, and any coherent patterns noted. Several codes were combined to form sub-themes whilst some other themes were broken down into separate themes. An initial thematic map was developed that appeared to adequately capture the coded data (See Figure 7).
Figure 7. Initial thematic map. Key: Circles denote Organising themes, rectangles denote Basic themes, and rounded rectangles denote data extracts.
Using the initial thematic map, the themes were reviewed further and codes were refined until a detailed thematic network was arrived at. The themes were grouped and systematised into three levels: Lowest-order premises evident in the text (Basic Themes); Categories of basic themes grouped together to summarise more abstract principles (Organising Themes); and Super-ordinate themes encapsulating the principal metaphors in the text as a whole (Global Themes; Attride-Stirling, 2001). These are represented as web-like maps depicting the salient themes at each of the three levels, and illustrating the relationships between them. The aim was to make identifying parallels more easily and provides a technique for breaking up text, and uncovering explicit rationalisations and their implicit signification (Attride-Stirling, 2001). To make sense of a basic theme beyond its immediate meaning, they were read within the context of other basic themes. The process of refinement after deducing each theme at each thematic level was an ongoing reflective task. Thematic labels were compared with field notes taken at the time of the interviews, and conversations with the clinical psychology auditor helped clarify and recognise impressions and responses throughout the data collection process. Suggestions were made to rename some Basic and Organising Themes such that they appropriately reflected the abstraction.

The original transcripts were reread, and the basic themes were summarised into clusters that were more abstract, and enhanced the meaning and significance of a broader theme. A total of eleven basic themes were clustered to form three broad organising themes, and a principal metaphor that took the form of a global theme (See Figure 8). Before the global theme was given a descriptor, the basic and organising themes were read with their corresponding interview extracts to consider in summation what was the core aspect or issue these clients had in common. Initial labels took the form of “Problems Interacting with Others and Getting into Close Relationships”, and “Relational Problems”, but finally developed into “Relational Dilemma” as it best captured the clients’ primary difficulty. This Relational Dilemma summarised clients’ intra and inter-personal difficulties characterised by
their ambivalence and insecurity, in dealing with others; and patterns of substance use.

Relationally, these clients described significant struggles leading to approach and avoidance behaviours, as a function of their personal insecurities.
Figure 8. Developed thematic network displaying Global, Organising and Basic Themes
After the thematic network was constructed, text segments related to each basic theme were verified to ensure that the global theme, organising themes and basic themes reflected the data, and the data supported the basic, organising and global themes. Codes were revisited and checked against most frequently occurring references across all the participants’ transcripts with NVivo’s Tree Map function, to ensure that each theme was valid. The analysis focused on discursive themes common across the interviewees, therefore the themes that were more common were given precedence. This criterion for selection was not intended to attribute greater overall explanatory value to themes on a quantitative basis; it simply made it possible to focus attention on the common, homogenous, popular themes, which was the specific interest of this study.

The organising theme of Clients’ Unmet Emotional Needs was split up to form another theme, Clients’ Reactions to Unmet Emotional Needs, which better described the data. In addition, after much reflection, two basic themes, Self-Regulation Difficulties and To Cope with Difficulties, were merged as clients’ views tended to highlight both their unmet needs and substance use as related issues. Therefore, the new basic theme will be described as Coping with Emotional Self-Regulation Difficulties, and shared between Clients’ Reactions to Unmet Emotional Needs and Clients’ Experience of Substance-Use. A decision was then made to stop the process of refinement when minimal edits did little to add more to the map. The resulting thematic network consisted of four Organising Themes and ten Basic Themes, encapsulated by the Global Theme, Relational Dilemma (See Figure 9) and summarised in Table 14.
Figure 9. Final thematic network. Note: Bold elliptical denotes the Global theme, regular elliptical denotes Organising themes, and rectangles denote Basic themes.

Table 14. Higher order (Organising) themes and sub (Basic) themes

<table>
<thead>
<tr>
<th>Relational Dilemma</th>
<th>Organising Themes</th>
<th>Basic Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients’ Unmet Emotional Needs</td>
<td>Lack of Others’ Sensitivity/ Understanding</td>
<td>Deficits in Parenting/ Caregiving</td>
</tr>
<tr>
<td>Addressing Clients’ Needs in Therapy</td>
<td>Safe Therapist Characteristics</td>
<td>Working Through Enactments</td>
</tr>
<tr>
<td></td>
<td>Making Sense of Client’s Experiences</td>
<td>More Dependable than People</td>
</tr>
<tr>
<td>Clients’ Reactions to Unmet Emotional Needs</td>
<td>Approval Seeking Tendencies</td>
<td>Self-loathing</td>
</tr>
<tr>
<td></td>
<td>* Coping with Emotional Self-Regulation Difficulties</td>
<td></td>
</tr>
<tr>
<td>Clients’ Experience of Substance-Use</td>
<td>More Dependable than People</td>
<td>Unreliable</td>
</tr>
<tr>
<td></td>
<td>* Coping with Emotional Self-Regulation Difficulties</td>
<td></td>
</tr>
</tbody>
</table>

Note. * denotes basic themes that are shared between organising themes.
To enable greater clarity and analysis of the higher order themes (i.e., Organising and Global Themes) across the data set (O’Neill, 2013), a three-dimensional cluster analysis of the codes was performed using NVivo with a focus on coding similarity, using the Jaccard similarity coefficient (O’Neill, 2013). Nine codes stood out against the rest of the 305 codes that clustered together. Hence, these extraordinary codes were re-examined to ascertain if interview participants had any similarities or differences in their views. One client (3B) was found to have made most these views, which formed the basis of seven codes, whereas the remaining two codes consisted of views made by several other clients (i.e., Clients 1B, 2B, 4A, and 4B). These two clusters appeared to flesh out dynamics that assist with validating and interpreting the final thematic network above.

On scrutiny of Client 3B’s profile, this client reported aggregate familial stressors, including abuse by his primary caregivers, and both parents struggled with both drug and alcohol dependence issues. Apart from a basic level of education and a low-wage income earner, Client 3B is in the middle phase of therapy. Upon review of the context of the interview extracts, it was found that therapy had triggered ambivalent views with his therapist that paralleled his struggles with substance use and relationship patterns. Client 3B reportedly always struggled with being single (needing to be in a relationship with someone), and spent at least 25 years using amphetamines and heroin to achieve a “sense of stability”. On inspection of his SDS questionnaire responses, he received a high score of dependence (16 out of 20), and indicated that he “always/nearly always” felt anxious or worried when there was the prospect of missing a fix (or dose). This pattern of ambivalence is also evident in his discourse about self.
5.3 Results

Results from the questionnaires will be presented first to provide context for the client sample, followed by a presentation of the qualitative findings. Clients’ responses on the ECR, displaying their four-way attachment organisation, comprising of Secure, Fearful Avoidant, Preoccupied, and Dismissing Avoidant, as conceptualised by Bartholomew and Horowitz (1991) and Bartholomew and Shaver (1998), showed that none of the client respondents showed a dominant secure attachment pattern. In other words, all the clients endorsed responses that indicated an insecure attachment pattern. Conceptually, taking their highest endorsed quadrant along the attachment-related anxiety and avoidance continuum as demarcating their attachment classification, their distribution was: fearful 6 (60%; Clients 1A, 1B, 2B, 3A, 3B, and 5A), preoccupied 2 (20%; Clients 4A and 4B), and dismissing 2 (20%; Clients 2A and 5B).

Table 15. Clients’ individual scores on the ASCQ, SDS and CATS questionnaires.

<table>
<thead>
<tr>
<th></th>
<th>ASCQ</th>
<th>SDS</th>
<th>CATS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M = 37$</td>
<td>$M = 16.2$</td>
<td>Secure</td>
</tr>
<tr>
<td></td>
<td>(6.73)</td>
<td>(1.69)</td>
<td>$M = 77.1$ (5.61)</td>
</tr>
<tr>
<td>Client 1A</td>
<td>46</td>
<td>19</td>
<td>83</td>
</tr>
<tr>
<td>Client 1B</td>
<td>38</td>
<td>17</td>
<td>73</td>
</tr>
<tr>
<td>Client 2A</td>
<td>29</td>
<td>13</td>
<td>81</td>
</tr>
<tr>
<td>Client 2B</td>
<td>45</td>
<td>16</td>
<td>77</td>
</tr>
<tr>
<td>Client 3A</td>
<td>29</td>
<td>16</td>
<td>81</td>
</tr>
<tr>
<td>Client 3B</td>
<td>38</td>
<td>16</td>
<td>73</td>
</tr>
<tr>
<td>Client 4A</td>
<td>44</td>
<td>17</td>
<td>84</td>
</tr>
<tr>
<td>Client 4B</td>
<td>29</td>
<td>17</td>
<td>80</td>
</tr>
<tr>
<td>Client 5A</td>
<td>33</td>
<td>14</td>
<td>72</td>
</tr>
<tr>
<td>Client 5B</td>
<td>39</td>
<td>17</td>
<td>67</td>
</tr>
</tbody>
</table>

Note. Standard deviations in parentheses and notable scores in bold. Higher ASCQ scores indicate more Insecure Dependence, and lower ASCQ scores indicate more Substance Reliability. Higher SDS scores indicate more problematic substance use (higher level of dependence), whereas lower SDS scores indicate less problematic use (lower level of dependence). Higher CATS subscale scores indicate more Secure, Avoidant-Fearful, and Preoccupied-Merger attachment to therapist.
A review of client scores in Table 15, provided a snapshot of their attachment to substance, severity of their substance dependence, as well as their attachment to therapist. Overall, client scores indicated heightened Insecure Dependence (extent to which perceived separation evokes protest and promotes proximity seeking to the object), and high levels of dependence (> 4) on their substance use. In addition, their CATS subscale scores indicated that all 10 clients had a secure pattern of attachment to their therapists (Secure subscale), when compared with insecure Avoidant-Fearful and Preoccupied-Merger subscales. However, Client 5B had a pattern of scores that strayed farther below the mean in Secure, and above the mean in Avoidant-Fearful. Although there are no cut-off scores for the CATS, this pattern of scores may suggest that despite an overall sense of security with his therapist, Client 5B may struggle with an avoidant-fearful pattern of attachment issues with his therapist – this includes a suspicion that the therapist is disapproving, dishonest, and likely to be rejecting if displeased; reluctance to make personal disclosures in therapy; and feeling threatened, shameful, and humiliated in the sessions (Mallinckrodt, et al., 1995).
Interestingly, Client 5B’s ECR scores indicated a dismissing pattern of attachment, which may support the view that there was a transference of attachment patterns onto others (in this case, his therapist), based on his own IWM of self and others. His overall high endorsement of the avoidant dimension on attachment scales, may contribute to a distant, more disconnected relational style, and heightened disregard for his therapist.

Based on the final thematic network, the qualitative results are presented according to their organising themes, highlighting the underlying basic themes and data extracts that drive the findings.
5.3.1 Clients’ Unmet Emotional Needs

The discussion of clients’ needs highlighted some fundamental issues revolving around others’ capacity to provide adequate parenting/care giving, and the ongoing lack of sensitivity in others’ responses to clients’ needs. The thematic sub-network illustrates concisely the key themes on which clients’ emotional needs were unmet: early and current experiences of others’ responses to clients’ emotional needs. This generated an interesting discussion in which one’s unmet emotional needs was seen as being a result of consistent deprivation of other’s sensitivity and attuned responses over time. In this sense clients’ unmet emotional needs emerged as fundamentally characterised by being chronically present and triggered by ongoing interactions with others (See Figure 10).

Figure 10. Thematic sub-network for “Clients’ Unmet Emotional Needs”. Note: Elliptical denotes the Organising theme, rectangles denote Basic themes, and rounded rectangles denote data extracts.

**Basic theme: Deficits in Parenting/Caregiving.** This basic theme pertains to the fundamental way in which clients received caregiving from his/her caregivers, particularly in times of perceived need, as characterised by participants. In this context, parents/caregivers were conceived as others who had a significant and distinct role: something essential for a secure foundation and determined one’s expectations of others from early on in life.
According to this basic theme, adequate parenting/caregiving is necessary for the satisfaction of one’s emotional needs, at least partially. The rise of one’s unmet needs was seen to be born from unfulfilled desires for human connection and understanding by others – uncovered when discussing clients’ recollections of situations in childhood or earlier life, where clients needed comforting but others could not be there for them. In fact, it was a common view between participants that parents were often emotionally unavailable, and sometimes abusive and critical:

As a child? Ohh…between my parents, probably my mum. But I wouldn’t get, just put a little add bit on there, but I probably wouldn’t get what I was looking for. It’d be more like buck up and get on with it…a bit like a futile way of asking, but you don’t really get what you were probably needing…yep. “Oh fuck, not again!” (((laughs))). You know, “fucking how did you get yourself into getting help?!”, type of thing or whatever the case may be…so that’s the type of response I would get. (3A)

Not only were parents/caregivers emotionally unavailable when requests for help were made, they were seen as dismissing of clients’ needs for validation and praise. Often putting down their feelings and being mean to them:

Umm... they were pretty harsh... if someone gave me a compliment, I can remember once, been about ten or twelve and someone gave me a compliment, a friend’s mother, and my father turned and said don’t let it go to your head and that stayed in my mind, I remember his response. (2B)

Very hard... not accepting, judgmental, critical... she said today that I’ve put on weight and... yeah I always go there wanting to be consoled and it just never happens... (((long pause - sounds upset))) (2B)
Many clients also felt that their parents/caregivers lacked the ability to truly understand them and their problems. This in turn, influenced their expectations of these significant others, and views of themselves:

I just kept quiet, I guess I learnt that with trying to tell people that I was getting bullied by my year three teacher, no one really listened they thought that was attention seeking, so I learnt from a young age to keep my feelings to myself and my feelings weren’t validated and it meant they’re not acceptable. (4B)

Much of the time, discussions with the participant clients brought up significant memories of childhood and feelings that were buried a long while ago. Clients viewed that there were often more problems at home that most people did not see, often involving their parents’ own struggles with personal difficulties. In some circumstances, if significant others were not being influenced by the effects of using substances themselves, it was about marital relationship difficulties. One client in particular, reported being caught between her parents’ relationships problems, and experienced confusion and resentment:

I always felt like I was the glue in the relationship knowing a bit of their history... they shouldn’t be together and they are separated at the moment and... they’re still together in a certain sense, they’re not divorced after four years and I’m just like, what’s going on here? ((sigh)) I feel a lot of resentment towards both of them, more so my mum because mum comes from Canada and they got married because mum’s visa was running out and then nine years later I was born to try and kind of, keep them together. (4A)
Dad had an affair... a few times, one of which I caught him out when I was sixteen, but there was never any ownership over it... there was never any communication in our home... I couldn’t wait to get away from them and, so when I was fifteen I met my ex-boyfriend and he was my saviour, he got me out of the house thank God... and I suppose the breakdown in our relationship comes from lack of communication. (4A)

According to this discussion, to be secure in one’s sense of self, required parental emotional availability, presence, kindness and understanding for a sufficient experience of closeness and felt sense that one was being kept in mind. By ignoring these essential human needs, sometimes expressed by these clients to their caregivers, meant laying the foundation for one’s emotional needs to be unfulfilled.

**Basic theme: Lack of Others’ Sensitivity/ Understanding.** This basic theme pertains to how the insensitivity of others impacted clients: specifically, their parents, and similar accounts with their therapists. Clients all gave descriptive accounts of their responses to significant others and talked about profound hurt at differing levels. Clients’ responses to both parents and therapists were grouped together given similarities in the way they expected others to treat them in an interpersonal situation. Firstly, clients expressed disappointment in their parents’ unattuned responses toward them, which included feelings of anger and frustration:

Yeah, so... disappointed in that he... I suppose my disappointment with dad was that he can’t communicate with me... I’m not disappointed in that he’d never do anything to hurt me or anything like that, it’s just his lack of understanding sometimes and lack of being able to control his emotions. (4A)
I couldn’t approach my mum or dad because I was too scared I’d get in trouble. I’d be
told what to do, I wouldn’t be talked through the situation in, in a social constructivist
manner, it was... this is what you should do and that’s it. It wasn’t this is what you
should do because or you could do this and it could be lead to this. There were no
options presented, it was just my way or the highway. Mum and dad’s way or the
highway. (4A)

There’s no way that I would raise my kids the way that I was raised. So, if you can
relate that to how I feel about my parents, then, you know, so basically what I’m saying
is that they probably did a pretty crappy job. …I think… I guess I could say I feel pretty
let down by them. When I see that really… ((sighs deeply)) …you know…if you gonna
have kids, then you really have to…it’s a big responsibility, so you gotta be prepared to
put in, to do whatever it takes to construct a good life for them. (3A)

This discussion raised wistful and sore responses about how one wished that things with their
parents were different. These interactions involved fearful responses toward parents, but also
wished for a better life with family. Secondly, some clients viewed that these
disappointments were present with their therapist at times when they felt their therapists
lacked sensitivity. These clients appeared to take their therapist responses personally, and
spoke with varied degrees of annoyance:

Yeah, umm...like telling me like I found very hard to hear from him to say that he’d
classify me as an alcoholic…yeah, that still doesn’t sit well with myself. I don’t want
to agree with that and then he’ll try to explain to me the reasoning why he thinks
that… Umm…bury my head in the sand, not wanting to admit it. Umm…sort of feel
ashamed, you know. (5A)
Yeah, pretty much…saying that it doesn’t just affect me, it affects everyone around me as well and just sort of explains that to myself. Umm and just…yeah…how it can…yeah, how it may have hurt other people…with what I’m doing [Felt like I was being judged]…mum and dad a little bit [Echoes these sort of sentiments like how therapist judged me]. (5A)

…but to be a hundred percent honest…sometimes I think…you know, he run out of things to say to me…that sort of thing. Maybe on occasion, I think we may be not going around in circles but sort of double-up a little bit… I don’t really like hearing things repeated sometimes, but sometimes you have to I suppose. (5A)

Umm…it’s good just having someone to talk to but it’s also hard talking to him when they haven’t been in your situation. It’s like I try explaining to mum and dad. They can’t work out why I have to have cocaine when I drink and then I try to like, use an analogy, which I’ve used with [therapist]. (5A)

It’s his tone, I think he’s a bit frustrated at my attitude. And I was moving in reverse, and I felt like I was backpedalling as well. I’ve done, since I’ve started therapy, what happened was that I’ve increased my drug intake by about 6 fold since the time I’ve saw after…yeah… ((paused a few seconds)). So I didn’t see him for a while and then I decided to go back and try more… (5B)

I didn’t feel particular insecurity but I didn’t feel security either. I guess that’s because I really want understanding or help. And even though I was blabbing my guts out, I really didn’t think I was getting much. There was a couple of things he said that I took to heart and was going to take away as kind of tools that I could use, but umm… I felt a little bit more desperate, and needed more understanding and more
help, whether it was locking me away or whatever it was, but whatever was happening, it was working in reverse. (5B)

So I notice that we go off track and it’s me that gets us back on track... [Therapist] and I could talk every session about his daughters and about... the politics of the hospital and it’s not a good thing and I sort of... get annoyed sometimes that I’m the one that’s mindful of it, he doesn’t seem to be mindful of it. (2B)

This discussion about clients’ views toward their therapists at particular points in therapy revealed how these clients perceived them. Whilst not feeling particularly insecure toward their therapists, there was a universal view that their therapists could have been more sensitive and understanding to them – to put in more effort or staying more focused on them, instead of being judgmental and assuming. There was a sense that these clients had a better understanding about what they needed than their therapists did, and expected their therapists to be [more] emotionally present with them. This included tracking the conversation and being able to stay with what needed addressing in the session. However, these client responses were never discussed with their therapists. The discussion appeared to have stimulated core underlying issues that was present in relationships with significant others. This basic theme contributed to the organising theme of clients’ unmet emotional needs.

