ATTACHMENT THEORY

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Attachment theory is a developmental model of interpersonal relationships. Attachment relationships are based on early caregiving experienced by an infant. It is through these relationships that infants and children develop the ability to regulate emotional states. From an attachment perspective, psychopathology is developed from an inability to effectively regulate emotional states in a healthy manner. For example, in the most recent National Survey of Youth Data, Barfield-Cottledge (2015) reported low family attachment as a significant predictor of adolescents' report of drug and alcohol use. Specifically, adolescents who reported low family attachment were more likely to report using marijuana and drinking compared with their counterparts with high family attachment. In addition, with an adult sample, individuals classified with an insecure style of attachment reported the highest rates of a diagnosis of substance dependence and/or abuse (Caspers, Yucuis, Troutman, & Spinks, 2006). Attachment-based therapists attempt to create an empathically attuned attachment relationship with the client in order to serve as a container for the client's emotions and to provide a safe base from which the client may explore presenting issues. The discussion of attachment theory developed out of the work of psychoanalysts and developmental psychologists and therefore builds on some of the concepts from other theoretical perspectives.

BASIC TENETS OF THE THEORY

Several basic assumptions about human nature underlie attachment theory. First, attachment theory posits that early attachment relationships to caregivers directly impact brain structure and oscillatory functioning related to emotion regulation. An infant initially relies on caregivers to externally or interpersonally regulate the infant's emotional state (Bowlby, 1988). So if the infant is in distress, an attuned caregiver is able to soothe the infant by doing something like offering food, changing the baby's diaper, adding or taking off a blanket, rocking, humming, or talking to the baby. Each of these examples relates to a sensory environmental trigger (taste, temperature, movement, pressure, sound) that prompts an emotional response. Emotions and other physical sensations are located in the limbic system and are functioning at birth to help the baby communicate its needs with the world, although perhaps in a rudimentary manner. It is through this communication that the infant learns how to get physical and emotional needs met.

For optimal development, an infant must have a caregiver who demonstrates accurate empathic attunement to the baby's needs at least two thirds of the time. In Winnicott's (1953) words, the caregiver must respond with "good enough" interventions to the baby's

needs. This does not mean that the caregiver is always able to choose the right intervention the first time but rather that the caregiver is responsive to the baby's distress and attempts to identify an intervention that soothes the child. Perfect attunement is not possible, nor is it optimal because people need misattuned interactions within these caregiving relationships in order to develop frustration tolerance. So the relationship must demonstrate consistent empathically attuned experiences for the child over time. This is how neuronal networks are built and strengthened, resulting in the infant's development of internal systems for emotion regulation (Cozolino, 2010). If they have had sufficient empathically attuned caregiving relationships, infants are able to develop internal working models of those responses to emotional arousal so that they are able to self-soothe (cope) in times of stress. For instance, self-soothing behaviors of a toddler might include humming or stating, "It'll be OK" after the toddler has been hurt. The child has internalized experiences of emotional regulation experienced from caregiver(s) in such a manner that the child is able to cope or self-soothe during a stressful time.

Attachment theorists believe that movement from interpersonal (caregiver) regulation of emotion to intrapersonal (self) regulation of emotion requires that the child have sufficiently empathically attuned relationships within the first 24 to 36 months of life (Bowlby, 1969/1982, 1988; Simpson, 1999). This is considered a critical period because if they do not have these experiences with at least one caregiver, then they may not develop the ability to cope with dysregulated emotional states and may even lack the ability to empathize with others. When individuals do not have healthy attachments early in life, it may be difficult to form healthy attachments as they get older.

However, attachment theorists also believe that people are adaptive, and their behavior, including the ability to regulate emotion, is also adaptive. Individuals may have different experiences with different caregivers (e.g., mother, father, grandparent), which helps them develop situational specific internal working models of relationships, which ultimately inform their subsequent relationships with others (Simpson, 1999). For example, when an infant feels some sort of threat in his environment, he will use proximity-seeking behaviors to make sure the caregiver is still available. If the caregiver is available in a consistent manner, the infant will create a positive/secure internal working model that that infant will rely on in social situations for his understanding of intimate relationships. If the caretaker is unavailable or inconsistent, the internal working model of the infant will become skewed. This skewness will result in maladjusted behaviors in the infant's subsequent future relationships. Similarly, in therapeutic settings, individuals may develop an attachment relationship with a therapist or group members, which are able to provide a foundation for development and strengthening of new neuronal networks that represent new internal working models for them.

We assume that all people experience stressful situations, such as a significant loss, which challenge their ability to cope. When this occurs they may become deregulated or overwhelmed by emotion. In these situations people often turn to others, usually attachment relationships, to help them through the crisis. However, people who do not have sufficiently secure attachment relationships have difficulty self-regulating when they become emotionally deregulated or are under significant stress, and they often do not feel emotionally safe to reach out to others for help in those situations (Mikulincer & Shaver, 2007). So when they become emotionally deregulated, these individuals identify unhealthy methods to help them self-soothe. Destructive methods of self-soothing include excessive use of alcohol or drugs, or other addictive behaviors such as gambling, sex, or shopping.

In optimal development, a child has at least one secure attachment relationship (Bowlby, 1988). This provides a secure base from which the child may explore the world, including making new friends and developing new significant attachment relationships. If development is less than optimal, then the child may experience caregivers as not being consistently available and internalize this experience as an insecure attachment relationship. In these instances, caregivers have generally demonstrated inconsistent attunement to their children's needs. This may have resulted from the parent's or caregiver's own insecurities about self-efficacy for parenting or from some mental or physical illness that impacted their ability to be available to the infant's distress in an optimal manner. An example of this is the result of the parent experiencing anxiety or depression around the parental relationship. Insecure attachment patterns may result in anxious attachment or avoidant attachment patterns of relating based on internal working models of these insecure attachments.

