

## **Alcohol Dependence and Avoidant Attachment – Implications for Therapy**

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**Alcohol Dependence and Avoidant Attachment –  
Implications for Therapy**

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**University of Wolverhampton**

**May 2007**

Signature .....

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# **Alcohol Dependence and Avoidant Attachment – Implications for Therapy**

**Jane Cornwall**

A thesis submitted in fulfilment of the requirements of the University of  
Wolverhampton for the award of practitioner doctorate degree in Counselling  
Psychology.

May 2007

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## **Acknowledgments**

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## **Abstract**

The literature review revealed co-morbidity between adverse childhood experiences, adult psychopathology and alcohol dependence, although causality was questionable due to multiple variables. The current study used 54 clients at the acute end of the spectrum of severe alcohol dependence from a specialist tertiary substance misuse service (clients) and a control group of 54 non-problematic drinkers from an NHS working population (controls) to examine possible differences in security of attachment and maladaptive schemas and investigated how early relational experiences influenced core beliefs regarding self, others and intimate relationships and therapeutic implications for severely alcohol dependent clients' engagement in specialist services. The study was divided into two sections: (1) quantitative analysis using Feeney, Noller and Hanrahan's (1994) Attachment Style Questionnaire to measure attachment style and Young's Schema Questionnaire (Young & Brown, 2001) to measure maladaptive schemas in the domain of disconnection and rejection and (2) qualitative analysis, using Interpretational Phenomenological Analysis (IPA) to explore eight severely alcohol dependent clients' subjective experiences of intimate relationships. Clients scored significantly lower in secure attachment style and significantly higher in both avoidant and ambivalent attachment style than controls and suggested overlapping between the two dimensions, known as 'fearful avoidant' attachment. Clients scored significantly higher than controls in all five sub-categories of maladaptive schemas in the domain of disconnection and rejection, namely mistrust/abuse, emotional deprivation, abandonment, social isolation/alienation and defectiveness/shame. IPA revealed common themes of negative parent-child interaction: physical and psychological abuse, neglect and explicit maternal rejection and emotional deprivation and hostile and abusive parent-parent interaction. These

aetiological factors influenced fearful avoidant attachment and maladaptive core beliefs. Negation of children's needs implicated an immaturely developed diffuseness of identity and defective self that inhibited formation of intimate adult relationships. A bio-psychosocial explanation suggested alcohol ameliorated hyper-vigilant anxiety and depression from adverse childhood experiences within a threatening family environment that implicated insecure attachment, maladaptive core beliefs and negative self-identity, inhibiting emotional intimacy. It advocated screening procedures and an integrated CBT and schema-based therapeutic approach for those at the more severe end of the spectrum of alcohol dependence deemed at risk of not engaging or disengaging prematurely from services.

### **Literature Review Search Strategy**

A search was conducted of international scientific electronic journal databases, using the keywords: substance misuse, alcohol misuse, alcohol abuse, alcohol dependence, insecure, secure, avoidant, ambivalent attachment, childhood abuse, sexual abuse, neglect, emotional deprivation, alcohol-related trauma, post-traumatic stress disorder, maladaptive schemas, Young's schema questionnaire, co-morbidity with mental health, personality disorder, alcohol and therapy, social network and behavioural therapy, alcohol and CBT, schema-based interventions, and IPA.

## **Literature Review**

### **Introduction**

Although social drinking is considered to be a positive experience enjoyed by many in the UK population, alcohol misuse can also have a multi-faceted, negative societal impact, affecting individuals, families and communities in several ways. Alcohol misuse is linked to anti-social and violent behaviour, with half of all violent crimes associated with alcohol (British Crime Survey, 2002). Research implicates alcohol misuse in domestic violence, and its influence is twofold, firstly, with 47% of assaults occurring when the perpetrator is under the influence of alcohol and, secondly, with the victims using alcohol as a maladaptive coping strategy (Werkerle & Wall, 2002; Galvani, 2004).

The potential harm to mental and physical health is also evident, with approximately 1000 suicides a year involving alcohol. Seventy per cent of all admissions to accident & emergency units are alcohol-related and 30,000 hospital admissions annually are for alcohol dependence syndrome (Cabinet Office, 2004). Between 1979 and 2000, alcohol-linked deaths more than doubled in the UK to a ratio of 13 deaths per 100,000 of the general population (Health Statistics Quarterly, 2003), suggesting a serious, escalating problem with nationwide social, health and economic implications.

Despite this problematic increase, on average only one in 18 problem drinkers access specialist alcohol treatment services and, of those, evidence suggested a high client 'did not attend' (DNA) rate of up to 50% for initial assessments and subsequent appointments, which can be both frustrating and demoralising for



health professionals working in the substance misuse field (Department of Health, 2006). The anomalous relationship between the high levels of alcohol dependence acknowledged within the general population and the relatively small and inhibited engagement with the appropriate specialist services warranted further exploration.

Various theories have attempted to explain the nature of excessive and chronic drinking, including attachment theory. However, in order to explore the possible relationship between insecure attachment, maladaptive schemas and alcohol, the classification of alcohol misuse and definition of 'alcohol dependence' were firstly outlined.

### **Definition of Alcohol Dependence**

The national terminology for problematic drinking is classified by the National Treatment Agency for Substance Misuse (2006) as: (1) *hazardous drinking*, which increases the risk of physical harm; (2) *harmful drinking*, which is already causing damage to health; (3) *moderate alcohol dependence*; and (4) *severe alcohol dependence with complex needs*.

A concise and concordant definition of alcohol dependence that is universally accepted is necessary for both research and practical application, so that international studies may be compared and analysed without fear of criticism. From the mid-1980s, this led to a revision of the two most commonly used criteria, outlined by Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) of the American Psychiatric Association (1994) and also the

International Classification of Diseases (ICD-10) of the World Health Organization (1992).

The two definitions align with the medical model of alcohol misuse as a disease with varying physical symptoms; they are similar in their clustered array of symptoms such as craving, physical signs of tolerance and withdrawal, and behavioural measures such as using alcohol to relieve unpleasant withdrawal symptoms. Studies showed that both diagnostic systems revealed good to excellent agreement across time, gender, age and ethnicity (Grant, 1996) and high reliability and validity for alcohol dependence (Hasin, 2003). For the purpose of the investigation, therefore, one definition, DSM-IV, is detailed below and the other, ICD-10, is situated in Appendix 20.

Alcohol dependence syndrome is now acknowledged as a recognised disorder by DSM-IV and is described as:

“A maladaptive pattern of alcohol use, leading to clinically significant impairment or distress, as manifested by three or more of the following seven criteria, occurring at any time in the same 12-month period”.

1. Tolerance, as defined by either of the following:

- A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
- Markedly diminished effect with continued use of the same amount of alcohol.

2. Withdrawal, as defined by either of the following:
  - The characteristic withdrawal syndrome for alcohol, with two or more of the following symptoms occurring over the next day or two, once a person stops drinking abruptly and completely.
  - Anxiety.
  - Autonomic hyperactivity (i.e., sweating, pulse rate greater than 100).
  - Delirium tremens (i.e., anxiety, increased heart rate, sweating, trembling, confusion).
  - Difficulty performing tasks involving motor co-ordination.
  - Grand mal seizures (i.e., convulsions resulting in loss of consciousness and muscle contractions).
  - Hallucinations (i.e., sights, sounds, or physical sensations on the skin, elevated or decreased temperature).
  - Hand tremor.
  - Insomnia.
  - Nausea, vomiting.
  - Alcohol is taken to relieve or avoid withdrawal symptoms.
3. Alcohol is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or there are unsuccessful efforts to cut down or control alcohol use.
5. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol or recover from its effects.

6. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
7. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the alcohol (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption).  
(American Psychiatric Association, 1994).

From a psychological perspective, DSM-IV may be criticised for the focus upon alcohol-related physical effects and medical symptoms of alcohol dependence and neglect of psychological problems such as paranoia, cognitive impairment, short-term memory deficits and emotional difficulties. Alcohol dependence has a significantly negative impact, not only upon an individual's physical health but also upon their psychological, mental and social wellbeing; nonetheless, the alcohol-dependent client's seeming over-riding compulsion is to perpetually drink, despite the hazardous and sometimes fatal consequences. The question arose, therefore, as to how this potentially destructive pattern of cognition, affect and behaviour occurred and the possible contributory influences.

In order to examine the possible role avoidant attachment may play in the development and maintenance of excessive and chronic drinking, it was necessary to compare and evaluate other theories of alcohol dependence.

## **Theories of Alcohol Dependence**

Various theories have attempted to explain the concept of alcohol dependence, and West (2001) provided a comprehensive summary of possible theories of addiction. The medical/disease model (Jellinek, 1960), well recognised within the NHS, perceived alcohol dependence as a recurrent, remitting and relapsing brain disorder, highlighting genetic factors and physiological vulnerability.