5.3.2 Clients’ Reactions to Unmet Emotional Needs

The discussion of clients’ unmet emotional needs revealed their reactions toward significant others – these included their own enduring patterns of behaviour that served as ineffective efforts at attaining interpersonal closeness, being authentic, and being competent at emotional self-regulation. The thematic sub-network illustrates the key themes clients viewed their responses to difficult relational circumstances: tendencies to seek others’
approval, rejection of oneself, and underdeveloped emotional self-competencies. This discussion unearthed an array of responses to their unmet emotional needs as a result of deficits in caregiving and sensitivity from significant others (See Figure 11).

Basic theme: Approval Seeking Tendencies. This theme refers to clients’ proclivities toward seeking others’ approval, at the cost of one’s own emotional needs. Clients reported that whilst they desired closeness and acceptance from their significant others, they were more concerned with how others viewed and responded to them. Many clients regarded that they were sensitive to criticism and afraid of letting others down because it meant disapproval, rejection and dismissal:

My dad says to me all the time where’s my beautiful blonde haired, blue eyed little girl gone, I just want her back, that happy, smiling, genuine... boisterous girl...

I go running back to dad or I continue my [substance] use because as I, as I get further and further into debt and as I want more and more help it becomes harder and harder
to ask for it because I’ve got to keep up a good appearance, I’ve got to keep up the happy smile and make sure people don’t know anything’s wrong so when it all comes crashing down it’s major, it’s like, like easily triggered into a psychotic episode if someone close to me like, it’s only mum or dad I’d ever go psycho, even just them looking at me. (4A)

Well I didn’t realise that I had a right to have what I like, I just didn’t realise ((inaudible)) I’d please others and then get fed up and annoyed and angry because I wasn’t happy and I didn’t realise that I wasn’t happy because I was just pleasing everybody else or thought I was and it wasn’t enough. Stiff bickies. Well, I didn’t realise at the time, I just wanted the company, I wanted to fit in... so I did what they did. (2A)

According to this discussion, the fear of letting others down coupled with sensitivities toward criticism drove clients to please others. Often this maintained their experience of guilt and/or shame towards significant others. Several clients described this ambivalent experience and resulting feelings of badness:

Oh, I think my life would be really very good if it wasn’t for the fact that I abuse drugs and the guilt and shame that I feel about that and the money that has been wasted, … it’s been about a year I’ve been using drugs at this time that’s…I’ve absolutely feel terrible about that and I feel like a terrible hypocrite that I expect other people to do good and at the same time, I could be doing everybody a lot more good by not using drugs. (5B)
Yep, because all I, all I knew was getting in trouble so I was thinking shit if I approach them [parents] for help, I’m going to get in trouble because I’m going to have to own up to something and it’s going to be a big massive debacle. (4A)

... we’ve been married for fifteen years and most, for the most part it’s been wonderful. [? Sarcasm] When I let him down he gets kind of angry at me and very disappointed and he makes me feel even worse. (1B)

Client 1B’s Transference Reaction to the Interviewer. It was found that Client 1B was the same client who was observed to be more passive and reserved than the other clients who participated. Reviewing field notes during the interview, it was noted that she appeared defensive throughout the interview and made brief responses. Client 1B frequently felt bad for letting others down and it appeared that she was experiencing similar relational patterns in the interview. She apologised at the end of the session, and stated that “I probably didn’t help you at all” for the study. By reviewing her audiotape and transcript, there were several points in the interview where she would say that she “could not recall”, or that “everything was fine”. It occurred to the interviewer that this client might have experienced a transference reaction during the interview, given that she reportedly “didn’t like to disappoint” others and she may have been triggered off by discussing how it was like when others let her down. She was particularly reserved when she paused for long periods of time and struggled with responding. The interview session only lasted about 35 minutes. When asked to clarify if she had felt the same way with her own therapist, she summarised similarities between letting down her significant others, as well as her therapist. Here is an excerpt of her discussion with the interviewer:
Just feeling... like I let myself down and upset about my behaviour and umm... just thinking in retrospect... what I could have done on another occasion, yeah. (1B)

When you said, you felt like you let yourself down, would you also feel like you let [therapist] down in some way? (Interviewer)

Yeah a little bit, my family and friends, yeah. (1B)

A similar sort of feeling that you, that you get with them as well? (Interviewer)

Yeah…. Oh, it just made me feel worse, yeah. ((long pause)) Well I’d just be quiet because I’m thinking, not really saying much, yeah, like now. ((laughter)) (1B)

This discussion on clients’ sensitivity to criticism or letting others down had stirred up some big emotions during the interviews, but helped to uncover some of these experiences clients struggled with. For Client 1B, this relational pattern was brought to life during the interview.

**Basic theme: Self-Loathing.** This theme pertained to clients’ harsh and critical views toward themselves which were frequently intolerable. Their severe dislike toward themselves were sufficient for many of them to live a façade/put up a false front, as they were uncomfortable being themselves. Clients also viewed that they would frequently attribute blame toward themselves for not being good enough, which undermined their acceptance of self and emotional needs:

Umm…you know, the way you’ve treated people, the way you’re treated yourself.

Umm...umm...how you’ve let things go, you know, talking like, you know, like your house or family relationships. You know, how you’ve used people, you know…so there’s a whole lot of lows there that I associate with using it.

...

Umm…I feel pretty rotten actually, to be honest. Umm…sad…a bastard, I
suppose...you know, probably use the “C” word if I was gonna go down that path as well, but umm...certainly, it just twists your mind into such a way that of course you’re only ever worried about the next, the next perceived high that you’re gonna get from, you know, sticking a piece of steel in your arm. (3A)

I turn my anger inward, I berate myself, I... yeah and I don’t, it annoys me when people can’t take responsibility for their own addiction you know and yeah, it’s no one else’s fault but mine and I’m the one who keeps walking through that door even though I know what the outcome’s going to be so suck it up princess you know. (1A)

Client 1A’s Transference Reaction to Therapist. For some clients like Client 1A, attending psychotherapy meant that it may reveal/expose her real self to her therapist – as someone “horrible”. According to Client 1A’s interview responses, she reported fear of being written off if her parents found out about her deeds, and hence, did not feel safe enough to speak honestly about her struggles:

My dad frustrates me a bit... because he’s very judgemental and I can understand that it’s his way of protecting his family, but if someone does the slightest mistake it’s, that’s it, they’re written off in his books and when he writes someone off, there’s no going back, you know, and people say that I’m a lot like him... and I would hate to think that I’m like that and I don’t think that I’m like that so... (1A)

And mum... she never gets angry; very rarely will she get angry... I probably don’t give her what she needs as much in the way of she likes her... I don’t tell my family my immediate family very much about what’s going on in my life or how I’m feeling. If I’m feeling really, really terrible or you know, I’ll say that I’m great you know, because
I’ve put them through so much you know and they’ve stuck by me and... they worry a lot about me so I want them to think everything’s fine. (1A)

Interestingly, whilst Client 1A’s mother “never gets angry” and “she was always there and supportive”, the apparent parallel/ similarity of her therapist may have triggered a transference reaction, resulting in fear of being exposed in the context of psychotherapy. According to Client 1A, such an experience was viewed as an inevitable but anxiety-provoking prospect. Her relational patterns which were present with her parents, were set in motion with her therapist:

I believe that generally only strong people can work with [therapist]. (1A)

Umm... I suppose I... because I didn’t really have confidence in who I was as a person and that I was a good person... I felt at risk of being exposed and for her to say you know, this is how it is you’re fucking full of bullshit rah, rah, rah you know because she’d just say it as it is you know, and... yeah that’s what I was worried about, but now I’m finding myself as a person I’m realising that I had nothing to fear because... there’s nothing really that I do that would make [therapist] have to say that to me you know. (1A)

Someone who... the bigger the front the bigger the, you know what I’m trying to say, the bigger the front someone puts on the, the more staunch they are, generally are more insecure. In, I’d say, that’s my experience from the drug world. Umm... but I don’t think [therapist] is insecure... so yeah that was my thought then because that’s always been my experience and that’s me you know, I’m very you know, fucken fuck you cunt, who do you think you are you know and I’m very insecure you know… I felt insecure
[when I perceived that]. Because I felt that she was going to see through me and see what a horrible person I was, because I knew that she was good at her job. (1A)

*Shared Basic theme: Coping with Emotional Self-Regulation Difficulties.* This theme described participants’ views about managing their own emotions, and coping with their struggles with emotional regulation in the context of their substance use. Clients viewed that difficulties with meeting ones’ emotional needs meant that they would cope by substance-seeking. Therefore, this theme is shared between the two organising themes: *Clients’ Reactions to Unmet Emotional Needs*, and *Clients’ Experience of Substance-Use* (See Figure 12).

*Figure 12.* Sub-network of shared theme “Coping with Emotional Self-Regulation Difficulties”.

Note: Ellipticals denote the Organising themes, dotted rectangles denote the Shared Basic theme, and rounded rectangles denote data extracts.

This discussion with the clients yielded consistent views throughout – there was a sense that difficult emotions were more easily tolerable when they were avoided or suppressed in some way. Sometimes the emotional pain was so intense that it was better not to experience
Clients described their experiences intentionally or unintentionally committing the avoidance/emotional suppression:

Because it was too easy to get to feeling content or less nervous or less inadequate. It was so easy, just pour some down your throat and the result is there, if you use your logic it’s not a good way to get a result if the result is not what I actually want so I’ve had to work on using my mind to deal with emotions. Do it the hard way. (2A)

With my first one it wasn’t that I didn’t... I didn’t know how to deal with emotions so I’d keep my emotions to myself and go… (2A)

Mum had to be careful because my grandfather, lovely man that he was, you didn’t show if you were upset or scared or anything … He would say... get over it, don’t do that... (2A)

Uhh…depressing…yep, depressing. Umm…but of course, there’s always the option there to forget about being depressed and of course, get on...keep getting more gear [substance], and basically continuing on. (3A)

Umm… my main problem is that I suppress my anger and emotions and... when I’m off my face I don’t have to think about why I do that because it’s something that weighs heavily on me... it just... yeah, I don’t know, it just, it just takes away all pain, all thoughts that lead to pain, emotional and physical... like a godsend. (4A)

I use drugs to be at peace with myself because otherwise my brain is just going at a hundred miles an hour... it just totally shuts off any outside relation to the world, I don’t have to think about my problems, I don’t have to feel. I don’t feel emotion, I’m
not elated or depressed, I’m just on a happy medium... it’s not a social thing for me, I
don’t use it with other people as such, like as I said I lock myself in my room for four
days ... (4A)

Clients described that they had problems emotionally self-regulating in relation to significant
others. Some clients viewed that this was due to the lack of positive experiences depending
on their significant others. Instead, there were reports of intrusive, preoccupied or dismissive
caregiving, which clients recalled being uncomfortable with. Hence, this lay the foundation
for their tendencies toward self-reliance:

I usually just deal with it on my own you know. The rest of my family are very let’s
talk it out, discuss it and that’s another reason why I don’t because I give them a little
bit and they want more and I’m like woah back off you know, I’m only giving you
this much, but they push and push and push because they want you know. Yep, so I
just, I just don’t go there you know. (1A)

I’d ask her [mum] but generally, I didn’t ask for help very much because my mother
was pretty…a lot preoccupied with the youngest daughter…the new daughter and
with my oldest sister who was terminally ill…so there was a lot of her time and her
concentration was towards that so generally yeah, so I suppose there wasn’t a lot of
help on offer but I mean…to say something was really serious, yeah of course…
((Clears throat)) Umm…oh, I guess probably sadness, I don’t know, probably
jealousy at the time, but generally I just kind of, I guess I just learnt to look after
myself… (3B)

I just kept quiet, I guess I learnt that with trying to tell people that I was getting
bullied by my year three teacher, no one really listened they thought that was attention seeking, so I learnt from a young age to keep my feelings to myself and my feelings weren’t validated and it meant they’re not acceptable. (4B)

Despite using substances to feel right or achieve a comfortable state, several clients viewed that they experienced a frequent sense of dissatisfaction when attempting to regulate themselves in this manner. By accessing their views on the matter, clients appeared to experience deep/profound emotional turmoil and struggled with containing those feelings. It was as if their emotional struggles were inadequately managed and they were expecting more from the experience.

Mmm, I was looking to feel comfortable and I like to feel comfortable, that’s not the right way to find that. It might not make sense, but it does to me. I was angry... because it took me a while to work it out that what I was look, what I was actually looking for. ... I just liked the feeling of feeling comfortable, not hurting anymore, wasn’t scared, just liked that … fortunately I didn’t get that same when I went back to drinking, I just couldn’t … (2A)

Not being satisfied? Well…I guess that’s just really compounded the depression and uhh…yeah…it’s…even though you’ve got what you wanted, to feel so umm… disappointed about it, is pretty upsetting, yeah…which again, maybe that motivates you to continue to, you know, try and obtain more. But when you got no money, and there is no more then it’s very frustrating so I suppose you get a lot of anger… uhh… along with that sort of feelings…so makes you probably angry…yeah, it used to make me pretty angry and pretty withdrawn… (3B)
5.3.3 **Clients’ Experience of Substance-Use**

The discussion of clients’ experience of their substance-use revealed two prominent basic themes: More Dependable than People, and Unreliable. These themes appear to be at odds with one another, but on closer examination, reflect the ambivalent views many clients have with their own patterns of use. On one hand, clients viewed that the substance was more dependable than people (i.e., significant others) in their lives, whereas on the other hand, clients had experienced unreliability in its effects on themselves. The substance was viewed to be inconsistently providing security-enhancing effects, leading to frustration, and more use (See Figure 13).

![Thematic sub-network of “Clients’ Experience of Substance-Use”](image)

*Figure 13.* Thematic sub-network of “Clients’ Experience of Substance-Use”. Note: Elliptical denotes the Organising theme, rectangles denote Basic themes, and rounded rectangles denote data extracts.

**Basic theme: More Dependable than People.** This theme relates to how the participant clients had experienced a sense of security with their substance. Compared with
disappointing experiences with significant others in their lives (presented above), the substance was seen as being more dependable. A client spoke specifically about how the substance was always there for her, and did not ask anything of her. As clients spoke and gave their views on their relationships with the substance, they began describing them as though the substance were a person. One client referred to his substance’s street name, “Tina”, relating to her like a person; another talked about loving it; and two others had called it their “friend”. Most the clients spoke of specific preferences for particular substances and their persistence in using despite negative consequences to them.