Children who consistently experienced neglect or maltreatment (abuse) early in life may not have had their emotional or physical needs met most of the time, or they were harmed, or were fearful of their caregivers. This is observed when children have a parent who was severely depressed, psychotic, or suffering with significant addiction issues (Brisch, 2012; Flores, 2004). These children may form avoidant or disorganized attachment patterns depending on the nature of the neglect or abuse experienced, whether there was an alternate caregiver who was attuned, and the timing and severity of the experiences (Lyons-Ruth & Jacobvitz, 1999). We discuss these attachment patterns in more depth shortly.

The quality of a person's attachment relationships impacts his or her need for or dependency on others. A securely attached person is effectively dependent on the attachment relationship, meaning that he or she is able to reach out for help and rely on others for social support during times of stress (Mikulincer & Shaver, 2007). Attachment theorists believe that secure attachment and autonomy are complementary experiences. Healthy securely attached people demonstrate the ability to rely on self and others in times of distress. Interdependence is reflected when a securely attached person is able to be physically separate or emotionally separate from others and continue to feel a secure consistent sense of self.

People with secure attachments are able to be in psychological conflict with someone they have a secure attachment with while still trusting that the relationship will not disappear or that the attachment figure (e.g., spouse, friend) will not do anything physically or psychologically harmful to them. They are also able to be physically separated, such as going to school, without feeling the attachment relationship will disappear or that leaving the attachment figure will result in physical or psychological harm. Attachment needs are activated during times of uncertainty, and a person may experience fear and anxiety when he or she is physically or psychologically distanced (i.e., conflicted) from an attachment figure.

When this happens, attachment theorists believe (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969/1982) that individuals demonstrate predictable patterns of distress beginning with protest, then depression and despair, and finally detachment. In this manner, significant relational trauma may have a serious long-lasting impact on a person's functioning. For these reasons, proximity of an attachment figure or a transitional object (something

BOX 7.1 Tenets of Attachment Theory

- The desire to attach is inborn across cultures.
- Early attachment relationships impact neurological development.
- Empathically attuned caregiving relationships lay the foundation for moving from interpersonal (caregiver) regulation of emotion to intrapersonal (self) regulation of emotion.
- There are critical periods for attachment.
- Empathically attuned attachment relationships provide a secure base for a person to explore the world, experience new things, grow, and develop.
- A predictable sequence of protest, despair, and detachment follows separation from the attachment figure.
- Attachment relationships serve as internal working models for new relationships.
- Attachment may change based on the caregiver-child relationship.
- Behavior is adaptive to context and based on experience with previous attachment relationships.
- During stressful times, people who have not developed sufficiently secure attachments have not developed a method for coping with dysregulated emotions without relying on other methods. One example is addictive substances or behaviors.

that reminds one of the attachment figure) provides comfort when one feels vulnerable. An example may be a child holding on to something significant from a parent, like a favorite hat, while a parent goes on a business trip. This provides a sense of psychological connectedness for the child when the parent is not physically present.

PHILOSOPHICAL UNDERPINNINGS AND KEY CONCEPTS OF THE THEORY

The foundation of the theory developed from psychoanalyst John Bowlby's clinical work with juvenile delinquents at the London Child Guidance Center. He observed that maternal relationships resulting in neglect, separation, or loss significantly negatively impacted the boys' interpersonal development. He later studied the effects of parental attachment disruptions resulting from long-term hospitalization of toddlers. From these observational studies, he identified a predictable sequence of responding to parental separation beginning with protest behaviors, moving to demonstrations of despair, and finally detachment (Bowlby, 1969/1982; Bretherton, 1991). He further theorized that early attachment relationships are the foundation for internal working models children develop for how the world and relationships with others work and for understanding their place in the world.

Mary Ainsworth, a developmental psychologist, empirically tested Bowlby's observations using the strange situation to study the sequence of protest, despair, and detachment (Ainsworth, 1967; Ainsworth et al., 1978). Mother-infant dyads were studied in a laboratory setting. Initially the children were introduced to a toy-filled room and encouraged to explore while the mother was present. There was a trained "babysitter" in the room who was previously unknown to the child. On two occasions the mother would leave the child with the stranger for 3 minutes. Each separation was followed by a reunion between child and parent. Behavioral observations of the children's reactions were recorded and analyzed by the research team.

Ainsworth's studies were conducted in Uganda and Baltimore with nearly identical results, indicating that the desire to attach is an inborn instinct that is cross-cultural. Additionally, she concluded that the quality of caregiving was more important than the quantity of caregiving. In other words, if a mother was consistently present but not empathically attuned to her child's needs, these infants would be more likely to develop insecure attachments, whereas those whose mothers may be more attentive to the child's needs but not always physically present may be more securely attached. Ainsworth is also credited with identifying that a person's inborn attachment system can change based on responses to different caregivers (Grossmann, Grossmann, Spangler, Suess, & Unzer, 1985). From these experiments, Ainsworth identified the following attachment styles: secure, ambivalent, and avoidant.