Prolonged, after-care monitoring and support of alcohol clients, similar to that prescribed in chronic illness treatment was therefore advocated (McLellan, McKay, Forman, Cacciola & Kemp, 2005). It presented a fatalistic and relatively negative picture of enduring physical illness and unremitting maladaptiveness, which contrasted to the positive, psychological approach focused upon striving towards emotional wellbeing and self-actualisation (Nelson-Jones, 1982).

The medical model suggested a qualitative difference between alcohol-dependent individuals and controlled drinkers, namely their inability to maintain control once they start drinking and abnormal cravings triggered once drinking commences. According to this model, abstinence was the only solution.

However, previously alcohol-dependent clients have shown the ability to manage controlled drinking, which suggested invalidation of that premise.

Research that administered alcohol to participants with or without their knowledge showed little evidence of increased craving in those who were unaware they have been given alcohol, implicating a psychological rather than physiological basis for craving (Merry, 1966) triggered by situational factors.

A study of self-reporting by alcohol dependent clients revealed substantive figures of 50% of fathers and 20% of mothers having similarly abusive drinking

patterns as themselves (Paton, 1992), suggesting a genetic factor. However, it is very difficult to distinguish between social conditioning and an inherent predisposition. The unresolved nature/nurture debate of inherited vulnerability versus learned behaviour continues. The likelihood is that familial drinking is a contributory rather than a causative factor. However, the medical model was useful in removing stigmatisation around alcohol dependence as a perceived moral weakness.

Unfortunately, the explanation of severe alcohol dependence as an illness may also remove a sense of self-responsibility, creating difficulties when psychologists are working towards client motivational change. A criticism of the medical model was its focus upon internal mechanisms and neglect of environmental and social mediators (Gorman, 1989), which often in clients' case histories may have had a strong influence upon their alcohol consumption. However, the difficulty here was reliance upon subjective and retrospective self-reporting.

Symptoms of generalised anxiety and depression were present with the vast majority of alcohol dependent clients, which was, according to the medical model, assumed to be physical consequences of long-term alcohol misuse, but which may also be linked to early negative experiences. The medical model neglected to acknowledge social and behavioural factors (Gorman, 1989) such as the destructive, psychological impact of recurrent and insidious patterns of childhood trauma, particularly sexual, physical and emotional abuse and parental neglect.

Conversely, the social learning model of alcohol dependence (Akers, 1989) suggested a functional purpose, in that drinking created positive consequences or alleviated negative ones, with extenuating social, cultural and environmental factors. All contributed to the individual's ability to cope with difficult or emotionally fraught situations or life events. However, the model ignored childhood experiences and failed to explain why some engage in a seemingly self-destructive and harmful pattern of drinking while others do not (West, 2006). The trans-theoretical model (Prochaska & Diclemente, 1983) provided a possible explanation, in that the drinker subjectively rationalised his/her need to drink in terms of short-term gains over-riding the objective long-term negative consequences. However, recently West (2005) has criticised the model for trying to organise the complex and inter-related process of behavioural change into discrete and simplistic stages and neglecting subconscious decision-making processes and motivational forces.

Difficulty in considering long-term, adverse effects was evident in many alcohol dependent clients who found it preferable to focus upon immediate benefits of reducing symptoms of stress, triggered by memories of interpersonal trauma (Zlotnick, Johnson, Stout, Zywiak, Johnson & Schneider, 2006). These theories provided plausible explanations for alcohol dependence despite their limitations, but neglected to explore external factors and past experiences that may have affected a child's transitional development into adulthood, which precipitated this study.

A developmental approach based upon Bowlby's (1969) attachment theory may be preferable in understanding the complex nature of alcohol dependence,

incorporating past and present environmental factors, such as family dynamics or external events that either assisted or inhibited a child's developmental progress from infancy into adulthood. Attachment theory focused upon the psychological, emotional and social impact of early childhood influences upon the formation and maintenance of cognitive, affective and behavioural patterns that were crucial for social interaction in later life. This psychosocial model suggested that early negative life experiences possibly disrupted the development of emotional bonds and implicated a learned inability to form intimate relationships, known as 'insecure attachment' (Bowlby, 1969, Rutter, 1978, Ainsworth, 1989, Sperling & Berman, 1994).

Insecure attachment was deemed to arise from early negative experiences and losses (Moncrieff, Drummond, Candy, Checinski & Farmer, 1996), such as 'childhood adversities of an interpersonal nature' (Mickelson, Kessler & Shaver, 1997), and was suggested as a risk factor in alcohol misuse (Mirsal, Kalyoncu, Pektas, Tan & Beyazyurek, 2004). From a counselling psychology perspective, the theory of insecure attachment, explored next, aligned with clients' anecdotal evidence of traumatic, sometimes hostile and neglectful early family life.



## **Attachment Theory**

*No variables have more far-reaching effects on personality development than a child's experiences within the family. Starting during his first months in his relation to both parents, he builds up working models of how attachment figures are likely to behave towards him in any of a variety of situations, and on all those models are based all his expectations, and therefore all his plans, for the rest of his life.*

(Bowlby, 1973)

John Bowlby's Attachment Theory (1969) emerged from Freud's psychoanalytical analysis of selfish, instinctive drives towards desire for a more positive approach, focusing upon infant competencies rather than inadequacies. The ethology-based theory stemmed from understanding that the human infant had an inherently, primeval instinct and drive primarily to form positive attachments with its primary care giver for survival purposes and affect regulation when threat is perceived; it was an evolutionary process pre-programmed into the brain.

As the child grew and developed mentally and physically, this relatively primitive design became a more sophisticated, regulated behavioural system of cognitive and emotional interaction that allowed it to explore its environment, confident in the knowledge that the nurturing parent's presence alleviated anxiety and distress when fearful or unpleasant situations or events were experienced and offered a consistently secure and protective base on its return. Gradually the child's mapping of its interpersonal experiences developed into more complex internal working mental models of its attachment figure and itself in relation to that primary care giver, similar to the 'object representation' of psycho-analytical

therapy or the 'schema' of cognitive and developmental psychology (Sperling & Berman, 1994).

Bowlby's (1969) research, based upon observational studies of separated and institutionalised children, theorised that absence, disruption to or denial of this bonding through maternal loss, rejection, deprivation, abuse and/or physical and emotional neglect resulted in the child's ambivalence towards, and reluctance or inability to form, intimate relationships later on in life, namely insecure attachment.

Ainsworth, Blehar, Waters and Wall (1978) supported Bowlby's theory with empirical studies, the "strange situation", where infants' responses to their mother's temporary absence and a stranger entering the room, varied according to the quality and consistency of the parent-child relationship. Three styles of attachment were identified, '*secure, anxious/ambivalent or avoidant attachment*'.

A study of preschool peers identified a positive correlation between insecure attachment and later peer rejection, which suggested the importance early on of attachment type (Wood, Emmerson & Cowan, 2004). Securely attached children who had received early, positive, relational experiences appeared to continue with those interpersonal expectations and style of interacting with their peers and subsequently developed friendships. Conversely, those insecurely attached children who had models of intimacy avoidance or inconsistency or an expectancy of relational conflict exhibited non-compliant, annoying, sometimes

aggressive behaviour that mirrored their experiences and expectations of relationships, resulting in peer rejection.

Internal working models, through repetitive experiences, became long-lasting and relatively stable representations of attachment relationships as the child became an adult (Bowlby, 1980). This unconscious processing formed familiar patterns that were increasingly resistant to change.

Parents of young children were interviewed regarding their memories of parenting and their attachment style established from the information given was mirrored both in the way they responded to their own children and how securely or insecurely attached were their offspring. This suggested not only stability over time of attachment style but also an intergenerational transmission of cognition, affect and behaviour (Main, Caplan & Cassidy, 1985).

A desire to investigate adult attachment drove the expansion of various ideas and methods to empirically study individual differences in attachment styles in later life. Initially, Hazan and Shaver's (1987) self-rating tool was used to categorise individuals as having either secure, avoidant or anxious/ambivalent attachment, according to the statement choice they made. Participants were asked to read the three statements listed below, and indicate which one best represented their thoughts, feelings and behaviour in intimate relationships:

- I am somewhat uncomfortable being close to others; I find it difficult to trust them completely, difficult to allow myself to depend on them. I am

nervous when anyone gets too close, and often, others want me to be more intimate than I feel comfortable being (*avoidant*).

- I find it relatively easy to get close to others and am comfortable depending on them and having them depend on me. I don't worry about being abandoned or about someone getting too close to me (*secure*).
- I find that others are reluctant to get as close as I would like. I often worry that my partner doesn't really love me or won't want to stay with me. I want to get very close to my partner, and this sometimes scares people away (*anxious/ambivalent*).