Clients reported patterns of use in their substance-use relationship, when feeling distressed and uncomfortable, seeking security and confidence. These encompassed psychological benefits such as being more in control, helped with managing their emotions, and an overall sense of security:

Security because if something’s going wrong, if I’m having a panic attack, if I’m at Uni in a lecture and I’m anxious I can pop some pills and you know, just for a while, it chills out you know... security because it’s there when you want it. (1A)

It was my friend, but it wasn’t, but at the time I thought it was my friend, that I can trust it. Well it’s, it was something that was always there, you’re not lonely … doesn’t ask anything of you... it’s just an evil little thing that, like a bad friend, does you more harm than good. (2A)

Umm…more security than insecurity. Yeah, definitely. Again, definitely comes back to umm…enjoying, enjoyment and confidence and increase self-esteem. Those would be probably the three key things but definitely enjoyment would be up there. (5A)

As a general sense of well-being is all I can describe it as, which might have been a
bit of a flood of a slightly orgasmic feeling. Then just to an overall feeling of invincibility. Not even that, not quite that strong as invincibility but I could handle everything. Same as in Vietnam when I started using it, I was working long hours and on my feet all day. I was going to a gymnasium; I was socialising every night. So in the traffic of Vietnam, in a 3rd world country, all the dramas could happen in that, didn’t bother me. I could handle it all. (5B)

Yeah…I guess so, it’s to find that feeling of confidence, that feeling of having a bit of control, uhh…of not being anxious. It really uhh…you know, even though withdrawal increased the anxiety tenfold, having it must have been really brought my anxiety right down. So I think that’s…a lot of my problem was really high anxiety, which could have been…(sighs)…why I was actually stressed, it’s something that’s probably a condition that I’ve learnt as a child…probably so, you know. (3B)

It was interesting how these individuals could be so dependent on their substances, despite the impact of its use on them. The following discussions laid out clients’ views of experiencing a relationship with the substance, as being something they could count on:

The connection or relationship…isolating…you believe it’s the only thing you can depend on. Because you love it so much you make excuses for it, you don’t want to believe that it’s doing that to you, you know, oh that’s not the reason and you try and you know, bullshit your way around it… but it’s a slap in the face you know and you’ve dedicated so much of your life to this one thing you know, and it’s, when you realise that it’s destroying you… and it’s got, it’s still got power over you because even though you know it’s destroying you, you still don’t want to give it up… it’s difficult. (1A)
It, it’s not a good friend, it, as I said the only way I can describe it now is like picking someone that is horrible to be your friend because all it does is damage you, it doesn’t allow you to be yourself and I preferred being myself. … Because I’m, I couldn’t see the damage it was doing to my body... again it was a habit because I’d always drunk, but I didn’t realise I had a problem with it until I quit work so... I was only sort of flat, work, drink, work, drink, work, drink and don’t think what it’s actually doing to me or not doing to me. (2A)

Yeah… she’s a, she’s a hard bitch, Tina [the substance]. You know, that’s the relationship I had with her. She took everything away, you know, and I let her. You know, and that’s the relationship that we had, you know. I gave and I got nothing back. Umm…uhh…just a…just a constant craving to…to, you know, be totally, totally…cut off from the real world. You know, literally, you know, like a week. You know, you drop out for a week, or two…((laughs)) sometimes. And umm…you know, that relationship was umm…ahh…ahh…can’t think of anything more to say about it. (3A)

Umm... well it used to be very fulfilling, it filled a great void in my life and so it got a hold of me that way, … it’s tender and giving and things like that. (1B)

Oh, it’s a, it’s a comfort... I usually drink the same label... it’s a bit of a friend yeah. it... ah... it, it’s just a comfort... and it won’t let me down... but I’m wary of it, I have a lot of respect for it, like I don’t drink spirits or liqueurs or ports, I don’t touch them because they can do bad things to me. (2B)
These discussions highlighted how clients personalised and viewed their substance-use as being a functional part of their lives. It was also evident in their discourse that there was a downside to this so called desirable relationship that purports to provide a sense of security. Whether it was described as “evil”, a “bad friend” or a “hard bitch”, their relationship with the substance was viewed as a difficult relationship they could not do without.

 BASIC theme: Unreliable. This theme, on the flipside, summarised what the clients disliked about their experience of their substance use. Despite their dependence on the substance, all the clients complained about its unreliability to consistently provide desirable effects, and often delivered contradicting effects than intended. Their ambivalent attitudes toward use of their substance can be identified all through their discussion:

Umm, you know, it’s let me down personally…you know, by, losing my job, putting myself under financial stress, putting myself under relationship stress…so there’s a whole lot of stuff there that has let me down. (3A)

I hate it ((laughter)) because my life was relatively together and I’m quite an intelligent girl and I have quite a lot to offer the world, but it’s just such a strong relationship that it’s so difficult to break and that’s why you see people rebounding back and forth through rehab, but I guess I just have to have the willpower to say no... (4A)

When you’re on drugs you feel happy, you’re at peace or I feel happy and at peace with myself… it’s just a happy medium, I can concentrate, I can function, I have energy and then when it all comes crashing down you don’t have energy, you have the
guilt trip... the lies that you’ve got to keep covering up, the financial burden...
everything that goes with it, yep. (4A)

I suppose you’d have to say it’s kind of a love, it’s kind of a strong desire. It’s like a
security, you know. So that’s the best way I could understand it...so yeah...I mean
how do you feel about that...ohh, I love it. That’s probably what I would answer
when I was using it. ((pause)) As much as you love it though, you dislike it too
because of the turmoil it causes because of the difficulty surrounded in...in
participating in that sort of behaviour so...but I guess the deep down feeling would be
that you really love it cause otherwise, you wouldn’t be prompted to be so...willing to
go through what you go through to obtain it, I guess. (3B)

Well, often it made me feel relieved and good, uhh...but at the same time, I would
feel very self-conscious and very like, emm...probably down on myself with
disappointment as well because of the fact that...I...you know, the whole time...most
of the time I was aware that the...you know, the negative side of using as well as the
positive side and often, I wasn’t getting...I wasn’t really being satisfied on a regular
basis too, so I was in a situation where basically I wasn’t just...uhh...I wasn’t just
umm...for...providing for myself but I was also providing for someone else. So it
was a constant sort of struggle and then there was the sharing of it and it just all gets
too hard, you know. (3B)

In order for clients to successfully use their substance for its desirable effects, clients
viewed that using itself, was a delicate balance that could determine their security or
insecurity to their substance. There was also a sense that many clients perceived an illusion
of control, which may add to the disappointment when they experienced ill effects. This
discussion summarised how achieving this balance was an elusive process:

Frustrated. Of course then, I would go and try and use more. I used to call it chasing the perfect wave. During that time, there would be uhh... I was able to talk... trying to chase the perfect wave. So there was still a little bit of, you know, rationale in there somewhere for me to be able to say that, you know, we’re chasing the perfect wave but we’re not getting it but let’s try again. (3A)

Yeah, that’s the sweet spot now you just keep it steady because if you drink too much more, which is why I chose alcohol, because you ((inaudible)) you’re in control again ((inaudible)) because you know what you’re taking, you know the strength of it and what you can deal with. (2A)

Yeahh…yep, yeahh… juggling it, yeah. Cause I think again, this is gonna sound stupid but I think, I’m a better person…I think I’d rather feel more in control on cocaine or by having cocaine, or by having too much alcohol… My biggest issue would be not knowing when to stop and I’d be out drinking and before, I’d either…before I’d know, it’d just be the next day…I’d have just blacked out and I couldn’t remember anything. So I suppose that would be the plateau or you’d get to a certain limit where you’d go from having confidence just to not being able to control yourself physically or anything. (5A)

You know; I never once been the same when I drank alcohol. I never drank to be completely pissed. I knew the warm feeling of mild inebriation when you can socialise and your inhibitions are down a bit. Which I think is good, you know, if people can stop at a couple, I really can’t stand drunks. (5B)
Yeah... yeah it just makes me feel important and worth something if I have a couple of drinks... however, if I get into the spirits or the liqueurs or the ports and drink too much it shatters my emotion, emotions and I’m thinking bad thoughts, I become suicidal and I’m very unsafe. (2B)

Nevertheless, clients viewed that the substances often gave contradicting effects and failed to consistently provide desirable effects, contributing to the view of its unreliability. There were experiences of being ripped off and feeling upset after depending on the substance for that security. Some clients described their negative experiences and underlying insecurity of being disappointed or let down by their substance:

The only thing that doesn’t answer back to you or treat you like shit even though it does treat you like shit ((laughter)) ... makes you feel incapable because you can’t function or get your life together without having something and that makes you powerless… because it makes you feel incompetent and powerless and weak because you can’t do it on your own. (1A)

I just get angry because why, why was I taking something that I didn’t enjoy and didn’t get pleasure out of, because you’re supposed to enjoy it and get pleasure, but I didn’t. I think it was a realisation that I didn’t. (2A)

Well…I guess that’s just really compounded the depression and uhh… yeah… it’s… even though you’ve got what you wanted, to feel so umm…disappointed about it, is pretty upsetting, yeah…which again, maybe that motivates you to continue to, you know, try and obtain more. Umm… well, after going through either the period of...
time waiting or whatever you had to do to get it and then having it and it being not what you expected it to be …so you feeling ripped off. And I guess that’s what the anti-climax is…it’s a really ripped off feeling, really disappointed feeling. (3B)

Security when you first started using it like when I just talk…like a one use type of thing, yeah…first off, security…yep. But, you know, towards the end of it, definitely very insecure. Umm…interpreting people’s body language, you know, obviously would have been totally skewed but of course, yep, totally insecure towards the end of it. (3A)

You know and you know, probably, although it makes me ahhh…although I say emotionally that it cuts you off, but I don’t think it does internally-wise, I think there’s still a very yearning to be close to people and all of that. But, when you know, it’s hard to say. I feel that certain emotions it really cuts you right off, other emotions, it really heightens the need to be close or…you know please someone, or something along those lines. The emotion sides where it’s been negative. (3A)

Umm…Umm…to be honest, it turned on the sex drive. You know, that’s it…that was my thing, to be honest. You know, that turned me on and then…then that was it. But, the joke is of course, there was very little sex going on, but in the head, it’s like ohh, everything’s sexy. You know, people down the back of my house, you know, waiting to come in, and all this type of stuff…so the psychosis side of it all, and all of that. So yeah. That’s what it was. (3A)
5.3.4 *Addressing Clients’ Needs in Therapy*

This discussion of clients’ experiences in psychological therapy provided clients an opportunity to share in their views about the therapy, as well as their relationship with their therapist. These included clients’ views about what was helpful and unhelpful during the course of their therapy. The thematic sub-network summarised these views into three succinct themes: Safe Therapist Characteristics, Working Through Enactments, and Making Sense of Clients’ Experiences (See Figure 14).

![Thematic sub-network of “Addressing Needs in Therapy”](image)

**Figure 14.** Thematic sub-network of “Addressing Needs in Therapy”. Note: Elliptical denotes the Organising theme, rectangles denote Basic themes, and rounded rectangles denote data extracts.

**Basic theme: Safe Therapist Characteristics.** This theme summed up what clients viewed were useful therapist attributes as a result of interacting with them in the context of psychotherapy. These served as critical to understanding what sort of experiences these clients encountered relating to their therapists, but also what they thought helped create a secure environment for examining clients’ issues. This discussion with clients yielded five characteristics that clients viewed were universally helpful – that therapists were Non-Judgemental, Supportive and Kind, Trust Helped Confront Fears, Predictability, and Attuned.
Whilst different clients appreciated what being safe meant for them, their views of these traits appeared to overlap with one other.

Clients appreciated that their therapists were non-judgemental – encouraging clients that it was okay for them to feel their emotions, and in a way, that helped clients begin self-acceptance. This was important for these clients since they had sensitivities toward self-criticism, and experienced disappointment from their parents/caregivers:

Just a...nice...nice feeling. What more can I say? Very calming. A very calming sense of security...I’m at ease, umm...you know...I mean, I swear in there and he swears back and stuff like that, you know... It’s just a good relationship. I thoroughly look forward to it. (3A)

She’s never judged... she’s given her opinion and at times I haven’t agreed with her opinion, when I wasn’t her patient, when I was with my ex-boyfriend that met across from there... but... she handled it brilliantly and so I have a lot of respect for her. (4A)

Oh, I think it’s really good, I think she’s helped me a lot, yeah. I feel... I can talk to her about anything and she wouldn’t be judgemental, yeah. (1B)

She just asked me can be calm to myself and accept how I’m feeling right now. Just the same things, the same words each time so just reminding me that it’s okay to feel how I’m feeling, acceptance. (4B)

Clients viewed that their therapists’ kindness, sensitivity, thoughtfulness, and patience helped them in periods of distress:
I haven’t seen [therapist] respond any way but with thoughtfulness, with mindfulness, you know (laughs), breathing exercises and stuff like that and you know, going through and reassuring me that, you know, this is normal, what you’re feeling and, you know, you need to get all parts of therapy in place type of thing. And you got to give your brain time to catch up to what your body’s feeling and stuff like that. So, no…all the time, he’s never shown me any frustration or anything like that, so it’s totally good. (3A)

In the midst of clients’ views of their therapists’ supportiveness and kindness, one client viewed that trust in the therapist helped clients’ willingness to be vulnerable with the therapist in session, despite their fear/apprehension. In this example, the trust enabled Client 1B to challenge her view of men that not all men were terrible.

It’s been really important because I’ve always had female therapists and I’ve always had a lot of fear with men and not trusted them and [therapist] is a very good and decent man and it has sort of, made me think that the bigger picture that you know, that all men aren’t terrible you know. It’s given me a bit more trust in my relationships with other men. Might be a neighbour or friend or an AA [Alcoholics Anonymous] member. (1B)

According to the discussion about clients’ trust in their therapists, clients viewed that even if their therapist upset them, there was some degree of understanding in the client-therapist relationship that helped clients to better tolerate their own insecurities. Another benefit included Client 4A’s view that trust in their therapist strengthened their relationship with each other.

I got a lot faith in [therapist] and, although at the present moment I didn’t understand
why she did it, I knew it was wasn’t malicious, I knew she wouldn’t want to hurt me. I trust her, I feel safe with her and, so I wasn’t angry at her or even upset with her really, I just went ((breathy noise)) ouch you know... so yeah I don’t really think there was any difficulty there you know. (1A)

He has given me the strength, not the strength ((inaudible)) I feel better about myself through being able to speak openly about how I feel and not getting negativity thrown at me. Because I never like to say anything that somebody might not like and it took me a long time to realise you can do that with a therapist because even if they’re good, even if they don’t like what you say, they can accept that it’s you working it out for yourself. (2A)

Umm... I don’t ((inaudible)) it was only last Tuesday... it kind of made me feel wary, it made me feel insecure I suppose thinking Oh shit she’s not going to trust me you know, but I left there knowing that it had to be said and I thanked her for it because I would have rather that she got out on the table. It didn’t make me feel bad or anything. It actually built our relationship. (4A)

Another trait that clients viewed that helped with creating a safe therapeutic space was a sense of predictability – essentially, knowing how their therapist reacts helps with displaying empathy and understanding.

Umm... empathising... not through words but through the looks she gives me and her body language, telling me that I’m not just going to move on from what was said this is important and you’re important to me and I’m going to take this in and you know... and... the other times that she’s silent she’s trying to figure out what’s going on in my
head, yeah. (1A)

He makes me think... or he doesn’t make me think... he uses words that I take as think about it, work it out ((inaudible)) I feel confident... ((long pause)) ... don’t know how he’s done that, but I’m receptive to his way of, because I listen so his use of words makes me think and work things out... without ((inaudible)) better way of saying it and I can’t think of ((inaudible)) ... whereas with [therapist] I know the silence is not, wait for something horrible to happen. I hadn’t thought of that ((inaudible)) (2A)

Lastly, clients viewed that their therapists possessed an ability to remain attuned to their needs. Clients discussed how they felt their therapist had good timing in their actions, and knowing exactly what to do, conveying a deep sense of understanding.

Umm... there’s a delicate balance and she’s very good at knowing... when to be gentle and when she needs to push, but... She did everything right. Times when I was dissociating, having flashback that weren’t so intense that she knew that I had to feel to... reinforce that I needed to stop what I was doing, she did and... but the majority of times when it’s happening she was very comforting and gentle and... caring... and a hundred percent focus is on you, you know, and doing what she can and she’s very understanding and... she explains things to me that I don’t understand if I’m meant to hear them, because she’s always very conscious about not triggering me. (1A)

Don’t know why... he... I’d like people that say what they mean, that are honest... very intelligent and wise enough to know what you can and can’t say... he fits the ((inaudible)), he’s very good at his job and I respect him... and for me that’s what you need with a therapist. (2A)
She has been someone who has listened to me and understood me... she delicately tells me when I’m wrong... she takes on board what I have to say, she’s kind and she’s caring and she’s just... a beautiful, beautiful person to have a relationship with. She’s an advocate for me and she’s, I feel like she’s got my back. She’s that friend that has power as such, to help me. All my other friends are helpless, they can’t tell my dad you know, nothing, anything, but she has a qualification behind her and as I said to my dad before, I said dad, you see things as a parent, you see things from a parent’s perspective, [therapist] sees things from an unbiased, clinical perspective and she really, she just gets me, yeah. (4A)

*Basic theme: Working Through Enactments.* This theme described the underlying processes that therapists could work through with clients, as a focus in treatment to address their underlying emotional needs. This discussion about their experiences with their therapist required time for clients to expand on, as field notes indicated that some clients were defensive/ protective of their therapists, whilst others were more direct about how their therapist could frustrate them. One client highlighted that she felt her therapist’s stance was similar to how her parents parented her. Clients provided views that included: Appreciates a Non-Directive Approach; Talking to Therapist Resembles Talking to Parents; and Personal Insecurities Impacting Therapy Relationship. By working through these issues that surface in the therapy, therapists may be able to address their clients’ needs more effectively.

Given that many clients had been judged by others and told what to do in their own lives, clients viewed that a directive approach to therapy would not be helpful or even detrimental. According to Client 1A, who was training as a family therapist, firmly did not believe in being told what to do:
[Therapist]’s gotten, I believe much the way of doing therapy that I believe in and... that is to... indirectly instill within me something which makes me come up with the answers of what I need to do which then gives me the motivation to do it because I haven’t been told to do it, it’s something I’ve figured out myself and I want to change and, yeah that’s what she does. (1A)

[As opposed to] I’m going to tell you how to interact with your family to change it and I’m the be all and end all and if you do what I say then it’s going to get better. It’s all a load of fucking bullshit you know and I don’t believe that’s the way therapy should be done at all. (1A)

Because a therapist is never always going to be right and... as much as the client learns from the therapist, the therapist learns from the client and yeah, it’s a collaborative thing you know, and I think that when you’ve got someone dictating to you, what you need to do, it strips you of your own self-confidence, of your own empowerment you know, of your self-confidence to know that you know, you can make changes in your life that you know, you can you know, it strips you of all of that you know and I don’t think that’s the ingredients to help someone in any shape, way or form. (1A)

Other clients viewed that a non-directive approach helped by allowing clients to think for themselves, and does not trigger off clients’ issues and insecurities in the midst of interaction.

It’s... when you’re discussing something or if you’re wanting to say something... there is a certain way you can say that will allow people to think, whereas if you give
advice that’s not allowing the other person to think for themselves so you say it in a way that makes the person think for themselves... He makes me think... or he doesn’t make me think... he uses words that I take as think about it, work it out ((inaudible)) I feel confident... ((long pause)) ... don’t know how he’s done that, but I’m receptive to his way of, because I listen so his use of words makes me think and work things out...