Mary Main conducted a longitudinal study of attachment following middle-class families from infancy into adolescence (Main, Kaplan, & Cassidy, 1985). Initially a "strange situation experiment" was conducted with the infant and each parent. The strange-situation research captured an infant's reaction to reunification with its caretaker after a brief separation. An infant's reaction was classified into four patterns of reaction correlated with an attachment orientation. When the child was 6 years old, she videotaped the family's interactions attempting to identify the internalized working models of relating that the children developed. From these studies, Main identified that the infant's strange-situation behavior toward the parent was consistent with the mental representations of the parent at age 6. In other words, the infant's reaction and attachment classification during the strange situation was correlated with the child's attachment orientation at age 6. Through this process Main documented the transition of parental interpersonal regulation of emotion for the child to intrapersonal regulation of emotion using internalized objects or mental representations of attachment relationships.

However, not all the children studied in the strange-situation experiments fell into one of the previously identified attachment styles. As a result, her research team reviewed 200 strange-situation videotapes that did not fit one of the previously identified attachment styles. This led to their identifying a fourth attachment style, disorganized attachment, which is discussed in more depth shortly (Main & Solomon, 1990).

To facilitate her research, Main developed the Adult Attachment Interview (AAI), a semistructured protocol aimed at studying attachment in late adolescence and adulthood (George, Kaplan, & Main, 1985). The assessment appears to be straightforward in asking strange-situation parents to reflect on their own relationships with their parents, including loss, rejection, and separation (George et al., 1985; Slade, 2000). However, Main was attempting to access unconscious material through seemingly obvious questions. For example, the AAI asks the interviewee to describe memories of early life with parents. The interviewee responses could vary in depth and language based on attachment orientation. More than observing the answers to the questions, she observed the process the participant went through to describe his or her own parental relationships during the assessment. Additionally, she identified similarities between the child's strange-situation behavior and the parent's mental representations of attachment. In other words, in this research there seemed to be similar reactions between parents' memories of their parents and their child's reaction in the strange situation. Attachment orientations were seen through the generations when all the data were compiled together. Based on these observations, she concluded that infant nonverbal behavior may predict internal representational patterns of attachment.

Attachment Styles

There are four identified attachment styles based on the work of Bowlby, Ainsworth, and Main. Each attachment style correlates with certain behaviors of the infant during the strange situation, certain parenting behaviors, and certain adult expressions of the corresponding adult attachment style. These characteristics are briefly described next.

Secure Attachment

In the strange-situation experiments, infants who were securely attached demonstrated more informative behavior when reunited with their mother than their behavior upon separations from the mother. Although these infants were distressed, as expected by the separations, they were easily reassured upon reuniting with their mothers because their mothers picked them up and held them to calm the babies when needed. Based on this early attachment classification, infants grow into predictable styles of attachment as adults in interpersonal and intimate relationships. Adults with secure attachment hold positive views of themselves and others and have friends who rate them as warm, intimate, confident, and involved in their relationships (Bartholomew & Horowitz, 1991).

Insecure Attachment: Anxious-Ambivalent Attachment

The first type of insecure attachment may be referred to as anxious, anxious-ambivalent, indiscriminate, or ambivalent attachment in the literature. In the strange-situation experiment, these infants would demonstrate overwhelming distress when their mothers left the room. These infants were so preoccupied with their mothers that they could not explore and play. When the mother returned, some of these infants demonstrated anger and others demonstrated passivity regarding the reunion. The angry infants would actively seek connection with the mother and then reject the mother's attempts at comforting them. The passive infants were so overwhelmed that they were not able to approach their mother for comfort they needed. Anxious-ambivalent attachments resulted from parenting that was inconsistent in being responsive to the child's needs and ultimately discouraged the child's autonomy (Ainsworth et al., 1978). Children with anxious-ambivalent attachment patterns grow up to demonstrate a preoccupied style of attachment as adults. These adults rely on emotion-focused coping strategies when faced with stress in relationships (Mikulincer & Shaver, 2007), report lower levels of self-esteem (Park, Crocker, & Vohs, 2006), and perceive themselves more negatively in intimate relationships (Bartholomew & Horowitz, 1991).

Insecure Attachment: Avoidant Attachment

Infants with avoidant attachment patterns demonstrated no distress when the mother left, no distress with the stranger, and no interest in the mother upon her return. However, these infants had similarly elevated heart rates as securely attached infants upon the mother's absence from the room. Additionally, the stress hormone cortisol was found to be elevated both prior to and after the experiment among these children (Spangler & Grossmann, 1993; Sroufe & Waters, 1977). Ainsworth et al. (1978) observed that these mothers demonstrated indifference to their children and did not demonstrate attachment behavior toward the infant. It is theorized that these infants had learned through previous comfort-seeking attempts that they would be met with rejection. The infants ultimately gave up trying to seek comfort. The mothers' state of mind impacted their ability to attune to their infants. These infants developed avoidant styles of attachment as a defense to deal with the unpredictability of the parent's behavior. Similarly, avoidant adults are more likely to rely on distance coping strategies when faced with stress or perceived pressure in relationships (Mikulincer & Shaver, 2007). These adults actually report higher levels of self-esteem (Park et al., 2006), but they hold negative views of others in relationships (Bartholomew & Horowitz, 1991).

Disorganized Attachment

Children demonstrating disorganized attachment styles would initially respond to their mother returning to the strange-situation room with bizarre behaviors that lasted about 10 to 30 seconds and then would proceed with behaviors consistent with one of the other previously identified attachment styles. The bizarre behaviors included a "frozen scream" where a child would cover his or her mouth similar to primates studied by Darwin, freezing in place and then collapsing to the ground, or going into a trance-like state similar to dissociation (Hesse & Main, 2000). These behavioral descriptions all indicate an activation of the body's fear response.