(Hazan & Shaver, 1987)

Using this three-category measure, Hazan and Shaver (1994) found that category distribution epitomised those attachment styles recorded in early childhood. Essentially, approximately 60% of adults rated themselves as *secure*, about 20% described themselves as *avoidant* and about 20% chose the *anxious/ambivalent* category. The limitation of this measure was its 'forced-choice response', which neglected the possibility of overlapping dimensions within an individual.

Various research groups then endeavoured to produce a reliable measure of attachment style, with differing results, depending upon what aspect of attachment they were attempting to measure. For example, West, Sheldon and Reiffer (1987) focused upon the dimensions of 'proximity-seeking' and 'separation protest' and the more pathological aspects of adult attachment, whereas the Intimate Bonds Measure (Wilhelm & Parker, 1988) explored the

degree to which 'care' and 'control' influenced the perception of 'self' and 'others' within an intimate relationship.

In criticism, this heterogeneity, although useful, prevented the emergence of a well-integrated evidence-based framework (Feeney, Noller & Hanrahan, 1994). This was remedied by the development of the self-report Attachment Style Questionnaire (Feeney *et al.*, 1994) that acknowledged attachment styles were not mutually exclusive, and that individuals could possess characteristics of all three types.

Thus, the questionnaire allowed participants to reveal elements of all three styles; studies showed a strong negative correlation between secure and avoidant attachment and a weak negative association between secure and anxious/ambivalent attachment. There was a lack of correlation between avoidant and anxious/ambivalent attachment, suggesting that individuals could score equally highly on anxious/ambivalent and avoidant attachment, thereby querying Hazan and Shaver's forced-choice categories as an accurate measure.

Feeney *et al.* (1994) developed their questionnaire based upon the positive or negative view of self and others, which was integral to adult attachment. They also wanted to explore and identify possible individual differences, hence the sub-scales of *confidence*, *discomfort with closeness*, *need for approval*, *preoccupation with relationships* and *relationships as secondary to achievement*.

No reported differences were identified in forced-choice measures, but in continuous measures the only significant effect was in *relationships as secondary*, with men more inclined to view relationships as less important than achievement compared to women, which could be explained in terms of social norms and gender role expectations.

The Attachment Style Questionnaire (Feeney *et al.*, 1994) has benefited research in this area by highlighting the distinction between secure and insecure attachment and also by revealing the overlap between avoidant and anxious/ambivalent styles. For example, *discomfort with closeness* was strongly identified in both *avoidant* and *anxious/ambivalent attachment* and which also showed a *preoccupation with relationships*. This implied a possible ambivalence related to emotional intimacy, which drove the preoccupation, rather than neediness. It also suggested that avoidance may be anxiety-related, rather than based upon dismissiveness, and that the two aspects of insecure attachment were not as dissimilar as first posited by forced-choice measures (Bartholomew & Horowitz, 1991).

The Attachment Style Questionnaire (Feeney *et al.*, 1994) provided empirical and reliable evidence for the differentiation between aspects of insecurity but also for the possibility that individuals' attachment styles could encompass that diversity. It was therefore chosen for this investigation for the reason that it reflected the complex cognitive and affective mechanisms in severely alcohol dependent clients, as they oscillated between neediness and rejection and between engaging and disengaging from alcohol services.

Insecure attachment style has been associated with attachment psychopathology (Lapsley, Varshney & Aalsma, 2000), such as compulsive care seeking, angry withdrawal and compulsive self-reliance and psychiatric disturbances (Mason, Platts & Tyson, 2005). Many severely alcohol dependent clients such as those interviewed presented at alcohol services with such symptoms; they appeared to possess maladaptive schemas that reinforced a negative and distorted view of relational experiences. Recent research revealed maladaptive schemas related to vulnerability to harm, subjugation of needs and emotional inhibition in alcohol misusers (Brotchie, Meyer, Copello, Kidney & Waller, 2004). Such core beliefs could increase susceptibility towards misunderstanding, mis-communication and misinterpretation within the therapeutic alliance. Inhibited interpersonal relatedness may lead to temporary ruptures in the relationship, or worse, disengagement with the service, due to the emotional conflict between needing to feel nurtured, yet fearing the sense of unfamiliarity and alienation that being cared for elicited.

A possible explanation for disengagement was that insecurely attached people with severe alcohol dependence found it difficult to contemplate engaging therapeutically as their internal working model of relating was unrewarding, if not threatening and avoidance was preferable. Ambivalence or avoidance in the form of non-compliance subsequently often prevailed, and premature disengagement from services was frequently re-enacted (Cosden & Cortez-Ison, 1999). Attachment theory therefore provided a sound explanatory framework for comprehending alcohol dependence and the challenges for therapists.

Criticisms of Bowlby's theory were the seeming permanence of insecure attachment, whereas experience of a positive, nurturing relationship in adulthood did seem to mediate the effect, as did personality traits, such as resilience, social support and perceived control (Bretherton, 1992). Bowlby's focus upon the mother ignored the psychological impact of a violent, abusive father (Clark, Lesnick & Hegedus, 1997), which in some client cases was often relevant.

Bowlby tended to neglect the mediating factors of situational and environmental influences, which could act as an emotional buffer. Nonetheless, attachment theory of affect regulation assisted in explaining how some clients utilised alcohol as a negative emotion regulator and as a psychological defence against childhood traumatic memories and subsequent insecure attachment behaviours; unfortunately, alcohol misuse tended to isolate them further from emotional intimacy, and its damaging consequences to health and relationships reinforced negative core beliefs regarding self.

Attachment theory has been invaluable towards understanding and suggesting possible explanations for adult psychopathology and in encouraging further related theoretical development and therapeutic interventions based upon adult attachment (Waters, Crowell, Elliott, Corcoran & Treboux, 2002). Young's Schema Therapy was one such example, which will be examined next and which formed the basis of the current study into the reciprocal relationship between insecure attachment, emotion and cognition.



## **Young's Schema Therapy**

Young's Schema Therapy, relatively recently developed from psychodynamic and attachment theory and integrated with traditional cognitive behavioural therapy (CBT), (Beck, 1976), is a systematic and structured approach. Its focus is upon facilitating insight into the client's problems and eliciting emotional, cognitive and behavioural changes. Jeffrey Young (1999) developed the therapy from recognising that some complex clients, particularly those with borderline personality disorder (Young, Klosko & Weishaar, 2003), did not respond well to traditional CBT techniques, and required a more in-depth approach.

Bowlby's 'internal working models' that developed from childhood to early adulthood formed the basis of how we perceived self and others in relation to the social context; if a situation was anxiety-provoking due to physical abuse or emotionally unrewarding in terms of lack of nurture or protection, then it was unlikely that the child's perception of relationships would be positive or trusting.

Young (1999) redefined these models as 'early maladaptive schemas', namely, repetitive, self-defeating learned patterns of cognition and behaviour, arising from unrequited childhood needs. Young argued that temperament and individual personality characteristics interacted with a threatening, possibly hostile and rejecting environment; he suggested that the inherently vulnerable child acquired maladaptive coping strategies to deal with these unmet requirements; this could include alcohol misuse.

Young (1999) divided groups of related schemas into five 'domains':

- *disconnection/rejection.*
- *impaired autonomy/performance.*
- *other-directedness.*
- *over-vigilance/inhibition.*
- *impaired limits.*

The domain of *disconnection and rejection* appeared to encompass many alcohol clients' psychological and emotional difficulties regarding interpersonal relatedness and a negative perception of self and others, although there was as yet no research to support this hypothesis. However, a recent study of alcohol misusers (Brotchie et al., 2004) identified maladaptive schemas in vulnerability to harm, emotional inhibition and subjugation of needs but the severity of clients' alcohol dependence was unclear, which may have affected the outcomes.

Young *et al.* (2003) discovered that clients who possessed schemas in the domain of *disconnection/rejection* tended to be the most psychologically damaged and found it really difficult to form and maintain intimate and rewarding relationships. There was usually an early pattern of abusive, cold and rejecting parenting, with little stability or nurturing.

The five core elements of '*disconnection and rejection*' were:

1. Abandonment/Instability.
2. Mistrust/Abuse.
3. Emotional Deprivation.
4. Defectiveness/Shame.
5. Social Isolation/Alienation.

Clients with the *abandonment/instability* schema held the negative belief that people were essentially emotionally unreliable and unavailable; their perception was that they would inevitably be abandoned, either through death or others finding someone better or more deserving. Those with the *mistrust/abuse* schema perceived others as basically self-oriented and who utilised abusive and hurtful means to manipulate the client. Clients possessing the *emotional deprivation* schema believed that their emotional needs would not be adequately met, either through nurture, protection or empathic connection.