(2A)

As highlighted above, Client 5B’s view of his therapist’s critical comments on him resembled how his father spoke with him, and Client 1A viewed that her therapists’ strong stance could have put her off. Client 1A was reportedly used to being told off and shamed by her parents. In addition, Client 5A pointed out that talking to his therapist resembled talking to his parents – he explained that they (i.e., parents and therapist) did not understand him. He viewed that like his parents, his therapist could not comprehend his substance-use:

Yeah nah…it’s all…I enjoy going to see him and speaking to him [therapist]. Umm…it’s good just having someone to talk to but it’s also hard talking to him when they haven’t been in your situation. It’s like I try explaining to mum and dad. They can’t work out why I have to have cocaine when I drink and then I try to like, use an analogy, which I’ve used with [therapist]. For instance, like you might not be able to have…umm…you might associate having a glass of wine and having some cashews with it. To me, the alcohol is the wine and the cocaine is the cashews. I just uhh…they just go hand in hand. You know, if you umm, have a burger, you have chips with it. That’s to me, how I see things and it’s hard explaining it and people taking that on board when they haven’t been in that situation…so it’s sort of poor experience to themselves. That’s what I find the hardest. (5A)
Another theme emerged following a discussion about clients’ personal insecurities, and how they thought impacted the relationship with their therapist. Several clients viewed that their personal insecurities had inadvertently led to their experience of a sense of insecurity with their therapist. Clients appeared to struggle with a sense of ambiguity or ambivalence as they experienced discomforts engaging with their therapists:

I see vulnerability as a weakness because whenever I’d be vulnerable before she’s gone down, even though I know that you know, that a sense of vulnerability is a strength, I can’t process that yet. I’m not there yet you know so I don’t like to be vulnerable and when I’m with [therapist] I’m vulnerable and that’s uncomfortable for me. It’s comforting because I know that she always reassures me and builds me up and, and that through it, but I still, it’s uncomfortable for me. (1A)

Because I never like to say anything that somebody might not like and it took me a long time to realise you can do that with a therapist because even if they’re good, even if they don’t like what you say, they can accept that it’s you working it out for yourself. (2A)

I was insecure because I didn’t realise therapists will... there’s two points to this one. One, I wasn’t ready... in that I couldn’t... ((long pause)) ... say half the things I would have said or that I can say to [therapist] and some of the, one of the particular therapists I had, spent the time working out where they were going for holidays. So, I didn’t see ((inaudible)) after that. They need to be able to... at least portray that they’re there to help me. (2A)

I was terrified of him [therapist] ((inaudible)) but that’s why I liken him to my
granddad, because my granddad terrified me to begin with, but... after a while you realise that it, doing things for a good reason not a bad one, so you can, you can be there safely sussing him out which is important for me. (2A)

…Oh because I was always nervous, I’d think I have to keep saying something so silence is not bad. That’s quite interesting relating back to my parents, that’s how I’ve changed... because now I’m, I’m not insecure in silence, whereas I must have been and not realised it. (2A)

Yeah, trust yeah couldn’t trust them [therapist], thought they were judging me, didn’t like them... yeah just saying the same stuff each time, yep. (4B)

I felt that I knew what he [therapist] was looking for when he asked a question or asked me ...and I was answering those questions as well as anybody could, ahh…considering the circumstances. So I think maybe I wanted a bit more probing, you know, from him that I felt that …ah, this is almost what I…very much what I would expect. That, you know, I want more as well I know what these people get paid. I want to see some progress. (5B)

I guess that was interacting with someone new…with someone that I didn’t know…with a stranger. I haven’t really had much to do with psychology or anything then with any sort of counselling…so…umm…I was open minded though…I was of a…of a …I’ve got nothing to lose from this. And because I’m pretty insular, I don’t really talk to anyone else apart from my partner, I guess it’s a good thing to have somebody that’s not attached to my life…but is very understanding of anything that I’ve got to say, so it’s helpful in that way. (3B)
While some clients balanced their views with presenting a more positive view of the therapist, others shared angry and contemptuous experiences as a response to their therapists:

Not insecurity, maybe once when I was disagreeing with him. I maybe felt like he was being a little bit too firm. Umm when I was trying to tell him I didn’t have an issue but he was trying to tell me that I did. Yeah he was a little firmer than I’d thought he would have been with his opinion. (5A)

Umm…it’s sometimes in my head, that obviously he’s still human, so he’s still…inside his head, he’s still judging as well…so it does go through my head quite a lot. Obviously, he’s talking to me as a therapist but inside his head, he’s a human being as well, probably thinking…thinking uhh…you know, sort out your issues you idiot…rah rah rah… (5A)

You know; I give everybody the benefit of the doubt. I think he’s a good person and a good therapist so I think it’s me with the problem and not him. I’m …I don’t wanna shift the blame like some drug users do, won’t see their own fault. You know, and I…I don’t like it in other people so I don’t blame people for my mistakes. So I think sometimes you do the best you can and you can’t intuitively know everything about me that I know, so I do say well, I can’t expect more, I doubt whether there is more. No, I wouldn’t say I doubt completely. I think there are people who are super terrific and there are people that rich people go. That, you know when you go to the Betty Ford Centre or something, and they get the better…people who work for them. I’m getting one free. (5B)
Well, I don’t know whether it’s that I’m thinking why doesn’t he ask you about this, why doesn’t he understand this, he’s a psychologist. Why doesn’t he, hasn’t he got a greater…do I have to teach him what it is to be a junkie? Have you done that training? And so, you know, you’re wishing and hoping that somebody would give you a cure or help you and I don’t think there’s a terrible lot that they can do. It’s a physical thing, drugs, and when you’re in the psychologist chair, it’s not; it’s a mental thing. (5B)

Nevertheless, these clients share an acknowledgement of their own personal insecurities influencing the relationship they have with their therapist. Given that the therapists had no knowledge about their own clients’ internal responses to them, could mean missing good opportunities to address relational issues or patterns.

Basic theme: Making Sense of Clients’ Experiences. This theme was about a collection of clients’ views of what their therapist did in the course of treatment that they found useful and critical in shaping their experiences toward healing, and assisted with their substance use. Three succinct views emerged: Building Confidence, Encourages Emotional Exploration, and Understanding by Talking Through. By focusing on these areas that make up this basic theme, therapists can legitimise and assist with helping clients bring meaning and understanding to their own individual experiences – crucial for addressing clients’ needs in therapy.

Clients who benefitted immensely from their therapy experience reported views that their therapists gave them confidence or helped them build their capacity for reflective thinking. By focusing on increasing one’s self-confidence, it helped bring clarity and put
them in a better frame of mind to cope with tough situations. More crucially, regarding one’s relationship with substance, confidence building also appeared to generalise to one’s own perceived ability to cope with their difficulties without the use of substances – possibly as a result of feeling more secure in themselves.

Yeah my therapy has been helping a lot, really building up my self-confidence and now I’m kind of getting clean and not using. (1A)

Umm…good…actually, very good. You know, I’m feeling strong. I’m feeling better than I’ve felt for many, many years. I’ve got a clarity of mind, strength, a bit of determination there to continue on being clean and improving myself again.

Ahh…because I’m getting so much out of it, I think. I think that after every visit, I feel initially better. I’m always better after seeing [therapist] than before seeing him. But in the long term, I’ve seen a totally different me coming out of it. That’s why. (3A)

From the time since I’ve been seeing [therapist], was when I basically had stopped using drugs. So prior to that maybe, I’d had maybe one or two binges, sort of. But now, it’s actually…I get a lot of self…I guess I get a bit of self-esteem out of it. I get a bit of confidence and of course, financial, I’m better off. Life functions a lot easier, things don’t go wrong…and if they do go wrong, I’m in a peace…frame of mind, in a position to deal with those things, instead of just being like any small occurrence would be a major problem. But now, I can actually participate in life, feeling a lot more normal. (3B)

Uhh…I think my relationship with him has been beneficial to my…going forward. Umm…umm…it’s a clinical relationship but also I do feel comfortable with him, just
talking to someone that I can trust, I guess. (3B)

Prior to seeing him, I was a lot more confused and probably a lot more withdrawn… umm…I guess, maybe seeing him has gave me the encouragement to try and change things in my life. It gave me a bit of umm…umm…confidence. (3B)

By encouraging emotional exploration, clients viewed that it gave them the space to accept how they feel and that it was acceptable to feel a certain way. This helped clients be more authentic in the articulation of their emotional experiences, and build awareness about what was going on when they felt particular emotions. Essentially, building on their emotional competence.

No, not that, no my, [therapist] allows emotion, my grandad doesn’t and that’s the difference. (2A)

Umm…he would probably, he would be compassionate and understanding…probably give me…breathing and stuff like that to try and…umm but if I was upset, I guess he would allow me to be upset. Sometimes when you get to that stage, he might ask other questions just to explore that emotion…that’s there when it comes out. He would ask me to think about what I’m feeling at that stage and how it’s making me feel. They’re difficult questions to answer but umm…yeah, I guess it’s part of…of…of understanding what’s going on when you are feeling a certain emotion…when you are expressing a certain emotion. (3B)

Umm... the most... [therapist] only seen me cry a couple of times and she’s only seen me escalate to a state of nah once or twice and it’s only when she’s mentioned the
thought of moving back home with my parents and she uses grounding techniques so, “[Client 4A], I understand, just calm down, breathe”, and I do calm down, she just gives me time... and she’s, she’s reassured me in the past when she’s seen me cry that it’s okay because she’s getting to see the real [Client 4A] and she’s getting to see a range of emotions that she wouldn’t usually see because all she usually sees is my happy, yeah I’m okay, you know, persona... and I mean a lot of the time I am happy because I suppress a lot so it just becomes second nature to keep the smile on my face ((laughter)) ... yeah, so that’s that. (4A)

She just... helps me to accept it, that it’s okay. Not really give me strategies to be honest, more just, just... helped me learn to accept that it’s okay that this happens, whereas before I couldn’t accept that it, that it was happening and I’d get on drugs to get away from it. So now it’s just having to deal with the sadness and the loss and the acceptance and accept it and forgive myself and not carry that guilt. (4B)

Another aspect of helping clients build emotional acceptance and competence, is that of helping them build that understanding by talking through their experiences. Through this discussion, many clients shared how this process made them feel secure, validated, and assisted them to analyse the meanings behind their emotional experiences. This process gave way to a deeper self-understanding of the nature of their struggles and put their substance use into perspective. A clients’ discourse also showed that this process can help the client focus less on their own insecurities and be more open to observe one’s impact on others.

Umm... well it’s validation usually so it makes me feel secure. ((long pause)) Umm... well secure, validating my feelings, umm... yeah just allows my... Oh just talking through them, yeah. (1B)
But it seems and appears to be, very free-flowing and he gives me the tips and the tools of the stuff behind what I’m feeling. I’m a little bit of a thinker and you know, that helps me then mesh it all together and I feel better…better for it. (3A)

Umm…I guess he kind of helps me to analyse what’s going on. Umm…and he also confirms some of…you know, if things are stressing me out and I’m giving him the reasons, well he confirms to me that those are credible, genuine reasons for feeling that way. (3B)

When things do stress me out, he does often say…but try it…when things are doing that to you, try and think how that makes you feel inside…it’s a hard thing to do…but obviously, it’s all part of trying to understand emotions and stuff so…it’s hard to put into words but…yeah. I don’t really know what to say…so. (3B)

Oh she’s… helped me recognise when I’m actually getting agitated because I’m either calm or… I’m just totally off the planet angry, aggressive, violent and she’s taught me to be assertive and that it’s okay to be assertive providing you don’t get aggressive and she’s, she’s done that through, I’m a very visual person, she used the, she used a pen to kind of identify… simulate a speedometer so when I’m calm I’m like this and when I’m escalating I’m going like this and when I’m going like this I need to enforce those grounding techniques and take a second to think about what the situation is and how I can respond assertively, yeah. (4A)

Umm…puts things in perspective…that’s one thing I’ve got out of it. Umm…and to try being more, more understanding of other people’s concerns. Umm…since I’ve been
seeing him, to start off with…I’d dismiss them. And just think, oh you know, they’re not concerned…rah rah rah. But more now lately, when I haven’t been drinking as much, to taking on board and actually see how my actions ((coughs)) were affecting other people. (5A)

By talking through and making sense of clients’ experiences, clients had universally viewed that it helped them feel more secure. From these clients’ discourses, it is evident that clients were able to call to mind how their therapists would react or say to them verbatim.

*Clarification of Themes.* By reviewing Client 3B’s clinical profile as a result of the cluster analysis, it was found that the collection of data codes that grouped was consistent with the following themes that emerged from interviews with the rest of the clients. These clusters and their basic characteristics served as guides and added a degree of confidence in the identification of the following themes in the current study (Macia, 2015). When compared with the other clients’ (i.e., 1B, 2B, 4A, 4B) codes that clustered together that highlighted the positive aspects of their therapists, Client 3B’s views reflected a more critical, in-depth interpretation into how he experienced the therapist, despite a good connection with his therapist. Although Client 3B had a secure attachment to his therapist (as indicated by the CATS), he viewed that his difficulties communicating with his therapist, was based on his own personal insecurities:

I guess the insecurity was...you know, what have I got to gain from this …this [therapy] situation. Umm…umm…how is this going to benefit me. Umm…this is prior to initially seeing him, you know. Umm…at the same time, because it was recommended, I’ve kind of felt well, I’ve got nothing to lose by going so we’ll see how it goes, you know, so…umm…I can’t…it’s hard to describe the insecurity. (3B)
Ohh…probably just feelings of inadequacy about myself, and…and feelings of, I don’t know, withdrawing and stuff like that. ((pause)) yeah, feelings of failure I guess, and stuff like that. ((pause)) feelings of probably of…of, like I said, what have I got to gain from this…how’s this gonna help me. Umm…I guess that’s about it. (3B)

Given that Client 3B’s attachment organisation is characterised by a Fearful attachment (as indicated by the ECR), his expectation of potential attachment figures (such as his therapist) involved an extreme discomfort with being able to trust and depend on others. This parallel exists with his caregivers as he viewed that his parents had let him down:

So, if you can relate that to how I feel about my parents, then, you know, so basically what I’m saying is that they probably did a pretty crappy job. Now, whether circumstances surrounding that, you know, had a lot to do with that I guess, but yeah, …I think…I guess I could say I feel pretty let down by them. (3B)

Similarly, that parallel of being unable to depend on unreliable others was also seen in his views about how the effects [of the substance] were never constant, and something would always eventually go wrong:

It can be, yeah…it can be…but sometimes it would be alright but you know, often that level of fulfilment of…uhh…what you call it…of…uhhh… contentment, you know, was very iffy. Maybe you’d be content but something would always eventually go wrong. Whether it was lack of being able to get it, having to wait longer, and longer and longer to be able to get it. Or the quality of it being just not what it was yesterday. Whether it had to do with tolerance…your tolerance going up as well, your emotional state at the time…I mean, there’s probably a lot of factors but in general, I think it was basically, things were never…never stayed on a constant. It
was always different every time, so, you know, it’s a very daunting sort of. You
never know what you gonna end up with kind of thing…even when it’s been constant
for a long time. You could go on a fourth day, on a fifth day, on a third week,
whatever, and all of a sudden, things have changed and it’s not the same. (3B)

5.4 Discussion

The current study pursued an exploration of the relational patterns substance
dependent clients in psychotherapy have toward their interpersonal relationships and
substance use, and how these patterns/ dynamics work at depth. Core research questions in
the current study encompassed (1) how substance dependent clients view themselves, as
opposed to others (i.e., primary caregivers/ significant others, therapist), and (2) how these
relationships impacted their substance use. Also, to understand (3) how these individuals
experience the psychotherapy process, (4) how their interpersonal patterns of relating was
played out with their therapists, and (5) how to address these attachment-related issues in
psychotherapy.

Firstly, consistent with attachment studies that gathered evidence for a relation
between insecure attachment and drug addiction, it was found that all the clients in the current
study displayed dominant insecure attachment patterns, and levels of attachment security were
comparatively low. In particular, the majority of clients had a fearfully avoidant attachment
(high on both attachment anxiety and attachment avoidance dimensions), followed by
dismissing (low on attachment anxiety and high on attachment avoidance dimensions), and
preoccupied (high on attachment anxiety and low on attachment avoidance dimensions)
patterns of attachment. This finding is consistent with reported high prevalence of the fearful-
avoidant style in the addictions population (P. R. Shaver & Mikulincer, 2002) and this view
leads to the assumption that a high risk for dysregulation, associated with overwhelming
feelings of separation, solitude, danger, fear, rage, helplessness, abandonment, and isolation
would be present in clients with substance dependence (George & West, 2012). The clients in the current study reported difficulties coping with distress in several contexts, including familial abuse and parental history of substance use. Consistent with attachment theory in the substance dependence literature, because of their severe lack of attachment strategies to reduce emotional distress, most clients with addiction showed unresolved and dysregulated attachment (Juen, Arnold, Meissner, Nolte, & Buchheim, 2013), or dismissing and preoccupied attachment representations (J. P. Allen, Hauser, & Borman-Spurrell, 1996; Fonagy, et al., 1996).

Four discrete but inter-related organising themes were found to be core themes that influenced clients’ global theme of a relational dilemma: (i) Clients’ Unmet Emotional Needs; (ii) Clients’ Reactions to Unmet Emotional Needs; (iii) Clients’ Experience of Substance Use; and (iv) Addressing Clients’ Needs in Therapy (See Figure 15 for an illustration of these salient themes). This Relational Dilemma summarised clients’ intra and inter-personal difficulties characterised by their ambivalence and insecurities dealing with others, which in turn, impacted their patterns of substance use. A key finding was that this relational dilemma was also found to be present in the process of relating to their therapist. Relationally, these clients described significant struggles leading to approach and avoidance behaviours with others, as a function of their own personal insecurities. This finding provided support for the notion that underlying substance dependence/addiction, is an inherent difficulty to function effectively in interpersonal relationships, and in other words, lends weight to the conceptualisation of addiction as an attachment disorder (Flores, 2001, 2004). It also supports Bowlby’s original concept of the IWM’s people hold of past relationships that are highly accessible, and used to guide interpersonal behaviour in novel circumstances (Bowlby, 1973). In line with more recent studies that investigated how working models of attachment are carried from one relationship to the next (Brumbaugh & Fraley, 2006), and another that examined how these working models are transferred to novel relationships (Brumbaugh &
Fraley, 2007), the current findings discussed below offer an in-depth look into the first-hand experiences of substance-dependent clients of their substance use, in the course of their psychotherapy.