The combination of this initial fear response followed by ambivalent or avoidant patterns of attachment behavior indicated that these children may experience their mothers as both a safe haven and as potentially dangerous. This phenomenon is supported by literature demonstrating that 82% of infants with disorganized attachment styles were identified as having experienced abuse or maltreatment (Carlson, Cicchetti, Barnett, & Braunwald, 1989). However, Main also identified that some of these children's responses developed from their experience of the parent being frightened by the child resulting in the parent withdrawing or going into a trance-like state. Fearfully attached adults exhibit both preoccupied and avoidant styles of attachment strategies in intimate relationships. Generally, they hold negative internal working models of both self and others in relationships (Bartholomew & Horowitz, 1991). These individuals are fearful of intimacy and socially avoidant.

Reflective Function and Emotion Regulation

When Bowlby served as a Freud Memorial Professor of Psychoanalysis, he inspired Peter Fonagy to further study the mental representations of attachment and how an individual's intersubjective, or how we understand ourselves, experience of self may impact attachment. Fonagy was particularly impressed by Bowlby's concern for how to positively impact disadvantaged populations. He is credited with developing the concept of awareness of oneself as a psychological being, referred to as *mentalization* (Fonagy & Target, 1997). He built on this concept to study the reflective function one uses to view oneself with psychological depth, insight, and empathy through the development of the Reflective-Functioning Scale (RFS). The RFS was created to assess the influence of attachment orientations on perception of self and others in relationships. In 1987, his research group met with 100 pregnant couples to assess each parent's state of mind as assessed by the RFS related to attachment prior to their child's birth. They later conducted a strange-situation experiment with the infants at 1 year. This study resulted in documented evidence that parents' expression of attachment orientation prior to the birth of their child accurately predicted the child's strange-situation behavior at 1 year old. Fonagy concluded that the attachment system functions so that people are able to develop internal working models or schemas for understanding the self and others in relationships that subsequently impact their development, whether healthy or maladaptive.

Fonagy's work resulted in the development of three types of intersubjective experiences of the self in the world: psychic equivalence, pretense, and mentalizing. Each of these intersubjective modes of functioning indicates its own style of emotional regulation. An individual functioning in the mode of psychic experience understands no differentiation between his or her inner world and the external world. This individual does not have the ability to think of the self as separate from others, similar to an infant's experience of the world. A person in the mode of psychic experience is impacted immediately by others' actions and defines the self by the way he or she is treated by others. This concept may be popularized in addiction treatment culture as enmeshed relationships, lacking all boundaries between people in intimate relationships.

The opposite is true for those living in pretend mode, where a person does not allow the inner world to be impacted by external realities. Dissociation and narcissism are examples of this mode of being. This individual feels that the external reality is potentially threatening to what he or she imagines the world to be. The person blocks from conscious awareness thoughts, events, or feelings that are fearful. This concept is popularized by addiction treatment as disengaged or rigid boundaries.

Finally, the mentalizing/reflective mode allows people to identify both the self and others as separate but interrelated. This individual may self-reflect or think about thoughts and feelings, interpret experiences, and understand that events experienced are separate from a reaction to those events. These individuals are generally better able to manage emotional dysregulation in a healthy manner. An example of this is using healthy coping mechanisms when an individual experiences an unsettling event. This concept is popularly called permeable boundaries or healthy boundaries.

Fonagy used Bion's (1962/1977) concept of a mother's containment of an infant's distressing emotions in order to reflect that caregivers are able to effectively communicate empathic attunement and demonstrate physical care for their infant. He suggests that a parent can communicate understanding of the child's distress and can help the infant regulate emotional distress either through ending the distressing stimuli (e.g., providing food, a diaper change) or through helping the infant cope with the distress (e.g., rocking, humming). Most importantly, Bion believed caregivers can recognize that infants have a mind of their own, separate from the caregiver's, and can infer the intention that underlies the parent's behavior (Dennett, 1987). Caregivers who are able to communicate empathic understanding, assist in coping, and appreciate that the child has an experience of the world separate from the caregiver reinforce the attachment relationship as secure.

Through the experience of affectively attuned interpersonal regulation of emotion, a child develops an internal representation of the self as worthy of empathic attunement and a belief that attachment relationships can be a source of support, comfort, and even pleasure. The securely attached individual, when emotionally dysregulated, is able to find a way to understand emotions, either through interpersonal attachments or through the internal schema or classification of those attachment relationships. However, if a child develops insecure attachment patterns it is in reaction to his or her internal experience of attachment relationships that are empathically misattuned and therefore have resulted in extending if not causing the child's emotional dysregulation. Insecurely attached individuals do not experience intimate relationships as a safe place to gain support, comfort, or pleasure. These individuals then do not learn to regulate emotional states in a healthy manner, so they seek "containers" for their dysregulated emotions elsewhere such as dissociation, narcissism, addictions, and unhealthy ways of relating to others.

BOX 7.2 Jessica McClure

A toddler named Jessica McClure fell into a well in Texas while playing near her home. Initially, first responders sent a microphone down into the well to attempt to identify whether she was alive. They heard Jessica singing quietly to herself. Person-centered therapists may say this is evidence that one has it within oneself to self-soothe. However, attachment theorists would conceptualize this behavior differently. Using the information described in this chapter, how would an attachment theorist understand Jessica's ability to self-regulate during a frightening time of her life? How and where did this skill develop? How might this story inform an addiction treatment provider's work with a client who has few resources for self-regulating dysregulated emotional states?