The *defectiveness/shame* schema was the belief about self, that the client was unlovable through personal flaws and inadequacies, combined with a sense of shame and lack of self-worth. Clients who had the *social isolation/alienation* schema perceived themselves as being essentially different from the rest, on the periphery of a group and having had difficulty in engaging in communal activities. Individuals with these schemas want to avoid triggering them, for fear of unleashing the uncomfortable and threatening associated negative emotions. For this reason, people develop maladaptive coping styles and responses to alleviate or avoid the schemas.

The three maladaptive coping styles identified by Young *et al.* (2003) were:

1. Surrender – a resigned acceptance of the truth of the schema that results in their reinforcing the perceived reality by re-enacting and reliving the emotional pain.
2. Avoidance – the purpose is to avoid activating the feared schema by repressing the associated thoughts and feelings that might trigger it, such as emotional intimacy or engaging in therapy. Distraction techniques such as excessive drinking may occur.
3. Over-compensation – the strategy here is to behave in an oppositional manner to the reality of the childhood schema they despise. For example, an individual who feels essentially worthless may strive for perfection.

The difficulty is that the maladaptive coping styles and responses inevitably maintain the unhelpful schemas, interfering with their capacity to have rewarding lives and fulfilling relationships.

**Table 1: Examples of Maladaptive Coping Responses**

<b>Schemas</b>	<b>Surrender</b>	<b>Avoidance</b>	<b>Over-compensation</b>
<b>Abandonment/Instability</b>	Chooses and stays with unreliable and uncommitted partners	Avoids emotionally intimate relationships. Drinks in isolation	Becomes clingy and avoids and remonstrates against any separation
<b>Mistrust/Abuse</b>	Chooses and stays with abusive partners	Mistrustful of people and avoids vulnerability through superficial relationships	Abuses other people
<b>Emotional Deprivation</b>	Chooses emotionally distant partners unable to meet their needs	Avoids intimate relationships	Makes excessively emotional demands upon relationships
<b>Defectiveness/Shame</b>	Chooses critical and rejecting partners	Avoids closeness and expressing thoughts and feelings	Critical and rejecting of others
<b>Social Isolation/ Alienation</b>	Focuses upon difference from others	Avoids social situations	Alters behaviour to blend in with groups

These schemas, coping styles and responses are resistant to change and have the potential to sabotage or disrupt CBT in substance misusers (Beck, 1995).

An integrated and in-depth therapeutic approach such as Young's Schema Therapy, underpinned by attachment theory, which explored the individual's early experience of and ability to form later adult intimate relationships may

therefore be suggested as a positive way forward to effectively assist some severely alcohol dependent clients (Brotchie *et al.*, 2004). However, a limitation to this approach may be therapists requiring specialist training if schema-based interventions are to be effective with severely alcohol dependent clients with complex needs.

### **Contributory Factors Towards Alcohol Dependence**

There are numerous contributory factors to alcohol dependence, such as the link between adverse childhood experiences and the brain's development, and the possible negative effect of such trauma upon later ability to engage with and maintain emotional intimacy within relationships, namely insecure attachment (Green, 2003). The co-morbidity between alcohol dependence, particularly in those clients at the most severe end of the spectrum, and mental health issues and the inter-relatedness with childhood abuse is an important association, and has implications for current and future therapeutic practice within specialist alcohol services.

The medical model of alcohol dependency highlighted genetic predisposition and physiological and familial vulnerability as likely factors (Brown, Goodson & Linnoila, 1993), whereas the functional theory maintained that alcohol acted as a varying maladaptive coping strategy according to self-efficacy (Marlatt, 1985). In contrast, developmental theory focused upon how a child's negative experiences of relationships, through parental unavailability, inconsistency or hostility, may influence later insecure attachment and difficulty with emotional intimacy (Bowlby, 1969; Rutter, 1978; Ainsworth, 1989; Sperling & Berman, 1994). It suggested that such "childhood adversities of an interpersonal nature"

(Mickelson *et al.*, 1997) could be risk factors in alcohol misuse, but causal explanations were questionable. Further exploration was therefore required to evaluate the complex inter-relationship between attachment and alcohol dependence.

### **Attachment and the Brain**

Recent research on depression suggests a neurobiological link to insecure attachment. Early, adverse relational experiences activated the hypothalamic-pituitary-adrenal axis during childhood development, which predisposed the individual to depression following negative life events (Beatson & Taryan, 2003). Alcohol may assist in suppressing traumatic memories and associated feelings. The biological theory was supported by a review (Glaser, 2000) that explored the effects of child abuse and neglect upon the brain's biological structure, development and function. It argued that chronic stress induced by prolonged child maltreatment could result in perpetual hyper-arousal by the autonomic nervous system.

Alcohol dependence could be explained by the activation of the 'flight/fight' responses, whereby an insecurely attached child subjected to the fearful presence of perpetual abuse and uncertainty within the family developed a hyper-vigilant arousal system and was consequently biologically 'hard-wired' from an early age to expect threat. The child therefore became more vulnerable and attuned to anxiety-provoking situations. The emotional regulatory system was thus impaired and later on alcohol served to assist in reducing chronic, raised anxiety levels.

This was further supported in a recent review that suggested a model of disruption to the right brain's developmental progress, due to early abuse, that impaired the coping mechanisms to deal with relational stress, resulting in emotional dysregulation and post-traumatic stress disorder-type (PTSD) symptomatology (Schore, 2002).

Childhood traumatic stress was implicated in possible abiding alterations in the brain. There was evidence that neurological development anomalies occurred on a number of levels that included not only the messaging system of the autonomic and somatic nervous system but also in the brain's very structure and function (Teicher, Andersen, Polcari, Anderson, Navalta & Kim, 2003). Weakened development of the left neocortex (controls higher level cognitive functioning), hippocampus (responsible for memory) and amygdala (processes and memorises emotional experiences) has been identified, which may be intrinsically linked to subsequent mental health issues and alcohol misuse (Green, 2003).

A bio-psychosocial association between mental health problems, alcohol dependence and insecure attachment was suggested (Green, 2003). However, it still did not explain why members of the same family with similar parental and life experiences do not all succumb to alcohol misuse and/or psychiatric problems; individual personality traits, such as personal resilience, social support and perceived control (Voges & Romney, 2003) could also be integral factors.



## **Attachment and Health**

Research showed that secure attachment tended to reflect remembered, positive and supportive past and present family environment, self-confidence and emotional wellbeing (Diehl, Elnick, Bourbeau & Labouvie-Vief, 1998). How securely attached an individual is had implications for both physical and mental health and health care (Feeney, 2000). Feeney (2000) argued that illness was likely to activate the attachment system of emotional regulation; however, those children who grew up in an environment of neglect or abuse may have learned to minimise or deny their distress or hurt, in order not to antagonise further emotionally unavailable parents.

Insecure attachment could explain why alcohol dependent clients often present with chronic, physical symptoms that may have been untreated because help or concern had not been previously experienced in childhood and was therefore not expected (Feeney, 2000). It may also be difficult for such clients to access self-help due to emotional inhibition and subjugation of needs, which were identified as familiar core beliefs in alcohol misusers (Brotchie *et al.*, 2004).

The link between self-belief and risk to health was further supported in a study of 366 college drinkers, whereby a negative view of self and insecurity around relationships, in terms of feeling “both inadequate and undeserving” predicted greater likelihood of alcohol problems to cope with these negative cognitions and affect (McNally, Palfai, Levine & Moore, 2003). However, the acknowledged limitation was in the cross-sectional design of the study; causality could not be inferred, merely an association established, unless a longitudinal study was conducted.

A study of 793 students also revealed how self-esteem played an integral part in health; it was positively correlated with the level of secure attachment and the degree to which individuals took a positive role in safeguarding their health (Huntsinger & Luecken, 2004). Those identified as being insecurely attached had significantly lower self-esteem. Poor self-concept was also linked to more risky behaviours in anxious/ambivalent-attached adolescents (Cooper, Shaver & Collins, 1998), such as drug misuse (Schindler, Thomasius, Sack, Gemeinhardt, Kustner & Eckert, 2005).

Negative core beliefs regarding 'self' and 'others' were replicated in studies exploring self-reporting by adult children of alcoholic parents that suggested predominant patterns of avoidant and anxious/ambivalent attachment style and avoidance of intimate relationships, due to inability to trust and consummate fear of rejection (Kelley, Cash, Grant, Miles & Santos, 2004; Kelley, Nair, Rawlings, Cash, Steer & Fals-Stewart, 2005). The level of secure/insecure attachment style did seem to play an important role in determining risk factors for self-perception and interpersonal relatedness, emotional and physical well being, and developing substance misuse later on in life.