**Figure 15.** Final thematic network depicting the salient themes. Note: Bold elliptical denotes the Global theme, regular ellipticals denote Organising themes, and dotted rectangle denotes the Shared Basic theme.

(1) **How did the substance dependent clients view themselves, as opposed to significant others?**

It was found that two organising themes (i.e., (i) Clients’ Unmet Emotional Needs, and (ii) Clients’ Reactions to Unmet Emotional Needs) summarised clients’ views of their experiences on their own personal issues and how this relates to their significant others.

(i) **Clients’ Unmet Emotional Needs.** One’s unmet emotional needs were seen as being a result of consistent deprivation of significant others’ sensitivity and inadequate
parenting/ caregiving over time. These patterns were seen as being chronically present in their reports of early and current experiences of significant others, viewed as a result of receiving inadequate parenting/ caregiving from significant others, and triggered by ongoing interactions with others. This finding supports the view that negative interactions with an inadequately available or responsive attachment figure indicate that the primary attachment strategy (i.e., proximity seeking), has failed to accomplish its set goal (Mikulincer & Shaver, 2016). Cassidy and Kobak (1988) and Main (1990) emphasised that this process would mean the attachment system would have to be adjusted, which mobilises the adoption of secondary attachment strategies – hyperactivation and deactivation of the attachment system.

It was found that parents/ caregivers were seen as dismissing of clients’ emotional needs for validation and praise, often putting down their feelings and being mean to them. This view is reminiscent of the situation that may lead to the triggering of deactivation strategies. Regarded as a “flight” reaction to an attachment figure’s unavailability, deactivating strategies seem to develop in relationships with figures who disapprove of and punish closeness and expressions of need or vulnerability (Mikulincer & Shaver, 2016). In this way, the individual learns to expect better outcomes if signs of their need or vulnerability are hidden or suppressed, and the person attempts to deal with their own issues alone. This may serve to keep the attachment system down-regulated so as to avoid frustration and distress caused by others’ availability (Mikulincer & Shaver, 2016).

Many clients also felt that their parents/ caregivers lacked the ability to truly understand them and their problems, and may be under the influence of substances themselves. Contrary to attachment deactivation, this finding may resemble interpersonal situations that lead to the triggering of hyperactivating strategies. Here, individuals’ views of an attachment figure are sometimes responsive and sometimes not (i.e., preoccupied), placing the dependent, attached individual on a partial reinforcement schedule that rewards persistent proximity-seeking attempts, because these caregivers do sometimes respond (Mikulincer &
Shaver, 2016). If these parents/caregivers were indeed substance dependent as described, these others would be viewed as unreliable or insufficiently responsive, to pay more attention and provide better protection and support. Coupled with the reported presence of marital or relationship conflicts which may continue to trigger their secondary attachment strategies, confusion and resentment was reportedly experienced. Consistent with Bowlby’s (1969) view of IWMs, these patterns of interpersonal experiences may increase the likelihood that these substance dependent individuals would come to view themselves and others in particularly ways, allowing a person to predict future interactions with others. These findings support the literature that emphasised how patients with drug addiction have difficulty in managing high anxiety (Ahmadi & Ahmadi, 2005; Smith & Book, 2008), depressive symptoms (Davis, Uezato, Newell, & Frazier, 2008; Galanter & Kleber, 2008), as well as relationships with family members and peers (Feeney, 2005; Gorenstein, 2002; Semiz, et al., 2007).

(ii) Clients’ Reactions to Unmet Emotional Needs. This discussion on clients’ reactions, which served to complement the Organising theme of Clients’ Unmet Emotional Needs, revealed how clients reacted to their unmet emotional needs as arising from deficits in caregiving and sensitivity from significant others. Clients shared patterns of behaviours that were ineffective efforts at attaining interpersonal closeness, being more authentic (by denying their difficult emotions), and being competent at emotional self-regulation. Three key relational difficulties were summarised as tendencies to seek others’ approval, a rejection of oneself, and emotional self-regulation difficulties.

By seeking others’ approval, clients viewed that it was at the cost of one’s own emotional needs. Clients viewed that whilst they desired closeness and acceptance from their significant others, they were more concerned with how others viewed and responded to them. Their fear of being criticised by others and letting others down was viewed as motivations to prevent possible disapproval, rejection and dismissal from others. This set of attachment defenses to maintain one’s attachment security had been viewed by Higgins (1998) as a
prevention (i.e., avoidance) motivational orientation, which is a stance focused on the need for safety and security, and the avoidance of negative, painful experiences. Therefore, it can be interpreted that by pleasing others first, it increased the incidence of clients receiving care and acceptance (Kelly, Vuolo, & Marin, 2017; Santor, Messervey, & Kusumakar, 2000; Urberg, Luo, Pilgrim, & Degirmencioglu, 2003). Conversely, it also decreased the incidence of suffering the distress of being rejected or dismissed (Dijkstra, et al., 2010; Urberg, et al., 2003; Warr, 2002). However, clients viewed that their position maintained their experience of guilt and shame towards significant others, and brought on feelings of badness. It is possible that for the insecure or unresolved clients, their prevention orientation and the use of biased, distorting defences can sometimes compensate for the absence of attachment security, by creating a façade of self-esteem and self-efficacy, and a degree of adjustment (P. R. Shaver & Mikulincer, 2002). This may explain Client 1B’s interpersonal coping responses during her interview.

Client 1B’s Reaction toward the Interviewer – “Feeling like I let myself down”. She stood out as being more passive and reserved, as compared to the other clients who participated. Specifically, her frequent apologies for not being able to say more in the interview was noted (attachment anxiety response). It was found that Client 1B viewed that she frequently felt bad for letting others down and these similar relational patterns were experienced in the interview with the interviewer. She identified facing similar feelings toward her own therapist, and familiar experiences of letting down her significant others. These responses were accompanied by less interaction, and emotional distance/disconnection (attachment avoidance response). Her use of both anxious and avoidant strategies to achieve a sense of security, indicates a confused, inconsistent state of mind, consistent with her fearful endorsement on the ECR. For Client 1B, her failure to form secure attachments and inability to build a secure psychological foundation that permits clear and open mindfulness of her internal experience (i.e., letting others down) and expectation of others (i.e., how the
interviewer might view her responses), threaten her sense of safety and raise doubts about her life, identity and knowledge of the world (P. R. Shaver & Mikulincer, 2002).

Themes of self-rejection and being harsh/critical of oneself were reported by clients who disliked themselves. This underlined their tendencies toward living a façade/putting up a false front, as they were uncomfortable being themselves. Attributing blame towards themselves for not being good enough was interpreted as undermining their acceptance of self and emotional needs. This attitude for self-loathing, encompassed a negative view of self, reminiscent of the preoccupied (positive models of others and negative models of self) and fearful (negative models of both self and others) patterns of attachment (Ainsworth, et al., 1978; Bartholomew & Horowitz, 1991; P. R. Shaver & Mikulincer, 2002). This is also consistent with the research on attachment anxiety and emotion-focused coping (e.g., wishful thinking, self-blame), where attachment-anxious adults tended to direct their attention toward their own distress rather than focusing on possible solutions to the problem at hand (Mikulincer & Florian, 1998; P. R. Shaver & Mikulincer, 2002). These findings suggest that substance dependent clients may have significant and idiosyncratic patterns of difficulties dealing with their own distress, which are based on their concepts of self and others (IWM). These insecure ways of responding to their unmet emotional needs, are also consistent with the literature on secondary attachment strategies.

(2) How relationships with significant others impacted their substance use?

It was found that the organising theme, (iii) Clients’ Experience of Substance Use, summarised clients’ subjective experiences of their patterns of substance use. These experiences were varied but collectively formed several coherent patterns of substance use. In addition, a shared basic theme, Coping with Emotional Self-Regulation Difficulties, was found between two organising themes, namely (ii) Client’s Reactions to Unmet Emotional Needs, and (iii) Clients’ Experience of Substance Use. Consistent with earlier findings that
the abuse of drugs is more strongly tied to psychological factors and processes such as self-medicating against emotional distress (Carman, 1979; Newcomb & Bentler, 1990; Paton, Kessler, & Kandel, 1977), it was found that clients resorted to substance use as a way to cope with their reactions/ responses to unmet emotional needs, as a result of their disappointing experiences with significant others/ caregivers. As displayed by the schematic in Figure 9, though not necessarily representing cause and effect, it may be that the presence of clients’ relational dilemma, leads to their incapacity to use interpersonal relationships to emotionally regulate. Thus, in their specific circumstances, resorted to substance use as a way to cope with difficult insecure feelings.

Clients’ relational experiences were reinforced by subsequent relationships with others who lacked sensitivity and understanding. These clients reportedly struggled in their interpersonal relationships by adopting insecure compensatory strategies of engaging with others. These compensatory strategies were thematised into: avoidance/ emotional suppression helped with tolerating difficult emotions; using to feel right/ bringing a sense of comfort to oneself; dealing with their tendencies toward self-reliance in the context of unreliable significant others; and a deep sense of dissatisfaction with their substance use. These compensatory strategies resemble the attachment-avoidance (or deactivating) coping strategies of dismissing attachment or the more unresolved, fearful attachment – negative views of others, and negative views of self and other, respectively (Bartholomew & Horowitz, 1991; P. R. Shaver & Mikulincer, 2002). In response to the irresolution of these highly distressing interpersonal relationship patterns, clients had proclivities toward seeking others’ approval, held self-loathing attitudes, and coped with their emotional self-regulation difficulties with substance use, as discussed above. This was consistent with the overall findings on the endorsement of the ECR. These findings support other studies that found links between avoidant attachment and a reliance on distancing coping strategies, such as stress denial, diversion of attention, and behavioural and cognitive disengagement (e.g.,
Feeney, 1998; Lopez, Mauricio, Gormley, Simko, & Berger, 2001; Marshall, Serran, & Cortoni, 2000; Shapiro & Levendosky, 1999). The current finding is also compatible with the theory on secondary attachment strategies (i.e., hyperactivating and deactivating strategies; Daly & Mallinckrodt, 2009), the association between avoidance and repression (e.g., Gjerde, Onishi, & Carlson, 2004; Mikulincer & Orbach, 1995; Vetere & Myers, 2002), and behavioural blunting (using distraction to avoid having to confront stressors; Feeney, 1995).

Of particular interest, was the view that despite using their substances for their specific functions (e.g., emotional self-regulation), clients felt a deep sense of dissatisfaction with their substance use (Flores, 2004). Several clients viewed that the substance use frequently missed the point, as it never exactly addressed their problems. Rather, it merely induced some comfort or intensified present feelings of depression, as reported by some, which led to frustration and anger. In reference to Figure 9, as the interviews progressed, thematic patterns and relationships became clearer – clients used substances to deal with their difficulties in interpersonal relationship circumstances (i.e., disappointment, emotional self-regulation, helped them manage social contact), as a result of their internalised concepts of self and others (IWM's; Carse, 1998), and the chronic struggle with their unmet emotional needs (Flores, 2004).

Compared with their experiences with significant others, it was found that most clients viewed substance use as being more dependable than people, but its effects were constantly unreliable, leading to problematic use and irresolution of their unmet emotional needs. Despite this, most clients reportedly persisted with using as they perceived a sense of security with the substance. Consistent with Flores’ (2004) assertion that addiction is an attempt at self-repair that fails, clients viewed that their emotional struggles were somehow inadequately managed by substance use, and they were expecting more from the experience of using. Taking their deep sense of dissatisfaction with their substance use into consideration as highlighted above, parallel themes of disappointment toward their significant others, therapist
and substance were also found, where clients recognised the familiar feeling of being let down by something that was viewed to be dependable, but ultimately proving to be unreliable. Clients spoke of their love for their substance, described them like their friend, and spoke of them like they were human. Most of the clients were able to describe particular patterns of use that related to helping them engage with others more, or helping them be less in touch with their difficult emotions. However, these patterns of use were viewed to be a delicate balance that could easily determine their security or insecurity to their substance (Flores, 2004) – a process which clients perceived as being in control. As a result, their relationship with their substances can be interpreted as being ambivalent in nature, as its use often led to clients’ experience of its contradicting effects. This also meant that using their substance to emotionally regulate, usually meant taking a gamble at its outcome. It can be argued that substance use, to these clients, can be interpreted as an underlying desire to search for an elusive connection with someone or something, that might resolve their relational dilemma.

(3) How do these substance dependent clients experience the psychotherapy process?

(iv) Addressing Needs in Therapy. Three basic themes were found containing clients’ views that summarised their subjective experiences, helpful or unhelpful during their psychotherapy treatment. These were succinctly thematised as: Safe Therapist Characteristics; Working through Enactments; and Making Sense of Clients’ Experiences.

Consistent with decades of research into the working alliance (Hubble, Duncan, Miller, & Wampold, 2010; Rogers, 1957) and what constitutes a secure attachment figure (P. R. Shaver & Mikulincer, 2002), it was found that clients viewed five overall characteristics that were universally helpful. Consistent with the literature on the psychotherapy relationship as a secure base of attachment (Mallinckrodt, 2010; Mallinckrodt, et al., 2009; Mallinckrodt, et al., 1995), their therapists were viewed as being Non-Judgemental, Supportive and Kind, their Trust Helped Confront Fears, therapists had Predictability, and they were Attuned to
clients’ needs. Also consistent with their views were their endorsement on the CATS, where an overall secure attachment to their therapists were indicative of experiencing the therapist as responsive, sensitive, understanding, and emotionally available; feeling hopeful and comforted by the therapist; and feeling encouraged to explore frightening or troubling events (Mallinckrodt, et al., 1995). By providing these core conditions, all the therapists were able to form a secure base with which clients may comfortably explore and enhanced the development of mutual respect, trust, and responsibility (Flores, 2004). With an emphasis on the importance of the relationship, it is possible that a secure attachment with their therapist could mitigate the impact of insecure client attachment style on the working alliance, as client attachment was found to be a predictor of both working alliance and therapy outcome (Bachelor, Meunier, Lavadiere, & Gamache, 2010; Byrd, Patterson, & Turchik, 2010; Eames & Roth, 2000; Marmorosh, et al., 2009; Meyer & Pilkonis, 2001). Given that all the clients in the current study displayed insecure attachment on the ECR and reported difficulties in patterns of interpersonal relating, a focus on building a reliable, safe place in the context of psychotherapy to address their relational dilemma is justified.

(4) How were clients’ interpersonal patterns of relating played out with their therapists?

Similarities in the ways clients responded to both parents and their therapists were found, providing support for the concepts of transference and re-enactments (Andersen & Baum, 1994; Bateman, et al., 2010; Bowlby, 2006; Brumbaugh & Fraley, 2006, 2007; Holmes, 2010; Main, et al., 1985; Mallinckrodt, 1991; Mikulincer, Gillath, & Shaver, 2002; Mikulincer & Shaver, 2004; van IJzendoorn, 1995; van IJzendoorn & Bakermans-Kranenburg, 1996). Specifically, clients expected similar kinds of treatment from their therapists, just as they were treated by their parents. In order for clients to begin addressing their needs in therapy, clients would have to work through interpersonal enactments with their therapists, commonly known as working in the transference (Hobson & Kapur, 2005).

According to Mallinckrodt, et al. (1995), transference may be understood as a misperception
of the therapist and of the therapeutic relationship resulting from the client’s use of long-established working models of self and others to resolve ambiguities in the new caregiving (therapeutic) attachment and to anticipate the motives and behaviour of the new attachment figure (therapist). Clients’ views were summarised into three themes: Appreciates a non-directive approach toward therapy; Talking to therapist resembles talking to parents; and Clients’ personal insecurities impacting the therapy relationship.

Many clients expressed their disappointment in their parents’ unattuned responses toward them, and some viewed that these disappointments were present with their therapist at times when they felt their therapists lacked sensitivity. Whilst all the participants reported overall security with their therapists as indicated on the CATS, therapists’ lapses in sensitivity and attunement were viewed as difficult to deal with. Some clients expected their therapists to be more emotionally present with them, whereas others viewed that their therapist could have tracked the conversation better and to stay with what really needed addressing in the session. And this sometimes led to clients withholding subjective experiences of difficulty from their therapists, consistent with a prevention orientation (Higgins, 1998) discussed above. These findings support the notion that attachment patterns are relatively stable across time and context, as a core assumption in attachment theory (Brumbaugh & Fraley, 2006, 2007; N. L. Collins & Read, 1990; Fraley, 2002), and would require careful attention to these individual’s needs, particularly since the core argument is their relational dilemma. Thus, it follows that creating and maintaining the attachment or therapeutic alliance with substance dependent individuals require a special set of skills and knowledge about what constitutes addiction so that the therapist will not be “adrift in a sea of material that they [are] at a loss to organise and process” (Flores, 2004, p. 247).
Apart from practicing these safe therapist characteristics, adopting a non-directive approach helped clients experience therapy as being more collaborative and less restrictive – Client 1A viewed that she did not appreciate being told what to do, as it was reminiscent of being judged and told off by significant others. Being non-directive was viewed as facilitating clients to think for themselves, and prevented the activation of clients’ issues and insecurities through the therapy interaction. Although therapists should not avoid the activation of clients’ insecurities during therapy and thus feel restricted themselves, a focus on their clients’ emotional needs and an awareness of their specific set of relational insecurities is necessary. This supports the view that what works to establish a relationship with one client is different from what works with another (Ackerman, et al., 2001; Bohart & Tallman, 2010; Sprenkle, Davis, & Lebow, 2009), and a consideration of client attachment patterns and their IWM’s is one variable that will assist therapists to facilitate a positive working alliance.