HOW THE THEORETICAL APPROACH IS USED BY PRACTITIONERS

Mental health workers specializing in addiction treatment practicing under the guiding principles of attachment theory believe fundamentally that the therapeutic relationship can be developed as a secure base for the client's work in therapy. If the therapist successfully provides consistent accurately attuned empathic responses to the client's presenting issues, the client will be able to use the therapeutic relationship to learn to modulate challenging emotional states. A primary assumption in attachment theory is that people's interpersonal interactions are based on their attachment style, which is reflective of their sense of self. A fragmented sense of self results from insecure attachment styles. When individuals have a fragmented sense of self, they do not have the confidence to believe they are capable of coping with challenging interpersonal situations that lead to strong emotions. In this manner, attachment style dictates how a person regulates emotion (Mikulincer & Shaver, 2007). Difficulty managing dysregulated emotional states often results in maladaptive interactional patterns, which are a reflection of underlying fear, anger, and/or grief.

For those clients challenged with addiction issues, they are likely using the focus of the addiction (e.g., alcohol, food, gambling, sex) as a container for these dysregulated emotions. Therapists understand that these clients did not develop a healthy sense of self or the ability to effectively cope with dysregulated emotions through healthy empathically attuned caregiving relationships when they were young. Therefore, when they experienced complex emotions, they did not have the necessary healthy coping mechanisms to work through these emotions. Where a healthy, securely attached person would use the attachment relationship or an internal working model of that relationship to work through these emotions, insecurely attached individuals seek containers for these emotions elsewhere, such as alcohol, drugs, gambling, or food.

Because of this, these clients also have developed attachment relationships with their addictive substance or behavior. This is a complicating factor in treatment because their attachment relationship with the addiction becomes increasingly more important to the client's sense of self and inability to manage emotional states as the addiction progresses. Until clients are able to function from a secure attachment style that promotes healthy

interpersonal relationships and a sense of self-efficacy for regulating emotional states, they will remain at an increased vulnerability to relapse triggers. Therefore, helping clients develop the ability to form healthy secure attachments is a major goal of therapy.

Generally, attachment-conscious therapists are aware that their clients' triggers for engaging in the addictive behavior are related to their attempts to cope with difficult emotions experienced during interpersonal relationships. Conversely, the addictive behavior(s) often negatively impact existing relationships, resulting in further damage to the client's ability to experience healthy interpersonal attachments. For example, a person who relies on alcohol as a social lubricant will choose that substance over developing a healthy relationship. People challenged with addictions demonstrate behaviors consistent with insecure attachment styles. There are multiple ways a person can experience early caregiving that result in an insecure attachment style. These experiences exist on a continuum of severity and also involve multiple methods of problematic caregiving (e.g., parental mental illness, parental addiction, physical/sexual abuse, rejection, abandonment). This means that the therapist must examine the client's experience of early and significant interpersonal relationships, so that the therapist and client can understand the client's experiences of attachment. Early relational trauma is particularly damaging to the client's sense of self and therefore must be addressed as part of addiction treatment for the client to have any real chance at a successful long-term outcome.

Because trauma work often involves working through intense emotions, the therapist must be willing and able to provide a safe holding environment for the client's intense, often negative emotions. This includes being able to tolerate a client who addresses the therapist in anger or hostility as a result of a transference reaction the client has toward the therapist because of previous relationship ruptures. The therapist must be able to assist the client in containing these emotions during therapy sessions. This means that the therapist will help the client manage healthy emotional expression rather than using a substance to deal with emotions. In other words, addiction has been called a feeling disease because of the addict's use of substances to manage emotions. This may be accomplished through ensuring the client is able to process through the emotions experienced before leaving the session. If the client's trauma is too complex to work through completely in one session, then the therapist must be able to guide the client in some method of containing the emotion so that the client can go out and function in the world between sessions without becoming seriously emotionally dysregulated by the work done in therapy. This can be accomplished through the use of metaphors, guided imagery, ritual, or amplifying the emotion and helping the client sit in that experience. An example might be identifying a song metaphor to represent the client's current attachment pattern and asking the client to choose a new song to replace the maladaptive coping associated with the old song. If the therapist is unable to provide a successful container, a relationship rupture occurs that can jeopardize the client's success in treatment because the client will not experience therapy as a safe base from which to explore addiction.

If emotional dysregulation is directed at the therapist, he or she may also contain the client's emotion through using an interpersonal process to discuss the relationship dynamics occurring between the therapist and client in the here and now, relating the dynamics to the client's addiction issues and past relationship ruptures. In these situations, the therapist must always be cognizant of the need to be consistent in setting boundaries and limits with clients when the client oversteps in a manner that is inappropriate for the relationship (e.g., makes sexual advances, verbally threatens the therapist, or personally ridicules the therapist during a therapy group), followed by processing the interaction as it relates to the therapeutic focus for the client's work.

Additionally, if the client is currently in a therapeutic milieu, the therapist may need to observe the client's interpersonal maneuvering within that system to learn more about how and why the client functions in certain ways. Similarly, the therapist must be mindful of how the client attempts to elicit interpersonal reactions from the therapist and any transference reactions the client acts out with the therapist in session. All of these methods help the therapist understand the client's unique experience of the world, sense of self, and how the client manipulates the world and other people to get needs (physical and psychological) met. Part of the therapeutic process is for therapists to observe these patterns of emotional trigger and attachment/detachment behaviors and help the client begin to think about himself or herself in these situations as a psychological being, or as an individual who can manage in a more adaptable manner. This requires the therapist to help the client develop the ability to self-reflect on thoughts, feelings, and relationships. Reflecting on the interpersonal process observed is one method of engaging the client in self-reflecting on the emotional experience of the world and also how that experience may influence the world around the client.