### **Attachment and Childhood Experiences**

Often alcohol dependent clients reported negative childhood memories, difficult or abusive family relationships and a pattern of drinking that began in early teens at assessment. It was suggested by research that the greater the number of adverse childhood experiences, the higher the risk of developing adult alcohol problems (Dube, Anda, Felitti, Edwards & Croft, 2002).

Also, a longitudinal Finnish study showed that the earlier the onset of drinking, particularly at age 13 or younger, the greater likelihood of developing alcohol problems in adulthood (Pitkanen, Lyyra & Pulkkinen, 2005). Supporting evidence was found in numerous studies over the past decade concerning the prevalence of child abuse and/or deprivation in substance misusing populations (Bernstein, Stein & Handelsman, 1998). However, the question arose as to the aetiological part played by childhood experiences such as abuse and subsequent insecure attachment in the onset and development of alcohol dependence. There did seem to be complicating factors in the form of several confounding variables. For example, three London alcohol services administering a sexual abuse questionnaire to their clients found that 54% of women and 24% of men disclosed sexual abuse history before the age of 16 (Moncrieff, Drummond, Candy, Checinski & Farmer, 1996). However, it was also shown that they were more likely to have a familial history of alcohol misuse. How could this information be interpreted from an attachment perspective?

Research evidence of high instances of childhood sexual abuse could be explained, in that a family history of alcohol abuse increased the likelihood of childhood insecure attachment due to neglectful or inconsistent parenting, and consequently the child's vulnerability towards sexual predators, as reported in interviews with 26 male survivors of sexual abuse (Lisak, 1994). Attempted disclosure was met with parental disinterest or worse, disbelief, which increased their sense of isolation and negative self-perception.

However, a longitudinal study comparing 'high-risk' (homeless) and matched samples of adolescents highlighted the influence of a positive, supportive family environment, irrespective of whether the parents drank or not, as a mediating factor upon peer pressures to misuse alcohol, and the absence of such parental involvement presented a risk factor (Nash, McQueen & Bray, 2005). Research suggested that secure attachment in the form of strong emotional bonds to family and friends appeared to reduce the risk factor of later alcohol abuse (DeFronzo & Pawlak, 1993), which suggested the quality of the parental relationship was a pivotal factor, rather than whether parents drank or not.

Another possible explanation for the link between later alcohol dependence, familial drinking and childhood abuse was that the accessibility and acceptance of alcohol in the home increased the possibility of the use of alcohol as initially an available coping strategy from a relatively early age to deal with the emotional and psychological consequences of childhood trauma, which then became maladaptive in later years.

Co-morbidity between anxiety and depression in alcohol dependent drinkers is recognised (Evans & Sullivan, 2001). Recent research showed a significant difference in reported traumatic childhood experiences between 80 alcohol-dependent hospitalised clients and a matched control group of 60, and a positive correlation with anxiety and affective symptoms in the alcohol misusers (Mirsal, Kalyoncu, Pektas, Tan & Beyazyurek, 2004). However, the client group used in this study were hospitalised, which suggested they were at the more severe end of the spectrum of alcohol dependence and the results cannot necessarily be generalised to all problem drinkers.

The issue here was identifying causality; the anxiety and depression could be regarded as a consequence of childhood abuse or symptomatic of long-term alcohol dependence. One explanation is that alcohol acted upon the brain as a depressant and alcohol withdrawal manifested as acute anxiety symptoms. However, often anxiety and depression persisted well beyond the time that abstinence from drinking occurs, which suggested alcohol was a contributory rather than a causative factor and that anxiety and depression tended to precede alcohol dependence.

Extensive interviews with adolescent detainees reported 88% having co-morbidity of PTSD, alcohol misuse and sexual and/or physical abuse; the study implicated both forms of abuse as predictors and contributors towards alcohol misuse and had gender and temporal consistency (Watts & Ellis, 1993). However, other studies revealed gender differences in the type of childhood victimisation reported, with men tending to disclose physical abuse (Schaefer, Sobieraj & Hollyfield, 1988) and women sexual abuse (Moncrieff *et al.*, 1996).

The prevalence of sexual abuse as a contributory factor was further supported in a longitudinal study conducted since 1991 in the United States (Jancin, 2003), which revealed 20-26% of women reporting childhood sexual abuse. Of those, 18.8% were alcohol dependent, compared to 5.8% of women with no known sexual abuse history, a ratio of 3.04:1, much greater than would occur by chance. This research suggested an association between abuse and alcohol misuse but revealed little concerning individual, predisposing factors or explanations as to why some women developed alcohol problems as a coping

mechanism for abuse and others did not. Similarly, an explanation for those women with alcohol dependence but who were not abused was not explored.

A critical review of numerous studies (Stewart, 1996) explored the link between alcohol misuse and exposure to trauma and subsequent PTSD symptoms, particularly in relation to childhood physical and/or sexual abuse. A plausible explanation was that initially alcohol reduced or controlled unpleasant and intrusive PTSD symptoms, but which then developed into a further problem to be treated.

The severity and longevity of the abuse and non-disclosure all seemed to be a good predictor of the risk of developing subsequent alcohol dependence. Also, the abuse occurring before the age of 13 appeared to be a significant risk factor (Spak, Spak & Allebeck, 1998). The reporting of prolonged trauma related to incest and sexual abuse histories in women was significantly higher in women with alcohol misuse issues than for the general population.

However, a retrospective case-control study that explored the association between reported sexual abuse and alcohol dependence in women (Fleming, Mullen, Sibthorpe, Attewell & Bammer, 1998) argued that childhood sexual abuse alone was not a causative factor and that other confounding variables may co-exist, such as the client's perception of an emotionally unavailable and rejecting mother, and having an alcoholic partner.

Similarly, a study of 155 (33 females, 122 males) alcohol-dependent clients seeking treatment implicated maternal dysfunction as a factor and revealed a

complex relationship between childhood abuse, associative PTSD and co-morbid and affective anxiety disorders and suicide attempts (Langeland, Draijer & van den Brink, 2004). The limitation to this study is that it was difficult to make associations and draw generalised conclusions from research with such a gender imbalance.

Criticism of the three studies previously quoted was that many were conducted using female participants and focused upon childhood sexual abuse, despite men predominantly accessing alcohol services and thereby neglecting half of the population. Research suggested a similar prevalence of sexual abuse reported in alcohol dependent men (Lisak, 1994). It was entirely plausible that men were not as likely as women to disclose such personal and potentially distressing information to an unknown research interviewer.

Possible explanations for this apparent under-disclosure of male sexual abuse were explored in a literature review that revealed the likelihood that only 1 in 25 men disclosed or received any help (Dimock, 1988). It argued that men did not regard their experiences as necessarily abusive and tended to deny or minimise the negative impact. The autonomic physiological stimulation that occurred with male rape had the potential to elicit confused feelings of guilt and shame around being complicit, or worse, enjoying the experience.

A review (Holmes, Offen & Waller, 1997) revealed that the social norms around masculinity and dominance increased men's reluctance to disclose and admit to perceived weakness, passivity and helplessness; it also implicated health professionals' lack of expertise and inability to create an appropriate

environment of safety as further reasons for non-disclosure. This was further suggested in a paper that explored the possibility that mental health nurses' own experiences of abuse created a barrier to working effectively with clients who disclosed (Warne & McAndrews, 2005). Nonetheless, autobiographical interviews of 26 male sexual abuse victims, the majority of whom engaged in substance misuse, revealed similarly distinctive patterns of feelings of helplessness, isolation, guilt and shame as women. Negative concepts related to self and others were also identified and relationship difficulties with school age peers (Lisak, 1994).

The difficulty with previous research into childhood abuse and alcohol dependence was that prevalence appeared to vary according to the population examined, the types of trauma investigated and the different methods used to elicit information (Bernstein, Stein & Handelsman, 1998). It was argued that this variance and the lack of corroborative evidence provided little support for concluding that childhood ill-treatment was a causal factor in alcohol dependence (Langeland & Hartgers, 1998). All that could be deduced was that childhood abuse and/or neglect was linked to PTSD and alcohol misuse, which may be used to self-medicate against trauma-related symptoms. Parental paucity of care, lack of support and emotional unavailability were also associated with risk factors for developing subsequent adult alcohol dependence.

### **Attachment and Mental Disorder**

Research suggested that mental health problems and intermittent or long-term, continuous contact with the psychiatric services seemed to co-exist with many



severely alcohol dependent clients (Bernstein, Stein & Handelsman, 1998; Baigent, 2005), and that insecure attachment appeared to play an intrinsic role in the equation.