All the clients displayed underlying issues present in relationships with significant others related to their unmet emotional needs and these experiences were found to parallel relational patterns with their therapist – i.e., talking to their therapist resembled talking to parents. A few clients described how their therapist’s comments were interpreted as being critical of them (Clients 5A and 5B), and their therapists’ strong reactions was viewed as negative and off putting (Client 1A). Feelings of shame were reported, and clients viewed their therapist as not being understanding were indicators of their personal insecurities. Other clients like Client 3B who exhibited a fearful attachment, were cognisant that their personal insecurities had inadvertently led to their experience of a sense of insecurity with their therapists, and resulted in discomfort engaging with their therapists. For instance, as pointed out in the results section, Client 5B has a dismissing attachment pattern (on the ECR) and an avoidant-fearful relational pattern of attachment toward his therapist, despite endorsing a largely secure attachment to his therapist (on the CATS). Given that clients with dismissing
attachment patterns formed weaker bonds (Marmarosh, et al., 2009) and consistently had poor therapeutic outcomes (Bachelor, et al., 2010), others like Client 5B may require targeted interventions to strengthen a therapy bond (Meyer & Pilkonis, 2001). In contrast, clients with preoccupied attachment patterns give lower ratings to the working alliance (Eames & Roth, 2000; Mohr, Gelso, & Hill, 2005) and had higher rates of negative transference in therapy sessions (Woodhouse, et al., 2003). For instance, Client 4B displayed a preoccupied-merger relational pattern of attachment toward her therapist, despite endorsing a largely secure attachment with her therapist (on the CATS). This suggests that therapists may provide a secure space for therapeutic engagement and have safe therapist characteristics, but it does not guarantee that clients would engage when their attachment insecurities were activated. In fact, therapists would need to be aware of the underlying attachment processes involved, specific to their client, and be attuned to their clients in session.

Lastly, it was found that it was important that therapists help clients make sense of their experiences, in the context of their substance use and presenting issues (Hobson & Kapur, 2005; Høglend, 2004; Siegel, 2010; Wylie & Turner, 2011). This finding complements the earlier findings on clients’ experiences in psychotherapy and how their interpersonal patterns of relating were enacted with both their parents and therapists (Andersen & Baum, 1994; Brumbaugh & Fraley, 2006, 2007; Hinkley & Andersen, 1996; King & O'Brien, 2011; Marmarosh, et al., 2009; Woodhouse, et al., 2003). Clients’ views were summarised into themes that included: Building their self-confidence; Encouraging their emotional exploration; and Creating understanding by talking through their experiences. These were interpreted as assisting clients bring meaning and understanding to their own individual experiences crucial for addressing their needs in therapy. Clients who benefitted from therapy viewed that therapists helped them nurture confidence by building their capacity for self-reflection. This supports the notion that understanding affect and thoughts builds the capacity to reflect on one’s story, and this is a feature of secure attachment in which people
find a middle path between being overwhelmed by emotion in anxious attachment, and
disregard in avoidant attachment (Holmes, 2010). Complementing the research on
reconciliation between attachment theory and psychoanalysis, Fonagy and colleagues
identified the “reflexive function” as the key feature of secure narratives on the Adult
Attachment Interview – it was found that the ability to think and talk about past pain is a
protective factor leading to secure attachment, no matter how traumatic a childhood may have
been (Fonagy, 1999, 2001; Fonagy & Target, 2000). This endorses the current findings on
psychotherapy’s focus on enhancing reflective functioning as an important ingredient in
therapy.

By allowing and encouraging the exploration of emotions in therapy, therapists can
legitimise clients’ emotional experience and create a space where painful feelings can be
explored in the presence of an attuned, reliable and non-threatening other. From an
attachment perspective, the therapist is not so much a physical presence as a mental
representation of an understanding figure who makes emotional pain bearable (Andersen &
Baum, 1994; Holmes, 2010; Main, et al., 1985; Mallinckrodt, 1991; Mikulincer, et al., 2002;
Mikulincer & Shaver, 2004; van IJzendoorn, 1995; van IJzendoorn & Bakermans-
Kranenburg, 1996). Here, therapy helped to create autonomy and foster emotional
competence, necessary for building self-confidence. If unmet emotional needs were at the
core of substance dependent clients’ relational dilemma, it follows that helping clients be
more authentic in the articulation of their emotional experiences and needs, would increase
their capacity for emotional acceptance and competence. Clients also viewed that one’s
perceived ability to cope with their difficulties without the use of substances was associated
with feeling more secure in themselves – some clients felt that they did not need to continue
using after being in therapy. This view is aligned with Holme’s (2010) exposition on the
inappropriate use of alcohol and drugs where, like self-harm, the patient turns to the body as a
surrogate secure base for self-soothing – substances similarly blot out pain physiologically,
and provides a feeling of being held and separated of responsibility comparable to that which is sought when attachment needs are activated and gratified. Along the same lines, by way of talking through clients’ experiences, therapists were viewed as having assisted with creating understanding of the nature of their struggles and put their substance use into perspective. Compared with the blame and shame that accompanied substance use, this process encouraged a gentler analysis of the meanings behind their emotional experience, the function of their substance use, and attachment strategies to attain a more coherent view of themselves.

5.5 Limitations

However, this study does have its limitations. Given that this is a qualitative study, variables like age of onset and comorbid personality disorders were unable to be explored specifically. Although this study does not have a comparison group, or sought to generalise findings quantitatively, the focus was to dig deep and provide a more nuanced look at how substance dependent clients’ attachment impacted their relationships with significant others and substance use. Nevertheless, the current findings do provide much clinically relevant detail about these complex dynamics inherent in the substance dependent population, and empirically supported many theoretical assertions.

A potential limitation may be that the small sample varied in age and number of treatment sessions, and that these clients who were interviewed were engaged in private practice treatment, which is not accessible to many people experiencing substance use disorders. However, given that this is a qualitative study, there was not so much the concern about keeping the sample homogenous (Hansen, 2006). Rather, the variation of clients interviewed would provide a broad brush of personally subjective, realistic views that may be more representative of the themes uncovered (Hansen, 2006). Nevertheless, future studies of this nature may like to focus on examining if the themes that emerge may be similar or different to clients interviewed in public health treatment facilities.
As the participants based their subjective reports purely on their knowledge and experience, the study was limited to how much or how little, clients were comfortable with sharing during the course of the interview. Some clients had more education, spent a longer time in therapy, whilst some had limited psychological understanding of their issues. Still, the intention of the study was to retain some ecological validity and make an investigation into the real world issues these clients struggle with, so no participants were rejected. Taking into consideration clients’ attachment patterns and degree of felt security in divulging their material during the interviews, some under-reporting and over-reporting of information is expected. However, the breadth and depth of information provided by the clients are deemed sufficient for the conclusions drawn.

5.6 Conclusion

Building on the results of the first study, the findings of the current study are consistent with the view that chronic and dependent substance use is an inadequate and often futile attempt to compensate for the failure to receive adequate love and care from relationships with others. The current findings support the attachment literature that have attempted to explain substance dependence over the years. Furthermore, there is evidence to show that this phenomenon can impact client’s attachment to their therapist, which may derive useful and alternative ways of addressing addictions issues in therapy. The depth of inquiry which the current study adopted in its methodology is a strength, as it not only provides a detailed understanding of the possible explanations that govern the findings found in the first study, but also serve to complement its quantitative conclusions. Taken together, the complementary findings of both studies provide a fresh insight and contribute to the current, almost non-existent area on attachment and substance dependence.
CHAPTER 6

General Discussion

The findings from studies one and two had generated interesting insights and provided a glimpse into the lives of this sample of substance dependent individuals and the complex internal struggles experienced. Broadly, Study One derived a new attachment questionnaire designed to assess one’s attachment to substance and tested a mediational model of attachment to substance. The findings here offer an interpretation of the influence attachment to substance, as a potential mediator, between a client’s global attachment and attachment to therapist. In Study Two, client participants provided first-hand views on their experiences in psychotherapy and on their therapists, which resulted in the emergence of several critical themes that serve to provide an in-depth look into how attachment processes work in the context of therapy. This chapter will review the major findings of these two studies and discuss its contributions to clinical practice.

6.1 Major Findings

Overall, the findings found in Studies One and Two were found to be largely consistent, and helped to uncover and understand different aspects of the research problem. All the research aims were met and the findings were argued to contribute largely to the literature on the treatment of substance dependence.

*Study 1: A Survey of Clients’ Attachment*

1) Attachment to substance was a significant mediator of the link between attachment anxiety and preoccupied-merger attachment to therapist.

2) Attachment anxiety and attachment avoidance significantly predicted attachment to therapist in the predicted directions, supporting the continuity of attachment organisation throughout the lifespan.
3) No mediation was found for attachment to substance for avoidant attachment through to attachment to therapist.

4) Gender comparisons found that men had significantly stronger associations between attachment anxiety and avoidant-fearful attachment to therapist, compared to women.

Study 2: A Client Interview Study

Four discrete but inter-related organising themes were found as core themes that influenced clients’ global theme of a Relational Dilemma. This relational dilemma was found to summarise clients’ intra and inter-personal difficulties characterised by their ambivalence and insecurities dealing with others, which in turn, impacted their patterns of substance use. A key finding was that this relational dilemma was also found to be present in the process of relating to therapists, similar to patterns in relationships with significant others (i.e., Parents/Caregivers).

The four organising themes are:

1) Clients’ Unmet Emotional Needs
2) Clients’ Reactions to Unmet Emotional Needs
3) Clients’ Experience of Substance Use
4) Addressing Clients’ Needs in Therapy

6.2 Clinical Implications

The key point about attachment strategies and defences is that they are interpersonal strategies for dealing with suboptimal environments (Holmes, 2010). The current research showed that substance use allowed clients to incorporate a function of distraction into their coping repertoire to deal with the chaotic relationships and emotional dysregulation, within their Relational Dilemma, as defined in Study Two. Consistent with this view was Study One’s finding that the quality of the therapeutic relationship can be highly influenced by the
presence of an insecure attachment to substance of choice, particularly for individuals high on anxious attachment. Not only does being dependent on a substance pose a threat to the establishment and use of the therapeutic attachment relationship, anxious clients’ desire for merger and consensus may cause them to agree readily with their therapists about the goals and tasks of therapy, while ambivalently deviating toward their substance to meet their insecure needs. Although Study One could not find a mediation effect for avoidant attachment, the study supported the view that attachment is consistent throughout the lifespan and the clinical implication is that therapists may then be able to ascertain how best to deal with attachment processes by first identifying what pattern of insecure attachment was present.

According to Holmes (2010), the aim is not so much to preserve the integrity of the individual when faced with conflicting inner drives, but to maintain attachments in the face of relational forces threatening to disrupt them. In other words, therapy will have to be modified such that it takes into consideration the quality of attachment inherent in the therapeutic engagement since clients would inevitably be faced with interpreting their therapists’ words, reactions, and emotional responses, based on their IWM of others. Questions are raised about what is the crucial ingredient that mechanises a good-enough therapeutic relationship for substance dependent clients, since for many clients in the second study, reportedly lowered their substance use after commencing therapy with their therapists. Hence, some treatment recommendations are suggested as a result of the conclusions made.

Firstly, recommended as a good start to any therapeutic relationship, particularly therapy involved in working with our concept of the relational dilemma, five overall characteristics that were seen as universally helpful may assist with creating adequate conditions for a secure and reliable working alliance. Therapists are advised to evaluate their current practice and consider adopting the safe therapist characteristics of being non-judgmental, supportive and kind, demonstrating trustworthiness that helps confront client
fears, the notion of therapist predictability, and the importance of maintaining attunement to clients’ needs (Mallinckrodt, 2010; Mallinckrodt, et al., 2009; Mallinckrodt, et al., 1995).

Secondly, by adopting a non-directive approach, therapists will inherently have to focus on what surfaces in the context of the therapy discussion and manage what comes up for the client. Encouraging clients to be more in touch with their feelings can assist with building self-acceptance, and guiding clients to articulate these struggles in a more coherent way. This approach is not dependent on any one therapeutic orientation but based on attachment theory, hence can be incorporated into different therapeutic orientations. See Kietaibl’s (2012) review of attachment and its relationship with the working alliance for a detailed look into applications of attachment theory in other model-specific therapies (e.g., implications on Psychoanalytic practice, applications within Interpersonal Therapy, Cognitive-Behavioural Therapy [CBT], and working within postmodern frameworks like Narrative Therapy). Given that this process-intensive style of therapy may be uncomfortable for therapists who are unfamiliar with more unstructured styles of therapy, it has been highlighted that attachment theory can be integrated such that a focus on client schemas can be related to the IWMs clients present with (McBride & Atkinson, 2009). For instance, either internal or external stimuli can activate IWMs proposed by attachment theory and inform CBT practitioners by providing insight into client schemas.

Thirdly, a recognition of the value of emotional exploration and expression, is viewed to take precedence over a prime focus on challenging client opinions or dysfunctional cognitions, as a general recommendation. As shown in the current findings, depending on their attachment patterns, clients may inadvertently exhibit features of their attachment strategies or IWMs to manage their attachment distress. It is recommended that therapists learn to manage interpersonal distance with clients based on Daly and Mallinckrodt’s (2009) concept of therapeutic distance, defined as the emotional closeness or distance between client and therapist based on client attachment patterns. Mallinckrodt (2010) viewed that
attachment aspects of the psychotherapy relationship are nearly always in a state of dynamic change, and a skilled therapist did not simply enact a single attachment, or caregiving pattern, but instead flexibly alters the pattern to help a client move away from a previously insecure attachment pattern of attachment. By adopting this approach, therapists can strategically move from, an initial indulging of an insecure client’s unique needs to gradually challenging the client’s habitual patterns of relational behaviour based on their insecure attachment.

Lastly, in order to work through client transference in the therapy process, it was found that it was crucial for therapists to identify and be sensitive to possible interpersonal enactments, otherwise known as recognising the presence of overly positive or negative transference. Depending on the quality of the transference, it was argued that “at the core of the love or hostility expressed in the transference were feelings about a primary person in the life of the client, such as a mother, a father, a sibling, or any other central person” (King & O'Brien, 2011, p. 13). By attending to these feelings and the client’s target attachment figure, the therapist can access the clients’ attachment IWM of self and others. In this way, the therapeutic task may then be to first identify these attachment IWM patterns during the course of therapy, and look out for evidence of client misperceptions to the therapist that appear more compatible with their history of relating with significant others. Therapists may reformulate and utilise attachment insights into more useful ways of coping with distress and emotional dysregulation. Although this process may be trickier for clients high on avoidant attachment, this may provide a more suitable avenue for therapists to raise and discuss their clients’ reactions in a sensitive and informed way, at the appropriate time.

However, given that this study did not include an examination into therapist counter-transference, it must be noted that this is not meant to be an exhaustive discussion on managing transference processes, as this is beyond the scope of this study. In fact, as highlighted by King and O'Brien (2011), using the term “transference” to refer to the negative emotional experience of the client in therapy is not only imprecise, but may also be dangerous
if it absolves us from the responsibility of finding out what is actually going on in the session. Therefore, therapists are advised to develop and maintain awareness of their own attachment patterns. By recognising their own attachment styles and triggers, therapists may be more present in their sessions and avoid reactions that may in turn trigger their clients (Kietaibl, 2012). If clients feel safe in therapy, they may be less prone to anxiety regarding therapy and premature termination of therapy (Mallinckrodt, et al., 2005).

Nevertheless, often the therapeutic milieu will come under the threat of rupture and either client or therapist may play a role in its formation. Clients may return to their substance use as a default coping position, and begin employing their attachment strategies in fear of interpersonal consequences and disappointment. Holmes (2010) pointed out that a crucial element in addition to reliability, consistency and feeling understood, is the repeated experience in therapy of emotional rupture and repair. As with the Ainsworth Strange Situation, the ability of the caregiver to withstand protest and help the child re-establish the secure base following a brief separation is a mark of secure attachment (Holmes, 2010). Similarly, therapy is characterised by a series of separations and reunions, misunderstandings, and acting out, so this alliance rupture and repair is argued to be an important therapeutic skill, and provides the client with a corrective emotional experience. Hence, therapists are advised to follow through alliance ruptures with kind and gentle repair, even if the rupture itself was inflicted by the therapist and appears daunting. This process can be internalised by clients as they begin to challenge their own expectations of relational rupture, and thus build the capacity for alliance repair, seen as being crucial to self-esteem and effective interpersonal functioning (Holmes, 2010).

The recommendations above are argued to be applicable for working with clients with substance-dependence in both individual or group psychotherapy. Since these are interpersonal processes and patterns of relating that are essentially being targeted in therapy, the goal would be to enhance relational connection and assist clients with resolving their
relational dilemma. In other words, therapists will find themselves influencing the relationship with the substance from secure to insecure, and interpersonal relationships from insecure to more secure. So far, to our knowledge, no earlier research had been able to demonstrate empirically the main findings of the current study, which serve to contribute to the existing research in the areas of attachment and substance dependence. Given the right ingredients in forming strong bonds in psychotherapy, it is possible to ultimately persuade the individual to detach from the object of their [substance] dependence, and gradually learn to adopt a more secure dependence on security-giving attachment figures.

6.3 Future Directions

Given that the participants mostly reported significant degrees of stress and abuse in their lives, it is not known how much of an impact it might have on clients’ unconscious versus conscious reporting of their experiences, let alone how they might display their emotions. For example, client reports in the current study led to conscious views of an overall secure attachment to therapist, to establish how their attachment to therapist may result from some way of controlling for clients’ defence mechanisms of approval seeking or understanding the underlying dynamic of reporting a positive picture of their therapists. An exploration into these aspects may assist with delineating the issues of assessing one’s attachment (Bartholomew & Shaver, 1998), which is an ongoing issue.

Although there has been evidence to suggest the ASCQ is a valid instrument, a larger sample size may have yielded a stronger scale reliability. Further development of the scale may be warranted by increasing the number of scale items and utilising a larger sample size. It is also recommended that convergent/discriminant validity studies be conducted with other established attachment questionnaires, for use with substance dependent populations. Test-retest studies can also be conducted to investigate its temporal stability since there is the view
that attachment is stable over the lifetime (Fraley, 2002, 2007; Fraley & Brumbaugh, 2004; Fraley, et al., 2011).