In a controlled treatment setting (e.g., prison, inpatient hospitalization, residential treatment center), clients will be required to abstain from their addictive behaviors. This will necessarily create increased anxiety related to their inability to use their addiction to cope with the intense emotions that surface during treatment. If their primary addiction (e.g., alcohol) is not available to them, they may choose a secondary addiction (e.g., sex) to aid in regulating their emotional states in these situations. This is crucial to understand in that cross-addictions are further evidence of the severity of the client's insecure attachment style that the therapist must identify and address through the therapeutic relationship.

Emotion-focused therapy is an extension of attachment therapy. By focusing on emotions in sessions, the therapist can help regulate a client's emotional states interpersonally just as would occur between a caregiver and an infant. Some therapists refer to this process as reparenting. If the therapist can provide a good-enough attachment base through the corrective emotional experience of therapy, the client and therapist can safely explore maladaptive attachment strategies while reinforcing their relationship connection in therapy.

However, some clients are so challenged by their early experiences that they are completely unable to identify emotional states with feelings words. This is common in addiction treatment, and it is called alexithymia (Sifneos, 1973, 1996; Taylor, Bagby, & Parker, 1999; Vanheule, Sesmet, Meganck, & Bogaets, 2007). Alexithymic clients are not able to form secure attachment relationships because attachment is intertwined with emotion. They are so detached from emotion that they cannot even identify or label emotional states when they are happening in the moment. In these cases, the most basic therapeutic intervention may be helping these clients identify when they are having emotional reactions without judgment and then helping them learn to label the emotions with feelings words. Other clients may be able to identify emotions, but they are either overwhelmed by them, resulting in demonstration of decompensating behaviors, or fearful of them, resulting in attempts to

restrict all emotional expression. These skills are developmentally similar to how children learn to identify and label emotions and then learn self-control or regulation of emotions as toddlers.

Clients who manifest these types of emotional dysregulation are likely to have significant histories of relational trauma. When this is the case, the therapist must be aware of the potential for *trauma bonding* (Carnes, 1997). Clients who have significant histories of interpersonal trauma may not have experienced any relationship that did not have a trauma component to it. This may include psychological trauma, physical trauma, and/or sexual trauma. Individuals who experience this type of trauma are more susceptible to developing new attachment relationships in therapy (group, AA, with the therapist) that are based on the common experience of trauma or on the shared expectation of trauma in interpersonal relationships. These clients often believe their trauma experiences are excuses (not explanations) for their addictive behaviors. So the therapist must take care to identify and reframe situations where the client uses trauma as a method to enable addictive behaviors.

Clients' perceptions of rejection or abandonment by the therapist may be triggered from their relational trauma histories as well. These transference reactions may develop when the client begins to feel securely attached to the therapeutic relationship and then becomes fearful of being harmed by the relationship. Alternatively, it may develop from a therapeutic relationship rupture occurring when the therapist is empathically misattuned with the client's needs. In these situations the most important goal is for the therapist to facilitate a relationship repair that results from processing the rupture and providing a corrective emotional experience for the client. For instance, when sessions are missed the therapist should focus attention on understanding the client's feelings about the therapeutic relationship because this relationship is the chance to correct maladaptive attachment patterns. The therapist should take care to accurately reflect the client's conflicting feelings about the relationship, while providing a secure holding environment for the client to express, experience, and name these feelings. The attempts at repair will help clients replace maladaptive coping strategies with adaptive ones.

Similarly, therapist absences (e.g., illness or vacation) and termination (planned or unplanned) will trigger clients' attachment-focused issues. Therapy should focus on changing interactional patterns, identify areas where clients feel their needs are not being met, and problem-solve ways to recognize those signs of distress and how to communicate those needs in a way they can be met in intimate relationships. If the client perceives that the therapist (new attachment figure) will no longer be available, this can trigger maladaptive coping strategies, such as acting out addictive behaviors. This is an assumption from the attachment model of addiction that may explain why many clients have lapses or relapses close to the end of treatment. It is a reflection of their anxiety about ending the relationship. It can be helpful for the therapist to provide a transitional object for the client, such as a rock with the word *strength* painted on it so that the client can carry it with him or her as a reminder of the work done in therapy. The therapist may also facilitate the client's termination process and internalization of the relationship and the work done in therapy through having the client keep a journal, an art project, or developing sandtrays or collages documented in pictures throughout therapy in order to help the client own his or her progress in treatment, honor the attachment relationship with the therapist, and have a transitional object that can be helpful when the client is away from treatment but having a difficult time emotionally.

Another tool that can be used to both create healthy attachments and provide ongoing interpersonal support is the client's participation in a 12-step or other support group. Attachment-focused therapists emphasize the importance of clients finding a group where they feel comfortable and can relate to the people in the group, rather than emphasizing location or time of the group. An important component of a 12-step group that may also facilitate the attachment process is identifying and engaging a sponsor. These can provide ongoing supports for the client when the therapist is not available. However, ultimately it is the therapeutic relationship and the client's experience of that relationship that will effect lasting change. To reiterate, from an attachment perspective, emotional experiences in securely attached relationships are powerful.