In a group of 215 Turkish substance misuse inpatients, 37% displayed Dissociative Disorder, which was also positively correlated with both alcohol or drug dependency, childhood abuse and disengaging unexpectedly early from the treatment programme (Karadag, Sar, Defne, Evren, Karagoz & Erkiran, 2005). This study argued that the mental health symptoms were often masked by alcohol dependence and therefore patients may not have been accurately diagnosed and treated. For some clients, their consequent, premature withdrawal from treatment mirrored a pattern of inadequate care, disconnection and rejection repeated throughout life.

Co-morbidity also existed between alcohol misuse and eating disorders (Bulik, Klump, Devlin, Fichter, Halmi, Strober, Woodside, Crow, Mitchell, Rotondo, Mauri, Cassano, Keel, Berrettini & Kaye, 2004), with two-thirds of the 672 women interviewed identifying that the eating disorder preceded the drinking. There was an association in the women between depression, anxiety and cluster B personality disorder symptoms. This suggested alcohol was used to moderate and control emotional dysregulation prevalent in both eating and personality disorder symptoms.

A study investigating attachment in anorexic and bulimic women concluded that both groups exhibited a higher score on anxious attachment style in comparison to female controls (Troisi, Massaroni & Cuzzolaro, 2005), which implicated early

childhood experiences in the development of eating disorders and alcohol dependence. The limitation of such studies was the single-sex basis that prevented any gender differences being explored. The results cannot be generalised to men, although alcohol may be used in a similar capacity, that is, to control negative affect experienced.

Concurrence with childhood maltreatment, personality disorder and alcohol dependence was highlighted in a study of 339 substance misuse patients; the type of disorder varied according to the abuse reported (Bernstein, Stein & Handelsman, 1998). Childhood physical abuse and physical neglect were linked to psychopathic personality disorders, emotional abuse corresponded to personality disorders in clusters A, B and C, whereas emotional neglect was linked to schizoid personality disorder. Interestingly, sexual abuse, which was expected to correlate with borderline personality disorder, did not appear to relate to any particular personality disorder cluster.

The difficulty as always with clients' retrospective reporting was its subjectivity and lack of actual evidence of abuse occurring unless other confirmation was available, such as social services reports. Often two siblings would give entirely different versions of the same events. Self-reporting was inevitably a personal reconstruction of experiences and therefore susceptible to bias and individual interpretation.

A recent single sample study, examining the relationship between adolescent alcohol misuse and adult personality disorder proposed a plausible model emphasising alcohol use as an observable characteristic of psychological

disruption that acted as a mediating factor between childhood sexual and/or physical abuse and adult borderline personality disorder (Thatcher, Cornelius & Clark, 2005). It could be suggested that alcohol assisted in moderating the emotional dysregulation commonly occurring with personality disorder and was used as a form of self-medication for the client.

A study of 180 depressed outpatients evaluated for personality disorders (Joyce, McKenzie, Luty, Mulder, Carter, Sullivan & Cloninger, 2003) showed that the risk factors for developing a voidant personality disorder were an inherent anxious personality type who developed childhood anxiety disorders and who received inadequate and/or neglectful parental care. This also seemed true for those at risk of developing severe alcohol problems.

Borderline personality disordered clients presented a more complex picture of childhood abuse and parental neglect, which Linehan (1993) termed an “invalidating environment”, resulting in childhood and later adult psychopathology, which may include substance dependence and depression. The difficulty with these studies was the mere presence or associations with environmental risk factors; there was a need to establish the internal individual mechanisms occurring that mediate child abuse/neglect and mental health issues.

Holmes’ (2003) research into borderline personality disorder, the characteristics of which seemed to co-exist with substance misuse (Graham, Copello, Birchwood & Mueser, 2003), suggested clients were trapped in an “approach-avoidance dilemma”, a double-bind situation when the person to whom they

approach for comfort from a perceived threat became that very source of violence or fear, resulting in a seemingly insoluble predicament of helplessness and disorganised attachment.

A recent review of possible co-morbidity with genetic influences, alcohol, mental disorder and childhood trauma (Baigent, 2005) suggested the need for alcohol screening prior to mental health assessment, which did not necessarily occur as a matter of course. Conversely, a study of three UK alcohol and four drug services revealed a high prevalence of personality disorder characteristics in 37% in the drug sample and 53% in the alcohol groups not previously identified by the alcohol services (Bowden-Jones, Iqbal, Tyrer, Seivewright, Cooper, Judd & Weaver, 2004). The study also showed that personality disorder diagnosis was positively correlated with difficulty in engaging in the alcohol or drugs service, poor compliance with treatment and chaotic behaviour.

Unfortunately, clients were not always screened for personality disorder by clinicians in substance misuse services. Unless they were already engaged with mental health services diagnosis may be missed. There appears to be a positive correlation between alcohol dependence and mental health issues, and in particular personality disorder type characteristics. However, in criticism, from the studies previously mentioned, often it is unclear as to whether clients attended secondary or tertiary services, which might reflect the severity of alcohol dependence. The association seems more likely to occur at the severe end of the spectrum of chronic and long-term drinking, for example those clients in inpatient care (Karadag *et al.*, 2005), and cannot be generalised to all problem drinkers. It is difficult to identify causality. It is possible that severe

alcohol dependence mediates or exacerbates the symptoms of mental disorders or it is a combination of the two.

### **Attachment and Maladaptive Schemas**

A specialised schema-focused form of cognitive therapy developed for borderline personality disorder clients who displayed interpersonal relatedness difficulties emphasised the importance of the therapeutic alliance by aligning traditional CBT theory and interventions with empathic understanding and validation of the client (Layden, Newman, Freeman & Morse, 1994). Therapy involved exploration of clients' entrenched core beliefs and unhelpful coping mechanisms, such as dissociation and emotional detachment, and using practical, grounding techniques to physically and emotionally re-connect with the detached client.

Young's Schema Theory is a similar integrative, schema-focused approach that has endeavoured to systematically identify and measure individual maladaptive schemas. As the use of the Schema Questionnaire (Young & Brown, 2001) is a relatively new measurement of core beliefs, Young's Schema Therapy (Young, 1999) has yet to be rigorously tested and evaluated in the research arena as a widely used therapeutic tool. However, a recent study reported its benefits in the treatment of BPD patients (Giesen-Bloo, van Dyck, Spinhoven, van Tilburg, Dirksen, van Asselt, Krenmers, Nadort & Arntz, 2006).

Consequently, there has been limited research so far examining possible meaningful associations between Bowlby's internal working models of attachment and maladaptive schemas in alcohol dependence. Recently,

however, Mason, Platts and Tyson (2005) discovered a positive correlation between insecure attachment and early maladaptive schemas in mental health service users, with 81% having an insecure attachment style. Those identified as having a fearful avoidant attachment style possessed maladaptive schemas in *emotional inhibition, mistrust/abuse, social isolation, dependence/incompetence* and *defectiveness/ shame*. Similarly, a recent study of substance misusers, using the Young's Schema Questionnaire (short version), found a higher prevalence of maladaptive schemas, particularly in the alcohol users who showed comparatively greater *vulnerability to harm, emotional inhibition* and *subjugation of needs* (Brotchie, Meyer, Copello, Kidney & Waller, 2004).

A comparative study between adolescent drug users and controls (Schindler, Thomasius, Sack, Gemeinhardt, Kustner & Eckert, 2005) revealed a predominantly fearful avoidant attachment style and a positive association with co-morbid psychiatric problems in the drug users, in contrast to a prevalence of secure attachment in the non-clinical controls. It suggested that insecure attachment played a vital role within the co-morbidity between substance misuse and mental health problems and the development of unhelpful coping responses, in the form of maladaptive schemas. There appeared to be a link between insecure attachment and maladaptive core beliefs in vulnerable groups, such as substance misusers and those with mental health issues, although further research was required in this area to see whether the association could be generalised to a non-clinical population.

In criticism of the current shift towards schema-focused interventions incorporated into traditional CBT, James (2001) highlighted the need for specialist training in this area. Whilst acknowledging that schema work has usefully emerged from CBT, he suggested that it was sometimes used inappropriately; this was due to therapists' insufficient knowledge or understanding of Schema Therapy and using it indiscriminately with primary care clients who had no previous history of mental illness and did not require such therapy. As Young (1999) maintained, it was originally developed with 'difficult to treat' complex clients in mind, who were resistant to traditional approaches, such as CBT, as an alternative therapy. This may also apply to clients at the more severe end of the spectrum of alcohol dependence with complex needs.

## **Attachment and Engagement in Therapy**

The next aspect of the review was to explore how childhood abuse, insecure attachment and the risk of developing mental health problems had the capacity to negatively impact upon the effectiveness of therapy currently offered within specialist alcohol services. The presence of mental disorder increased the likelihood of counselling psychologists' clinical involvement with alcohol clients (Bowden-Jones, Iqbal, Tyrer, Seivewright, Cooper, Judd & Weaver, 2004).