It is recognised that the concept of attachment to substance may well be different to the attachment that Bowlby referred to, which may require further exploration. The fact that people can use in the same way – and perhaps feel the same thing – to pets, objects, god, or in the current case, substances, as they feel toward attachment figures, may not necessarily mean that all of these things fall under the same attachment umbrella. Also, whilst Study 2 elucidates that according to participants’ experiences that there was indeed an “emotional bond” and their descriptions of its function may serve as an attachment bond to the substance, it would be useful to examine whether the attachment is to the substance itself, or the use of it.

As pointed out earlier, our model of attachment to substance will require refinement. Firstly, it will be useful to identify and test out the other potential mediators or constructs that may bridge or make a difference to our model. Second, given that attachment to caregiver (i.e., ECR) and attachment to therapist (i.e., CATS) were conceptualised differently, based on their respective authors’ work, our study had assumed that these scales would tap into the same construct of attachment. However, it is possible to state that on conceptual grounds, that attachment to one’s caregiver and therapist would realistically be different and understandably quite a different form of relationship. By clarifying these fundamental issues, the model fit of attachment to substance may be further improved, along with newer development of its underlying theory.

As suggested by Carse (1998), the proposed model could also be extended to less severe forms of substance use, along the continuum from recreational use through to substance abuse to dependence. If indeed Insecure Attachment to Substance is an influencing factor for substance dependence, and one’s attachment in the psychotherapy situation, its
early identification and treatment in recreational users and substance abusers may provide the client with the best chance of forming attachments in psychotherapy.

Given the themes that emerged in Study Two, there exists several opportunities to develop psychometric measures that are related to them. For instance, follow-up studies may consider developing a Relational Dilemma questionnaire that aims to measure aspects of clients’ Organising Themes (i.e., Clients’ Unmet Emotional Needs, Clients’ Reactions to Unmet Emotional Needs, Addressing Clients’ Needs in Therapy, and Clients’ Experience of Substance-Use). In addition, other potential investigations into the causal relationships and interactions between the themes may reveal interesting insights. For instance, the relationship between the two Organising Themes (i.e., Clients’ Reactions to Unmet Emotional Needs, and Clients’ Experience of Substance-Use) may be studied, as it was found to share the basic theme of Coping with Emotional Self-Regulation Difficulties.

Whilst this study focused only on clients’ point-of-view of the therapy process, it is recognised that an investigation into therapist attachment and specific reports of therapist counter-transference, could assist with a more comprehensive view of the dynamics in sessions. Future studies could consider matching the instances where clients and therapists both report difficulties, and develop focused intervention that assists with managing alliance ruptures. Also, whilst the exploration of the impact of therapist gender was not a prime focus in the current research, it might be beneficial to conduct further research to examine if this was a factor that mattered to many substance dependent clients, and their capacity to form interpersonal attachments.

6.4 Concluding Comments

The emphasis on attachment and relationships is a sobering reminder about how important interpersonal connection is with the significant others in our lives. While there is much to learn in this burgeoning field, therapists would have to first be courageous enough to
explore the interpersonal pitfalls that may quite possibly create an uncomfortable session with many substance dependent clients. Nevertheless, given that these clients have a high likelihood of an insecure history of attachment, this knowledge might make it easier for therapists to be kinder and more present with them, as opposed to being stricter and cold. It then follows that clients might find the courage because they know that another person understands that it is not an easy process to begin depending on someone.
References


Centre for Substance Abuse Treatment. (1994). Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse *Treatment Improvement Protocol (TIP) #9*. Washington, DC.


Horihan, A. J. (2014). *Gender Differences and Impact on Addictions Treatment: Special consideration for working with Female Clients*. Masters dissertation, Winona State University, Minnesota, USA.


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Participant No. ______

Research on the patterns of relationships with others and substance use of individuals

Study 1: A survey study

Participant consent

I have read the Participant Information Sheet about the nature and scope of this survey. Any questions I have about the research process have been answered to my satisfaction. I agree that by submitting the survey into the submission box I give my consent for the results to be used in the research. I am aware that this survey is anonymous and no personal identifying information will be collected or used. I know that I may change my mind, withdraw my consent, and stop participating at any time; and I acknowledge that once my survey has been submitted it may not be possible to withdraw my data.

I understand that all information provided is treated as confidential by the researchers and will not be released to a third party unless required to do so by law.

I understand that the findings of this study may be published and that no information which can specifically identify me will be published.

Survey Questions

Instructions:

Please CIRCLE where appropriate.

Sex: M / F Age: ___

Marital status: (i) Single (ii) Married (iii) Divorced (iv) Widowed (v) De facto

(vi) Separated (vii) Others, please state: ____________________________

Are you currently in a romantic relationship? Yes / No

If Yes, (i) How long were you both together? Specify in years: _____ months: _____

(ii) Please CIRCLE a number to indicate how satisfied you are in your current relationship.

<table>
<thead>
<tr>
<th>Extremely dissatisfied</th>
<th>Extremely satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
</tbody>
</table>

Are you a parent? Yes / No

If Yes, do your children normally live with you? Yes / No
1. Substance Use

Have you ever used any of the following, other than for treatment of a medical condition under proper medical supervision? (Please CIRCLE one or more)

A  Amphetamines e.g. ‘Ecstacy’, ‘Ice’, MDMA, ‘Speed’, Yes / No
    ‘Uppers’, Crystal Meth, Tina

B  Barbiturates e.g. ‘Downers’ Yes / No

C  Cannabis e.g. ‘Hashish’, Marijuana, ‘Pot’, ‘Weed’ Yes / No

D  Cocaine e.g. ‘Coke’, ‘Crack’, ‘Snow’ Yes / No

E  Hallucinogens e.g. ‘Acid’, ‘Angel dust’, ‘Haze’, LSD, Yes / No
    ‘Microdots’

F  Opiates e.g. Codeine, Heroin, Methadone, Morphine, Yes / No
    Opium, ‘Smack’

G  Sedatives e.g. Diazepam, ‘Downers’, Nitrazepam, ‘Tranks’ Yes / No

H  Solvents e.g. Aerosols, glue Yes / No

I  Alcohol/spirits e.g. Beer, Scotch, Wine, Brandy, Rum etc. Yes / No

J  Others, please specify: ________________________________

2. Substance of Choice

From the substances you listed above, what is your preferred substance you have been dependent on? (Your preferred substance is the one that you would go for above everything else.)

Please specify your preferred substance: ________________________________

How long have you been using this substance? ______ years ______ months

3. Education / Employment

For each of the next five questions, please tick the most appropriate response answer.

(i) Do you think your use of (preferred substance) was out of control? ☐ ☐ ☐ ☐ ☐

(ii) Does the prospect of missing a fix (or dose) make you anxious or worried? ☐ ☐ ☐ ☐ ☐

(iii) Do you worry about your use of (preferred substance)? ☐ ☐ ☐ ☐ ☐

(iv) Do you wish you could stop? ☐ ☐ ☐ ☐ ☐

(v) How difficult do you find it to stop or go without (preferred substance)?
    Highest level of education completed:
(i) Primary school (Year 1 – 7)   (ii) High school (Year 8 – 12)   (iii) TAFE   (iv) University
(v) Did not attend school

No. of years employed since school:   No. of years unemployed since school:
Are you currently working? Yes / No
If Yes, please specify your typical occupation:

4. Psychiatric History
Have you ever received a diagnosis of mental illness in the past Yes / No
e.g. anxiety, depression, schizophrenia, bi-polar disorder etc.?
If Yes, please circle one or more of the following:
   (i) Anxiety   (ii) Depression   (iii) Schizophrenia   (iv) Bi-polar disorder
   (v) Others, please specify:

Do you currently have a diagnosis of mental illness, Yes / No
e.g. anxiety, depression, schizophrenia, bi-polar disorder etc.?
If Yes, please circle one or more of the following:
   (i) Anxiety   (ii) Depression   (iii) Schizophrenia   (iv) Bi-polar disorder
   (v) Others, please specify:

5. Family History
No. of siblings (i.e., brothers, sisters, stepbrothers and stepsisters) raised with you:
Who was the main source of income in the family?
   (i) Father   (ii) Mother   (iii) Sibling   (iv) Yourself
   (v) Others, please specify:
Did any of your parents or main caregivers suffer from the following?
Please TICK one or more (if applicable):

<table>
<thead>
<tr>
<th>Alcohol dependence</th>
<th>Drug dependence</th>
<th>Compulsive gambling</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Father</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(ii) Mother</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(iii) Others, please specify:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(iv) Others, please specify:</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>
This section contains questions that may be difficult for you to answer. If you don’t feel comfortable answering them, you can choose to skip this section. Remember, this is an anonymous questionnaire so anything you disclose is entirely unidentifiable.

Was there abuse or violence in your family of origin?

(i) Physical violence (i.e., recurrent acts of violence resulting in physical injury)  Yes / No  
(ii) Sexual abuse (e.g., rape, molestation, inappropriate touching)  Yes / No  
(iii) Emotional abuse or neglect  Yes / No 

The person(s) who was/were abused (Please CIRCLE one or more):

(i) Yourself  (ii) A parent/step-parent  (iii) A sibling/step-sibling  (iv) Others, specify: 

The abuser(s) was/were (Please CIRCLE one or more):

(i) Parent/step-parent  (ii) Sibling/step-sibling  (iii) From extended family  (iv) Others, specify: 

Overall, how easy/difficult was it growing up in your family environment?

Please CIRCLE a number to indicate how easy/difficult it was for you back then.

<table>
<thead>
<tr>
<th>Extremely easy</th>
<th>Extremely difficult</th>
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<tr>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
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</tbody>
</table>

6. In Your Adult Life

Have you received abuse or violence in your adult sexual or partnership relationships?  Yes / No

If Yes, how significant is this abuse or violence?

Mildly significant  Extremely significant

| 1 2 3 4 5 6 7 8 9 10 |

Are you still in a relationship where this is the case, or intending to return to one?  Yes / No

7. Current Treatment

My therapist(s) (Please TICK): Prescribing Doctor  ☐  Psychologist/Counsellor  ☐

Approximate number of sessions you have been in therapy, please specify: 

Approximate length of time you have been in therapy, please specify:  years  months 

Why are you seeking treatment?  Please CIRCLE one or more of the following reasons.

(i) Because I want to get better.  (ii) Because someone I know asked me to seek help.  
(iii) Because I’m under a legal order or condition, or facing court for alcohol or drug-related offences.  
(iv) Other reasons, please specify: 

You’re almost done, three short questionnaires to go!
ASCQ

In each of these statements below, you are asked to rate how strongly you agree that the statement is typical of you. To answer the statements, think of how you feel about the relationship you have with your preferred substance. Remember, this is not a test. There are no right or wrong answers. The statements simply describe different relationships with substances.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat agree/ somewhat disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
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</tr>
</tbody>
</table>

1. I turn to my substance of choice for many things, including comfort and reassurance.
   1 2 3 4 5

2. I don’t object when I cannot get access to my substance of choice for a few days.
   1 2 3 4 5

3. I’m confident that my substance of choice will give me a feeling like I’m being understood.
   1 2 3 4 5

4. I worry that turning to my substance of choice will let me down.
   1 2 3 4 5

5. I feel uncomfortable going away and leaving my substance of choice behind for a few days.
   1 2 3 4 5

6. I have to have my substance of choice when I’m upset.
   1 2 3 4 5

7. When I’m upset, I am confident my substance of choice will soothe me.
   1 2 3 4 5

8. I feel vulnerable when I am away from my substance of choice for a few days.
   1 2 3 4 5

9. I have a terrible fear that I will have to get rid of my substance of choice for good.
   1 2 3 4 5

10. The relationship with my substance of choice is my only source of security.
    1 2 3 4 5

11. I’m afraid that I will lose access to my substance of choice.
    1 2 3 4 5

12. I feel lost if I’m upset and my substance of choice is not around.
    1 2 3 4 5

13. I’m confident that use of my substance of choice will always make me feel like I’m loved and accepted.
    1 2 3 4 5

14. Things have to be really good for me to not seek my substance of choice.
    1 2 3 4 5

15. When I am anxious, I desperately need to have my substance of choice close to help me feel better.
    1 2 3 4 5
The following statements concern how you generally feel in close relationships (e.g., with romantic partners, close friends, or family members). Respond to each statement by indicating how much you agree or disagree with it. CIRCLE the number that best represents how you feel about each statement, using the following rating scale:

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Somewhat disagree</th>
<th>Slightly disagree</th>
<th>Neutral/mixed</th>
<th>Slightly agree</th>
<th>Somewhat agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
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</table>

1. I prefer not to show others how I feel deep down.  
2. I worry about being rejected or abandoned.  
3. I am very comfortable being close to other people.  
4. I worry a lot about my relationships.  
5. Just when someone starts to get close to me I find myself pulling away.  
6. I worry that others won’t care about me as much as I care about them.  
7. I get uncomfortable when someone wants to be very close to me.  
8. I worry a fair amount about losing my close relationship partners.  
9. I don’t feel comfortable opening up to others.  
10. I often wish that close relationship partners’ feelings for me were as strong as my feelings for them.  
11. I want to get close to others, but I keep pulling back.  
12. I want to get very close to others, and this sometimes scares them away.  
13. I am nervous when another person gets too close to me.  
15. I feel comfortable sharing my private thoughts and feelings with others.  
16. My desire to be very close sometimes scares people away.  
17. I try not to avoid getting too close to others.  
18. I need a lot of reassurance that close relationship partners really care about me.

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<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Somewhat disagree</th>
<th>Slightly disagree</th>
<th>Neutral/mixed</th>
<th>Slightly agree</th>
<th>Somewhat agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

19. I find it relatively easy to get close to others. 1 2 3 4 5 6 7

20. Sometimes I feel that I try to force others to show more feeling, more commitment to our relationship than they otherwise would. 1 2 3 4 5 6 7

21. I find it difficult to allow myself to depend on close relationship partners. 1 2 3 4 5 6 7

22. I do not often worry about being abandoned. 1 2 3 4 5 6 7

23. I prefer not to be too close to others. 1 2 3 4 5 6 7

24. If I can’t get a relationship partner to show interest in me, I get upset or angry. 1 2 3 4 5 6 7

25. I tell my close relationship partners just about everything. 1 2 3 4 5 6 7

26. I find that my partners don’t want to get as close as I would like. 1 2 3 4 5 6 7

27. I usually discuss my problems and concerns with close others. 1 2 3 4 5 6 7

28. When I don’t have close others around, I feel somewhat anxious and insecure. 1 2 3 4 5 6 7

29. I feel comfortable depending on others. 1 2 3 4 5 6 7

30. I get frustrated when my close relationship partners are not around as much as I would like. 1 2 3 4 5 6 7

31. I don’t mind asking close others for comfort, advice, or help. 1 2 3 4 5 6 7

32. I get frustrated if relationship partners are not available when I need them. 1 2 3 4 5 6 7

33. It helps to turn to close others in times of need. 1 2 3 4 5 6 7

34. When other people disapprove of me, I feel really bad about myself. 1 2 3 4 5 6 7

35. I turn to close relationship partners for many things, including comfort and reassurance. 1 2 3 4 5 6 7

36. I resent it when my relationship partners spend time away from me. 1 2 3 4 5 6 7
These statements refer to how you *currently* feel about your therapist. Please try to respond to every item using the scale below to indicate how much you agree or disagree with each statement.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Somewhat disagree</th>
<th>Slightly disagree</th>
<th>Slightly agree</th>
<th>Somewhat agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

1. I don’t get enough emotional support from my therapist. 1 2 3 4 5 6
2. My therapist is sensitive to my needs. 1 2 3 4 5 6
3. I think my therapist disapproves of me. 1 2 3 4 5 6
4. I yearn to be “at one” with my therapist. 1 2 3 4 5 6
5. My therapist is dependable. 1 2 3 4 5 6
6. Talking over my problems with my therapist makes me feel ashamed or foolish. 1 2 3 4 5 6
7. I wish my therapist could be with me on a daily basis. 1 2 3 4 5 6
8. I feel that somehow things will work out OK for me when I am with my therapist. 1 2 3 4 5 6
9. I know I could tell my therapist anything and s/he would not reject me. 1 2 3 4 5 6
10. I would like my therapist to feel closer to me. 1 2 3 4 5 6
11. My therapist isn’t giving me enough attention. 1 2 3 4 5 6
12. I don’t like to share my feelings with my therapist. 1 2 3 4 5 6
13. I’d like to know more about my therapist as a person. 1 2 3 4 5 6
14. When I show my feelings, my therapist responds in a helpful way. 1 2 3 4 5 6
15. I feel humiliated in my therapy sessions. 1 2 3 4 5 6
16. I think about calling my therapist at home. 1 2 3 4 5 6
17. I don’t know how to expect my therapist to react from session to session. 1 2 3 4 5 6
18. Sometimes I’m afraid that if I don’t please my therapist, s/he will reject me. 1 2 3 4 5 6
19. I think about being my therapist’s favourite client. 1 2 3 4 5 6
20. I can tell that my therapist enjoys working with me. 1 2 3 4 5 6
21. I suspect my therapist probably isn’t honest with me. 1 2 3 4 5 6

*Continued on the next page*
<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Somewhat disagree</th>
<th>Slightly disagree</th>
<th>Slightly agree</th>
<th>Somewhat agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.</td>
<td>I wish there were a way I could spend more time with my therapist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23.</td>
<td>I resent having to handle problems on my own when my therapist could be more helpful.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24.</td>
<td>My therapist wants to know more about me than I am comfortable talking about.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25.</td>
<td>I wish I could do something for my therapist too.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26.</td>
<td>My therapist helps me to look closely at the frightening or troubling things that have happened to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>27.</td>
<td>I feel safe with my therapist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28.</td>
<td>I wish my therapist were not my therapist so that we could be friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>29.</td>
<td>My therapist is a comforting presence to me when I am upset.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>30.</td>
<td>My therapist treats me more like a child than an adult.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>31.</td>
<td>I often wonder about my therapist’s other clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>32.</td>
<td>I know my therapist will understand the things that bother me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>33.</td>
<td>It’s hard for me to trust my therapist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>34.</td>
<td>I feel sure that my therapist will be there if I really need her/him.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>35.</td>
<td>I’m not certain that my therapist is all that concerned about me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>36.</td>
<td>When I’m with my therapist, I feel I am his/her highest priority.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Participant Information

Research on the patterns of relationships with others
And substance use of individuals

Study 1: A survey study

At a glance...