ASSESSMENT AND PREVENTION IMPLICATIONS

Attachment theory was formed based on ethnographic behavioral observations that led to Bowlby's initial observation of protest, despair, and detachment as a predictable series of responses to children being separated from their parents. Behavioral observations in naturalistic settings continue to be useful for assessing attachment styles. This may occur with addiction clients in their natural environments or in therapeutic settings such as residential treatment programs or psychiatric inpatient programs. Bowlby's theory was further researched using the Strange Situation Protocol (SSP; Ainsworth, 1978), which formally assessed attachment styles as secure, insecure-ambivalent, or insecure-avoidant. Finally, further review of nontraditional responses to the SSP resulted in the identification of behaviors consistent with disorganized attachment.

These attachment styles have been used to formulate several attachment measures for older adolescents or adults who are more likely to be the focus of addiction treatment. In 1987, Hazan and Shaver developed a self-report measure for romantic attachment among adolescents and adults. The assessment consists of one statement for each of the attachment styles identified by Ainsworth (secure, avoidant, and anxious-ambivalent). An earlier version asked participants to identify which statement best identified their feelings, and a later version asked them to rate their agreement with each statement. This measure postulated that securely attached individuals demonstrated low anxiety and low avoidance related to attachment relationships. Preoccupied or anxious-ambivalent attachment styles demonstrated high anxiety but low avoidance of attachment relationships. Avoidant or dismissing attachment styles reflected low anxiety but high avoidance. Fearful avoidant (disorganized) attachment styles demonstrated high anxiety and high avoidance.

The Adult Attachment Interview (AAI) previously discussed is a semistructured clinical interview with 20 questions that attempt to assess adults' internal representation of attachment relationships by asking them to recall information from their childhood (George et al., 1985). Quality and content are coded to produce one of the following attachment styles: autonomous (e.g., secure), dismissing (e.g., anxious-ambivalent), preoccupied (e.g., avoidant), and disorganized. The same attachment style coding is used by the Adult Attachment Projective Picture System (AAP) that uses eight cards with different scenes

that the client tells stories about (George & West, 1999, 2012). One strength of the AAP is that it also provides information on defensive processing patterns, attachment synchrony, and personal agency, which can be useful in treatment for adolescents and adults.

Bartholomew and Horowitz (1991) developed the Relationship Questionnaire (RQ-CV) that consists of four sets of statements, similar to the Hazan and Shaver questionnaire, representing each of the four adult attachment styles: secure, dismissive, preoccupied, and fearful. The difference was that this instrument assessed both thoughts about whether they were the types of people whom others wanted to support and help and their thoughts about whether they judged their attachment partner as accessible and emotionally responsive. This assessment has been validated in 62 cultures, although different cultures indicated the different categories of attachments may have different meanings than originally assumed (Schmitt et al., 2004). For this assessment, securely attached individuals demonstrated positive thoughts of themselves and their attachment relationship. Preoccupied (anxious-ambivalent) attachment styles demonstrated negative thoughts about themselves but positive thoughts about their partner. Conversely, dismissive (avoidant) attachment styles demonstrated positive thoughts of themselves but negative thoughts about their partner. Finally, fearfully (disorganized) attached individuals demonstrated negative thoughts about themselves and their partners.

The Experiences in Close Relationships (ECR) questionnaire and the revised (ECR-R) questionnaire provide measurement of two dimensions of attachment, avoidance and anxiety (Brennan, Clark, & Shaver, 1998; Fraley, Waller, & Brennan, 2000). Respondents are asked to rate the degree of their agreement with multiple statements about relationships. Questions about an individual's beliefs related to propensity to be rejected by others and their self-worth are measured by the anxiety scale, and their beliefs about taking risks in approaching others are measured by the avoidance scales. These are some of the more noted formal assessments of attachment used to assist therapists in clinical situations.

Although each of these formal assessments provides helpful information to clinicians, none replaces the need for the therapist to conduct a thorough clinical interview that includes questions exploring the client's experience of early attachment relationships and current experiences of attachment relationships. Additionally, attachment-informed therapists are continuously assessing client dynamics in the therapeutic relationship with the therapist and any dynamics exhibited in the therapeutic milieu of the treatment program for evidence of attachment style and evidence for change in attachment beliefs, attitudes, and behaviors.

BOX 7.3 Assessing Your Attachment Style

Go to the following website to access the Experiences in Close Relationships Revised assessment: www.web-research-design.net/cgi-bin/crq/crq.pl.

Complete the assessment for yourself. What is your attachment style according to the assessment? How accurate do you believe it is, and why? Analyze the attachment style you have in relationship with your own psychosocial history. What are the strengths and challenges associated with this attachment style?

BOX 7.4 Analyzing How Clinician Attachment Style May Impact Treatment

Complete the assessment a second time as you think Gabriel would complete it. You may have to fill in some gaps in what you know about his history. What are the strengths and challenges of Gabriel's attachment style? Analyze your attachment assessment results in relationship to his. What unique challenges might occur based on these results? How would you address this in order to provide the most competent care for Gabriel? What resources do you have available to you to address these challenges?

STRENGTHS AND WEAKNESSES OF THE THEORY

Attachment theory approaches can be considered evidence-based practice. The theory is based on a solid foundation of research beginning with in-depth behavioral observations, followed up with specific experimental design studies both short term and longitudinal across multiple cultures and more recently increased functional magnetic resonance imaging (fMRI) research supporting the concept of interpersonal neurobiology that is based on attachment relationships and impacts emotion regulation (Ainsworth, 1967; Ainsworth et al., 1978; Bowlby, 1984, 1988; Main et al., 1985; Main & Solomon, 1990; Perry, 2009; Siegel, 2012). This approach provides potential lasting change by treating not only the symptom (addiction) but the underlying motivational issues and resultant neurobiological structures impacted by those underlying experiences and triggers. However, attachment relationships with secondary relationships other than parents have not been adequately studied to understand potential mediating effects of these. Additionally, research on attachment-focused addiction-specific treatment is lacking.