Research reported alcohol clients' resistance towards, and a recurrent pattern of engaging and disengaging and difficulty maintaining a therapeutic relationship; high DNA and relapse rates in specialist alcohol and psychiatric services suggested early histories of abusive or inconsistent parenting and subsequent insecure attachment prevented clients in substance abuse programmes from accessing support (Cosden & Cortez-Ison, 1999). Eighty-four women in residential substance misuse units were studied and sexual abuse was the main predictor for likelihood of dropping out of the programme, although those who disclosed also recalled low levels of parental support, with parents often described as "cold but controlling" (Cosden & Cortez-Ison, 1999).

Bowlby's Attachment Theory (1969) offered a possible explanatory link between childhood abuse and difficulty in engaging with therapy; through inconsistent, neglectful or abusive parenting, the child experienced insecurity and instability and developed related internal working models or schemas of 'self' as undeserving and unlovable and 'others' as unreliable and uncaring. The adult was unable to form later emotional attachments and through necessity became self-reliant and socially isolated to avoid disappointment. The perceived fear is



he/she would be rejected or abandoned by the alcohol worker/therapist with the result that the client's resistance and oscillation between engagement and disengagement became a self-fulfilling prophecy of ultimately being discharged from the service.

Research advocated assessing clients' social connectedness to match counselling services offered (Lee & Lee, 2001) and an initial assessment of maladaptive personality traits, which presented a risk factor for clients entering substance abuse treatment (Verheul & van der Brink, 2000). A previously highlighted study of alcohol dependent clients seeking treatment also suggested routine screening for childhood trauma prior to engaging in therapeutic treatment (Langeland *et al.*, 2004). However, although useful for the therapist, this would require sensitive handling in order not to deter prospective clients from continuing with therapy through premature disclosure and before a supportive therapeutic alliance could be established.

### **Attachment and Implications for Therapy**

The effectiveness of contemporary therapy and future recommendations for alcohol dependence was summarised in a recent review by the National Treatment Agency (Wanigaratne, Davis, Pryce & Brotchie, 2005). Cognitive therapy has developed into an effective treatment for a diverse array of psychological problems, including substance misuse. Interventions were based upon conceptualising clients' present difficulties and using cognitive restructuring to reframe negative automatic thoughts and assumptions into more positive schemas, thus eliciting behavioural change (Beck, 1995). CBT and motivational interviewing strategies are used widely in alcohol services and

have been shown to be beneficial, particularly in terms of positive short-term outcomes, relapse reduction and cost-effectiveness (Babor & Higgins-Biddle, 2001), although long-term relapse prevention was debatable as relapse within 12 months was likely (Wutzke, Conigrave, Saunders & Hall, 2002). Combining the anti-craving drug, Naltrexone, with a 12-week CBT outpatient programme appeared more beneficial and longer term than CBT alone, suggesting an integrated pharmacological and psychological approach was preferable (Feeney, Young, Connor, Tucker & McPherson, 2001) to address the recurring pattern of recovery and remission aptly described by the medical model.

It is possible that underlying causes of alcohol misuse may not always be sufficiently explored using CBT alone in those clients at the most severe end of the spectrum of alcohol dependence with complex needs and where causality of their alcohol problems was difficult to establish. Also, time limitations and financial constraints of some primary care services possibly drove the tendency to focus upon cognitive and behavioural change in the present situation, which was usually sufficient for those clients with hazardous or harmful drinking related to specific life events (Wanigaratne, Davis, Pryce & Brotchie, 2005).

Recent research comparing 80 alcohol-dependent hospitalised clients with a control group of 60 matched for age and gender with no alcohol issues discovered a positive correlation with anxiety and affective symptoms in the alcohol misusers. It highlighted the preference for an integrated plan of care for alcohol dependent clients presenting with anxiety and depression, tackling both issues simultaneously in order to achieve an effective outcome (Mirsal, Kalyoncu, Pektas, Tan & Beyazyurek, 2004). The Dual Diagnosis Good

Practice Guide (Department of Health, 2002) revealed that currently, mental health and alcohol specialist services in the UK tended to operate relatively independently, using the serial or parallel model of working. A more pro-active and collaborative way of working based upon the integrated model was proposed in the guide to keep clients engaged in alcohol services.

A study of 61 male and 57 female alcohol-dependent patients with co-morbid psychiatric disorders one year after inpatient detoxification treatment revealed that 39% suffered a relapse but interestingly, 55% of the non-co-morbid compared to 28% of the co-morbid women suffered a relapse, while the male population showed no significant difference in relapse rates (Mann, Hintz & Jung, 2004). This suggested that concurrence with severe alcohol dependence and concurrent mental disorder did not necessarily prevent people from recovering; in fact it could assist, possibly due to the extra levels of social support from health professionals within the psychiatric services. The gender difference may also be due to women finding it easier to access the necessary social support.

However, a study exploring the prevalence and correlations for both abstinent and non-abstinent recovery cited the presence of personality disorder, considered prevalent in the more severe alcohol-dependent population, as appearing to decrease the rate of abstinent recovery (Dawson, Grant, Stinson, Chou, Huang & Ruan, 2005). The explanation for this discrepancy in the two studies cited could be that the first investigation chose patients who were “socially well integrated”. This could well have prevented those with personality disorder from being included in the analysis.

Interestingly, studies revealed the mode of approach was insignificant (Miller & Wilbourne, 2002; UKATT trial, 2005) but that a positive therapeutic relationship was relevant in successful outcomes (Beck, Wright, Newman & Liese, 1993), suggesting the client's ability to form a close attachment to the therapist was a necessary prerequisite. It could be argued that more emphasis needed to be placed upon building a positive and trusting relationship, particularly for those severely alcohol dependent clients whose experiences of such were possibly both negative and threatening. Orford (2006) supported the notion that efforts should be made to try and comprehend "*the process whereby the patient decided to trust the therapist, to communicate openly*" rather than focus upon types of treatment or cost-effectiveness.

Prolonged, after-care monitoring and support of alcohol dependent clients, similar to chronic illness care was advocated (McLellan *et al.*, 2005) and lengthier intervention time predicted a long-term positive outcome (Moos & Moos, 2003). These studies were limited by their tendency to focus upon external mediating factors such as type and duration of therapy and neglected internal individual mechanisms that may interfere with or encourage a positive outcome. Criticism of this type of research was the omission of possible social influences in a negative or positive way upon the client, and the possibility of natural recovery irrespective of interventions, which was difficult, if not impossible to measure (Raistrick & Tober, 2003). A limitation to the previous research mentioned was that the type of alcohol misuse service was not always indicated, in terms of whether participants were engaged in primary, secondary or tertiary care, which would have reflected the severity of alcohol dependence

and the complexity of co-existing mental health needs. It was therefore difficult to draw conclusions that could be generalised to all problem drinkers.

## **The Current Study**

The current study investigated psychosocial explanations for alcohol dependence from a counselling psychology perspective, exploring clients' reluctance or resistance towards engaging with and maintaining therapeutic relationships within alcohol services. Using Bowlby's (1969) Attachment Theory as a theoretical framework of social relatedness, the research examined how clients' perceptions of early negative experiences of relationships may be reflected in later avoidant or ambivalent attachment styles; this insecurity of attachment may contribute towards alcohol misuse and also prevent clients from accessing help.

The current study explored how core beliefs regarding 'self' and 'others', namely maladaptive schemas (Young, 1999), developed from early adverse interpersonal experiences, may play a role in the maintenance of excessive and chronic drinking behaviour. Both adult attachment style and maladaptive schemas associated with disconnection and rejection to reflect the client's internal mental model of relating were measured, using self-report questionnaires.

Subsequent interviews with eight clients about their individual experiences of relationships with others and alcohol and the questionnaires were analysed; implications for current and future clinical practice in the field of substance misuse were discussed in the light of the results. Emergent themes arising from alcohol clients' personal reflections about themselves within their relationship with alcohol and other people illuminated the relational process from an experiential perspective (Smith, 2004). The qualitative aspect of the research

revealed individual contributory factors towards avoidant attachment and maladaptive schema development, which the questionnaires neglected to reveal.

In contrast to research citing external or situational factors contributing to severe alcohol dependence, such as childhood abuse (Jancin, 2003), the current study explored explanations related to individual clients' attachment style and internal maladaptive coping strategies that may negatively impact upon the current treatments offered. It was possible that unmet childhood emotional needs evoked unhelpful and potentially damaging behavioural coping strategies, such as excessive drinking (Young *et al.*, 2003). Such deep-seated emotional and interpersonal difficulties could mean a re-evaluation of therapy in alcohol services. Disputing resistant and deeply entrenched, self-defeating core beliefs and replacing them with more positive schemas by exploring underlying childhood issues may require in-depth therapy, requiring specialist schema-focused training and longer-term interventions.