What is this research about?
The study investigates the patterns of relationships between people who are dependent on alcohol or drugs, and their relationships, as well as their patterns of substance use to deal with difficulties.

Why do this research?
Because it is crucial to the understanding and development of better ways of working with patients struggling with substance dependence.

What will it involve?
It will involve 30 minutes or less of your time to complete a survey and series of questionnaires.

Who can be involved in this research?
You MUST be 18 years and above, AND be seeking help for a current drug or alcohol dependence.

For more details on the project, read on to the Participant Information Sheet.
Research on the patterns of relationships with others  
And substance use of individuals

Study 1: A survey study

Dear Sir/Ma’am,

We invite you to participate in a research study examining the patterns of relationships substance-dependent individuals have with others and their drug or alcohol use. This study is being conducted as part of a Doctor of Psychology Degree (DPsych) in Clinical Psychology, supervised by Associate Professor Pia Broderick at Murdoch University, and co-supervised by Dr. William Saunders, Clinical Psychologist at Abbotsford Private Hospital.

Nature and Purpose of the Study

Although there is a host of research supporting the relationship between interpersonal relationships and substance use as coping strategies, there is little published research on interpersonal relationships and substance use dependence.

Therefore, the aim of this study is to investigate the patterns of relationships between substance-dependent individuals and their relationships, as well as their patterns of substance use in dealing with difficult situations and emotions. The information gathered from this research will be crucial to the understanding and development of better ways of working with patients.

If you consent to take part in this research study, it is important that you understand the purpose of the study and the tasks you will be asked to complete. Please make sure that you ask any questions you may have, and that all your questions have been answered to your satisfaction before you agree to participate.

What the Study will Involve

Participant inclusion criteria:

(1) You must be seeking help for a current drug or alcohol dependence
(2) You must be at least 18 years old

If you decide to participate in this study, you will be asked to complete the following tasks:

- Complete an anonymous survey and a series of questionnaires that ask about your experiences in relationships, etc.

It is estimated that the questionnaires will take approximately 30 minutes or less to complete.

It is possible that you may experience some level of anxiety or stress during the session as a result of some of the questions. You do not have to complete the questionnaire and you are free to withdraw at anytime during the session. If these feelings persist after the completion of the session, you may contact me or my supervisor (see contact details below), or alternatively, we encourage you to process this with your own therapist.

Voluntary Participation and Withdrawal from the Study

Your participation in this study is entirely voluntary. You may withdraw at any time without discrimination or prejudice. All information is treated as confidential and no names or other details that might identify you will be used in any publication arising from the research. If you withdraw on the spot, all information you have provided will be destroyed. However, once the anonymous survey and questionnaires are submitted, it will no longer be possible to withdraw, as the survey cannot be identified to any particular participant.
Privacy

Your privacy is very important. Whether you elect to participate or not will be kept entirely confidential. It will thus not be possible to identify you; neither will you be identified in any publication arising out of this study. Apart from the anonymous consent you provide upon submission of the questionnaires, you will only be given a number to use on your questionnaires.

Benefits of the Study

It is possible that there may be no direct benefit to you from participation in this study. While there is no guarantee that you will personally benefit, the knowledge gained from your participation may help others in the future. This research could have considerable clinical utility and assist in the comprehension of substance-dependent individuals and the difficulties they experience in attempting to recover from their dependence.

Possible Risks

There are no specific risks anticipated with participation in this study. However, if you find that you are becoming distressed, you will be advised to receive support from your treating therapist.

If you have any questions about this project please feel free to contact either myself, Shawn Ee or co-supervisor, Dr. William (Bill) Saunders, on ph. (08) 9200 6024. My supervisor and I are happy to discuss with you any concerns you may have about this study.

Once we have analysed the information from this study, feedback of the results will be posted on the website, http://www.psychology.murdoch.edu.au/researchresults/research_results.html

You can expect to receive this feedback at the end of 2012.

If you are willing to consent to the participation in this study, please complete the survey questionnaires.

Thank you for your assistance with this research project.

Sincerely,

Mr. Shawn Ee
Postgraduate Student Researcher

This study has been approved by the Murdoch University Human Research Ethics Committee (Approval 2011/148). If you have experienced any significant distress as a result of participating in this research, you may choose to contact Dr. William Saunders (Tel. (08) 9200 6024). If you have any reservation or complaint about the ethical conduct of this research, you can ask Dr. Saunders to contact Murdoch University’s Research Ethics Office on your behalf. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix C

Participant Information (for clients)

Research on the patterns of relationships with others
And substance use of individuals

Study 2: A dyad interview study

Dear Sir/Ma’am,

We invite you to participate in a research study examining the patterns of relationships substance-dependent individuals have with others and their drug or alcohol use. This study is being conducted as part of a Doctor of Psychology Degree (DPsych) in Clinical Psychology, supervised by Associate Professor Pia Broderick and Dr. Helen Correia at Murdoch University, and co-supervised by Dr. William Saunders, Clinical Psychologist at Abbotsford Private Hospital.

Nature and Purpose of the Study

Although there is a host of research supporting the relationship between interpersonal relationships and substance use as coping strategies, there is little published research on interpersonal relationships and substance use dependence.

Therefore, the aim of this study is to investigate the patterns of relationships between substance-dependent individuals and their relationships, as well as their patterns of substance use in dealing with difficult situations and emotions. The information gathered from this research will be crucial to the understanding and development of better ways of working with patients.

If you consent to take part in this research study, it is important that you understand the purpose of the study and the tasks you will be asked to complete. Please make sure that you ask any questions you may have, and that all your questions have been answered to your satisfaction before you agree to participate.

What the Study will Involve

Participant inclusion criteria:

1. You must be seeking help for a current drug or alcohol dependence
2. You must be at least 18 years old

If you decide to participate in this study, you will be asked to complete the following tasks:

- To take part in a tape-recorded interview following the questionnaires you completed.
- To give your consent for me to interview your therapist about you.

It is estimated that the interview will take approximately 20-30 minutes.

It is possible that you may experience some level of anxiety or stress during the interview as a result of some of the issues discussed. You do not have to answer all of my questions and you are free to withdraw at anytime during the session. If these feelings persist after the completion of the session, you may contact me or my supervisor (see contact details below), or alternatively, we encourage you to process this with your own therapist.

Voluntary Participation and Withdrawal from the Study

Your participation in this study is entirely voluntary. You may withdraw at any time without discrimination or prejudice. All information is treated as confidential and no names or other details that might identify you will be used in any publication arising from the research. If you withdraw on the spot, all information you have provided will be destroyed. However, once your data has been submitted, it would not be possible to retrieve it.
Privacy

Your privacy is very important. Whether you elect to participate or not will be kept entirely confidential. It will thus not be possible to identify you; neither will you be identified in any publication arising out of this study. Apart from the consent form you sign, your name will not appear on anything. You will only be given a number to use on your questionnaires and your first name only will be used at the interview.

Benefits of the Study

It is possible that there may be no direct benefit to you from participation in this study. While there is no guarantee that you will personally benefit, the knowledge gained from your participation may help others in the future. This research could have considerable clinical utility and assist in the comprehension of substance-dependent individuals and the difficulties they experience in attempting to recover from their dependence.

Possible Risks

There are no specific risks anticipated with participation in this study. However, if you find that you are becoming distressed, you will be advised to receive support from your treating therapist.

If you have any questions about this project please feel free to contact either myself, Shawn Ee or my co-supervisor, Dr. William (Bill) Saunders, on ph. (08) 9200 6024. My supervisor and I are happy to discuss with you any concerns you may have about this study.

Once we have analysed the information from this study, feedback of the results will be posted on the website, [http://www.psychology.murdoch.edu.au/researchresults/research_results.html](http://www.psychology.murdoch.edu.au/researchresults/research_results.html)

You can expect to receive this feedback at the end of 2012.

If you are willing to consent to the participation in this study, please complete the Interview Consent Forms for yourself and for your therapist to be interviewed.

Thank you for your assistance with this research project.

Sincerely,

Mr. Shawn Ee

Postgraduate Student Researcher

This study has been approved by the Murdoch University Human Research Ethics Committee (Approval 2011/148). If you have experienced any significant distress as a result of participating in this research, you may choose to contact Dr. William Saunders (Tel. (08) 9200 6024). If you have any reservation or complaint about the ethical conduct of this research, you can ask Dr. Saunders to contact Murdoch University’s Research Ethics Office on your behalf. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Participant Information (for therapists)

Research on the patterns of relationships with others
And substance use of individuals

Study 2: A dyad interview study

Dear Sir/Ma’am,

We invite you to participate in a research study examining the patterns of relationships substance-dependent individuals have with others and their drug or alcohol use. This study is being conducted as part of a Doctor of Psychology Degree (DPsych) in Clinical Psychology, supervised by Associate Professor Pia Broderick and Dr. Helen Correia at Murdoch University, and co-supervised by Dr. William Saunders, Clinical Psychologist at Abbotsford Private Hospital.

Nature and Purpose of the Study

Although there is a host of research supporting the relationship between interpersonal relationships and substance use as coping strategies, there is little published research on interpersonal relationships and substance use dependence.

Therefore, the aim of this study is to investigate the patterns of relationships between substance-dependent individuals and their relationships (this includes the relationship with their treating therapist), as well as their patterns of substance use in dealing with difficult situations and emotions. The information gathered from this research will be crucial to the understanding and development of better ways of working with patients.

If you consent to take part in this research study, it is important that you understand the purpose of the study and the tasks you will be asked to complete. Please make sure that you ask any questions you may have, and that all your questions have been answered to your satisfaction before you agree to participate.

What the Study will Involve

Participant (therapist) inclusion criteria:

(1) You must be seeing a client for a current alcohol or drug dependence and be willing to take part in an interview where questions will be asked about your impressions of your client.

(2) Your client must be at least 18 years old and provide consent for you to be interviewed.

If you decide to participate in this study, you will be asked to complete the following tasks:

• To take part in a tape-recorded interview that is estimated to take approximately 20-30 minutes to complete.

It is possible that you may experience some level of anxiety or stress during the interview as a result of some of the issues discussed. You do not have to answer all of my questions and you are free to withdraw at anytime during the session. If these feelings persist after the completion of the session, you may contact me or my supervisor (see contact details below).

Voluntary Participation and Withdrawal from the Study

Your participation in this study is entirely voluntary. You may withdraw at any time without discrimination or prejudice. All information is treated as confidential and no names or other details that might identify you will be used in any publication arising from the research. If you withdraw on the spot, all information you have provided will be destroyed. However, once your data has been submitted, it would not be possible to retrieve it.
Privacy

Your privacy is very important. Whether you elect to participate or not will be kept entirely confidential. It will thus not be possible to identify you; neither will you be identified in any publication arising out of this study. Apart from the consent form you sign, your name will not appear on anything. You will be given a number and your first name will only be used at the interview.

Benefits of the Study

It is possible that there may be no direct benefit to you from participation in this study. While there is no guarantee that you will personally benefit, the knowledge gained from your participation may help others in the future. This research could have considerable clinical utility and assist in the comprehension of substance-dependent individuals and the difficulties they experience in attempting to recover from their dependence.

Possible Risks

There are no specific risks to you anticipated with participation in this study.

If you have any questions about this project please feel free to contact either myself, Shawn Ee or my co-supervisor, Dr. William (Bill) Saunders, on ph. (08) 9200 6024. My supervisor and I are happy to discuss with you any concerns you may have about this study.

Once we have analysed the information from this study, feedback of the results will be posted on the website, http://www.psychology.murdoch.edu.au/researchresults/research_results.html

You can expect to receive this feedback at the end of 2012.

If you are willing to consent to the participation in this study, please complete the Interview Consent Form for yourself to be interviewed.

Thank you for your assistance with this research project.

Sincerely,

Mr. Shawn Ee

Postgraduate Student Researcher

This study has been approved by the Murdoch University Human Research Ethics Committee (Approval 2011/148). If you have any reservation or complaint about the ethical conduct of this research, and wish to talk with an independent person, you may contact Murdoch University’s Research Ethics Office (Tel. 08 9360 6677 or e-mail ethics@murdoch.edu.au). Any issues you raise will be treated in confidence and investigated fully, and you will be
Appendix D

Interview Consent (for clients)

Research on the patterns of relationships with others and substance use of individuals

Study 2: A dyad interview study

Participant consent

I have read the Participant Information Sheet, which explains the nature of the research and the possible risks. The information has been explained to me and all my questions have been satisfactorily answered. I have been given a copy of the information sheet to keep.

I am happy to be interviewed and for the interview to be audio recorded as part of this research. I understand that I do not have to answer particular questions if I do not want to and that I can withdraw at any time without consequences to myself.

I consent to my therapist ___________________(insert name) being interviewed about me.

I agree that research data gathered from the results of the study may be published provided my name or any identifying data is not used. I have also been informed that I may not receive any direct benefits from participating in this study.

I understand that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.

__________________________       ____________________
Signature of Participant          Date

For the Investigator

I have fully explained to __________________________ the nature and purpose of the research, the procedures to be employed, and the possible risks involved. I have provided the participant with a copy of the Information Sheet.

__________________________       ____________________
Signature of Investigator          Date

Mr. Shawn Ee

Student Researcher

__________________________       ____________________
Print Name                      Position
Interview Consent (for therapists)

Research on the patterns of relationships with others and substance use of individuals

Study 2: A dyad interview study

Participant consent

I have read the Participant Information Sheet, which explains the nature of the research and the possible risks. The information has been explained to me and all my questions have been satisfactorily answered. I have been given a copy of the information sheet to keep.

I am happy to be interviewed and for the interview to be audio recorded as part of this research. I understand that I do not have to answer particular questions if I do not want to and that I can withdraw at any time without consequences to myself.

I agree that research data gathered from the results of the study may be published provided my name or any identifying data is not used. I have also been informed that I may not receive any direct benefits from participating in this study.

I understand that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.

_________________________  ______________________
Signature of Participant    Date

For the Investigator

I have fully explained to ___________________________ the nature and purpose of the research, the procedures to be employed, and the possible risks involved. I have provided the participant with a copy of the Information Sheet.

_________________________  ______________________
Signature of Investigator    Date

Mr. Shawn Ee
Student Researcher

_________________________  ______________________
Print Name         Position
Appendix E

**Interview Protocol – for clients**

(Welcome and orientate the participant to the interview setting)

(Remind the participant about confidentiality, the non-therapeutic nature and non-evaluative nature of the interview of the quality of services at the hospital/clinic)

The interview will last for about 20-30 minutes depending on how we go. You don’t have to know the answers to these questions already: you may not have thought about them. Just answer as honestly as you can, thinking about them in the interview. You don’t have to be positive and your answers don’t have to be positive, if that’s not how you see it.

Just to start us off, I’d like you to spend a few minutes telling me about how your life is at the moment, the good and the bad things. I’ll just be listening for those few minutes without interrupting you. Keeping in mind the brief time we have, I will stop you to move onto the next question.

Do you have any questions you would like to ask before we begin?

1. **Relationship with the “self” (Model of the self)**
   
   i. How do you feel about yourself at the moment?
   
   ii. How would you like to be?

2. **Relationship with the “other” (Model of the other)**

   a. **Attachment to the substance**
      
      i. Describe to me your substance of choice or preferred substance used.
         
         - Can you tell me how it affects you when you use it?
         - What are the highs/lows?
      
      ii. Tell me about the treatment you are on at the moment.
         
         - Are you on any particular drug replacement therapy at the moment? (if applicable)
         - Had there been times you were sober/clean?
         - How long has it been now?
      
      iii. Many people feel as if they had a connection/relationship with the substance they preferred.
         
         - How would you describe that connection/relationship with the substance you preferred?
      
      iv. A questionnaire you did earlier asked about how you viewed your use of <substance>.
         
         - How did it make you feel?
         - Did it give you a sense of security/insecurity? How would you describe that (security/insecurity)?
      
      v. Many people feel like their substances help them deal with stressors in their lives. In your opinion, how does the use of the substance help you deal with these stressors? What happens when you don’t use?
vi. Has using your preferred substance ever disappointed you or let you down (in other words, "backfire" on you)? How would you describe that experience?
   • How do you react when this happens?

b. **Attachment to significant others**
   The next few questions will be about people significant to you in your life. These people might be your family members, siblings, past and/or current relationship partners.
   i. How would you describe your relationship with your parents? Your siblings? Past/current relationship partners?
   ii. Recalling experiences in your childhood, how would you react to silences in your family?
   iii. Who would you turn to if you were feeling distressed, ill or uncomfortable?
       • How would you approach them for help?
       • What would be their reactions?
       • How did you feel following these interactions?

c. **Attachment to the therapist**
   i. Being in therapy with your therapist (psychologist) would naturally put you in a unique relationship with him/her. Remembering that your therapist will never hear about your confidential responses, how would you describe your relationship with him/her?
   ii. Did you perceive a sense of security/insecurity? How would you describe that (security/insecurity)?
   iii. There might have been times in your therapy sessions when you were feeling distressed, ill or uncomfortable. Generally, how did your therapist respond to you during those times?
   iv. In your opinion, how does your therapist help you deal with stressors in your life?
   v. Bearing in mind that this interview is totally confidential, have you had any interactions where your therapist had upset you, disappointed you or let you down?
       • How would you describe that experience?
       • How did you react to him/her?
   vi. During the course of your therapy, there might be times when there’s silence between the two of you. How do you react to that?

(Thank the client for participation and end interview. Debrief participant if needed.)