Attachment theory approaches do not use specific techniques that are easily translated into practice for novice therapists. In order to practice from this perspective, a new therapist needs to have a substantial understanding of the underlying theoretical concepts and supervised practice in treatment of clients and in conceptualizing client dynamics. Therefore, this approach takes more time, effort, and resources to learn and carry out than do more simplified approaches to treatment. Similarly, given that building a secure base in the way of an empathically attuned therapeutic relationship is a goal of this approach, therapy cannot be completed in a strict limited number of sessions. Another complication is that many treatment facilities in which individuals with addictions are treated have high staff turnover. This necessarily reinforces insecure attachment patterns rather than building secure ones.

CASE STUDY RESPONSES

Gabriel experienced his early caregivers as people he could not consistently trust to provide a safe holding environment for stressful emotional states. In fact, his father's addiction and abusive behavior indicate that Gabriel likely experienced both fear and love for his father. In order to attempt to connect with his father he began using substances in order to contain dysregulated emotions. He experienced his maternal relationship as loving but inconsistent in that his mother did not provide a safe holding environment to protect Gabriel or his sister from his father's abusive behaviors. Based on his stated close relationship with his sponsor that ended abruptly and the description of short intimate relationships with romantic partners, it is likely that he demonstrates an avoidant attachment style either as primary or as secondary to a disorganized style. More assessment needs to occur to make a clear determination about this.

The most important thing for Gabriel's therapist to do is to create a safe holding environment for him in therapy. This means that the therapist must be consistent and forthright in communication with Gabriel about all aspects of therapy. Additionally,

it is crucial for the therapist to conduct a thorough psychosocial evaluation to gain an understanding of Gabriel's early attachment relationships, his attachment attitudes, and his expectations of how he will be treated by others in interpersonal relationships. The limited information provided by the case study does not sufficiently provide this information.

Gabriel may demonstrate alexithymic behaviors given that he has only experienced his parents as individuals who were preoccupied with their own issues of anxiety, depression, addiction, and abuse. It is possible he did not learn how to identify the physical sensations of emotional states with feelings words. So the therapist may need to spend time initially in treatment building this understanding of emotions as feelings. The therapist may use sandtray, art, music, or other experiential means to help access emotional states in therapy, then help the client describe his bodily sensations resulting from the symbolic representation of triggering situations, and finally help him name those emotional sensations with feelings vocabulary. This will provide a foundation for communicating about emotions within interpersonal relationships. Building on this work, emotion-focused therapy techniques may then help Gabriel experience, express, and work through triggers for emotional dysregulation. By having consistent experiences in a safe empathically attuned therapeutic relationship, Gabriel will begin to build and strengthen new neural networks that support a healthier attachment style.

Gabriel likely demonstrates an emotional regulation mode of psychic experience where he does not think of himself as separate from others. This would result in Gabriel's enmeshed relationships with important others and demonstrated difficulty separating psychologically or physically from individuals such as his mother, sister, and niece. Similarly, he may also define himself as an addict without much of a foundation to build on for his nonaddictive lifestyle. In other words, he is an addict, but not an uncle, a son, or a lover of music. So the therapist may need to help Gabriel identify his personal characteristics and develop a self-concept separate from the addiction.

Enmeshment is an important concept in that he will likely have difficulty separating and self-reflecting on his own experiences separate from important family members or other group members. This may result in his inability to move forward toward a healthy nonaddictive lifestyle. In order to address this, the therapist may need to work with Gabriel on identifying himself as separate from significant others (e.g., mother, niece, father, girlfriend, sponsor, group members). This may occur by using specific language during therapy to identify and reframe conceptualizations of relationships in a manner that clearly identifies individual experiences and roles in the family or group. Additionally, the therapist will likely need to provide support for Gabriel in setting boundaries with significant others such as his mother and sister and perhaps other clients in group or 12-step meetings. The therapist should anticipate that Gabriel will experience increased anxiety at doing this and may need additional support and processing time in session when he attempts to set limits with significant others.

The therapist must also identify when Gabriel needs to set limits with the therapist or attempts to do so or when he asserts his needs in therapy (or avoids doing so). These are potentially powerful teachable moments for the therapist to use the here-and-now relationship to process how Gabriel's attachment style is impacting his ability to identify and meet his psychological and emotional needs. Another important therapeutic intervention that speaks to this issue is for the therapist to reiterate when the client has worked in treatment and made progress. Often a client like Gabriel will give the credit for his successes in therapy to the therapist rather than claiming them as his own. The therapist needs to consistently acknowledge that a therapist's role is to be on the journey as a guide with Gabriel, but the work done is his, and the resulting impact of that work is his as well.

Finally, termination or even separations due to weekends or vacations may be particularly difficult for Gabriel because he does not view himself as separate from other significant individuals in his life. Once Gabriel begins experiencing the therapeutic relationship as safe he may actually begin to experience an initial increase in emotional dysregulation because of the anxiety associated with giving up his fear of being hurt (emotionally or physically) by a caregiver, in this case the therapist. These points in therapy may be triggers for acting out addictive behaviors. They should be predicted in therapy as potentially difficult triggering times. When this type of trigger emerges, transitional objects or other methods of providing a physical connection to the mental representation of the safety of the relationship should be provided as one method to prevent or mitigate relapsing behavior.