Insecure attachment style screening and measures of maladaptive schemas prior to treatment may need to be incorporated into initial service assessments, which then shape individually tailored clinical interventions. Also, it may be advisable to incorporate schema work into current CBT interventions for those alcohol clients who display a high level of maladaptive schemas, and which prevents them from effectively engaging in therapy (Brotchie *et al.*, 2004).

However, it was important to acknowledge that the clients interviewed in the current study were engaged with a tertiary service, referred due to their need for

a community or inpatient detoxification and/or co-existing mental health issues. They could therefore be considered at the most severe end of the continuum of chronic alcohol dependence. Due to the consequent possible level of complexity of those clients interviewed, the results of the current study could not therefore be generalised to all problematic drinkers, and were specific to those attached to specialist tertiary services. Further research is needed to ascertain whether similar levels of insecure attachment and maladaptive schemas occurred with clients in primary and secondary substance misuse services.



## Procedure

### Research Questions Addressed in the Investigation

1. Do severely alcohol dependent clients have a significantly greater likelihood of an *avoidant attachment style* than non-problematic drinkers?
2. Do severely alcohol dependent clients have a significantly higher level of maladaptive schemas in relation to *disconnection and rejection* than non-problematic drinkers?
3. Is there an association between security of attachment style and maladaptive schemas?
4. How might severely alcohol dependent clients' personal experiences of themselves within their past and present relationships with others, contribute towards possible associations with *avoidant attachment style* and maladaptive schemas?
5. What are the implications for counselling psychologists' therapeutic approaches when working with severely alcohol dependent clients?

## Hypotheses

1. Severely alcohol dependent individuals\* will score significantly higher on the dimension of *avoidant attachment style* and significantly lower on *secure attachment style* than non-problematic drinkers.

*\*individuals with a severe, ongoing alcohol dependency scoring 30+ on SADQ  
(Appendix 18)*

2. Severely alcohol dependent individuals will score significantly lower on the attachment style sub-scales of *confidence* (in self and others), *need for approval*, and *preoccupation with relationships*, and significantly higher on *discomfort with closeness*, and *relationships as secondary* in Feeney, Noller & Hanrahan's (1994) Attachment Style Questionnaire (Appendices 10 & 11) than non-problematic drinkers \*.

*\*individuals scoring 0 or 1 on the CAGE Questionnaire (Appendix 16)*

3. Severely alcohol dependent individuals will score significantly higher on the five sub-scales of the early maladaptive schemas of *abandonment/instability*, *mistrust/abuse*, *emotional deprivation*, *defectiveness/shame*, and *social isolation/alienation* in the domain of *disconnection and rejection* in Young's Schema Inventory (shortened version, Young & Brown, 2001) (Appendices 13 & 14) than non-problematic drinkers \*.

*\*individuals scoring 0 or 1 on the CAGE Questionnaire*

## **Methodological Approach and Rationale**

The two-dimensional methodological approach primarily used two self-report questionnaires in Section 1 to objectively compare dimensions of *secure*, *avoidant and ambivalent attachment style* and *early maladaptive schema* mean scores of severely alcohol dependent individuals versus non-problematic drinkers.

However, questionnaires were limited by their directive and clinical nature; emergent themes from individual severely alcohol dependent clients' early perceptual experiences of themselves within relationships using IPA in Section 2 revealed a richness and depth of emotional detail unable to be captured by questionnaire data alone.

IPA suggested contributory factors influencing possible avoidance of emotional intimacy within close relationships, the consequent reluctance to engage in the therapeutic process and the mediating role of alcohol. It also illuminated how early experiences of relationships may have subsequently influenced the formation and maintenance of maladaptive schemas and insecure attachment.

## Method

### Section 1 Participants

The study contained both clinical and non-clinical samples and consisted of two groups:

- **Client Group** Fifty-four participants, consisting of a voluntary sample of 31 male (mean age = 44) and 23 female clients (mean age = 46) with long-term, severe alcohol dependence, identified with a score of 30+ using *SADQ* and engaged with a West Midlands multi-disciplinary team NHS Alcohol and Drugs Tertiary Service. Clients were referred for initial assessment through the secondary service community alcohol team, the referral criteria being their need for a community detoxification and/or complex co-existing mental health issues that required psychological and/or psychiatric input. The majority of clients were unemployed and new to the service, although for some it was a re-referral.
- **Control Group** Fifty-four participants, consisting of a voluntary sample of 21 male (mean age = 35) and 33 female workers (mean age = 37) from a working population, ranging from clerical and support workers to nursing and health professionals and managerial staff within West Midlands NHS Primary, Secondary and Tertiary Mental Health Care settings.

Interestingly, 43 prospective participants for the alcohol dependent client group (mean age = 30.5 years) did not attend the allotted appointments, which made the client group's mean age considerably higher than the controls.

Due to the significant difference between the two groups in age ( $F(1, 106) = 22.854, p = 0.000$ ), but not of gender, ( $F(1, 106) = 3.770, p = 0.055$ ), although it was approaching significance, age was used as a covariate in the analysis reported in the results section.

## **Section 2 Participants – Qualitative Analysis**

The first eight participants from the client group who were identified as scoring 4, 5 or 6 on *avoidant attachment* style (Attachment Style Questionnaire, Feeney *et al.*, 1994) and scoring 4, 5 or 6 on the schema domain of *disconnection and rejection* (Young's Schema Questionnaire, shortened version, Young & Brown, 2001) and who agreed to take part were interviewed a week later.

## **Section 1 Procedure – Quantitative Analysis**

1. Any clients identified as having severe alcohol dependence, using the inclusion criteria of a score of 30+ on the SADQ were invited by letter to participate in the research (Appendix 6) by completing the enclosed consent form 1 (Appendix 5) prior to initial assessment with the alcohol nurse. The first 54 of the voluntary sample who agreed to participate were used in the research.
2. Having ascertained that the clients did not have any difficulty with reading or writing by asking them directly at the interview, the researcher administered the Attachment Style Questionnaire (Feeney *et al.*, 1994) and the Young and Brown's (2001) Schema Questionnaire (shortened version) to the individual participants at their initial assessment in the counselling rooms at the tertiary service to which they were referred.

3. The clients' questionnaires were given choices of *a, b, c, d, e* or *f* rather than a score of *1, 2, 3, 4, 5*, or *6* in order not to influence their decision-making and thinking they were choosing a high or low score. The choices were then transcribed as scores for analysis.
4. The researcher assisted clients with any literacy problems in completing the questionnaires by reading out the statements and the choices available to them. Only three required assistance.
5. On completion, clients were asked whether any issues had arisen from answering the questionnaires. De-briefing was offered directly afterwards to ensure any possible feelings of disquiet or distress were alleviated.
6. Participants in the control group, by prior agreement with Human Resources at their place of work, were invited by letter (Appendix 7) to anonymously participate in the research by firstly completing the enclosed self-administered CAGE Questionnaire (Appendices 16 & 17, Ewing, 1984). Inclusion criteria for the research required a score of zero or one on the CAGE questionnaire. A score of two or more suggested a possible alcohol problem, and therefore anyone scoring two or more was requested not to complete the Attachment Style Questionnaire (Feeney *et al.*, 1994) and the Young and Brown's (2001) Schema Questionnaire (shortened version). Enclosed with the letter was an information sheet on 'Alcohol and Health' (Appendix 8) and contact details of a voluntary sector Alcohol Service, should they have identified personal concerns related to their drinking habits.

7. Those individuals scoring 0 or 1 were asked to complete the Attachment Style Questionnaire and the Young's Schema Questionnaire (shortened version). A stamped addressed envelope was provided for their return to ensure anonymity. Fifty-four out of 120 possible participants from a voluntary sample replied; all were included in the research.
8. De-briefing was offered by the researcher via telephone or e-mail for the control group in the invitation letter, in case any issues had arisen from completing the questionnaires. An e-mail address specifically designated for research purposes (jcresearch@btinternet.com) was set up for both client and control group contact, and to receive general feedback on the research outcomes if required. It was made clear in the information letter and consent form that no individual feedback could be given to participants.
9. Scores for the items allocated to each sub-scale of attachment style (Appendix 12) and early maladaptive schemas (Appendix 15) were totalled and a mean score calculated for each participant.
10. Scores were totalled for the participants in each group and divided by 54 to calculate the mean group score.
11. Descriptive analyses in the form of bar graphs and scatter plots revealed between-group differences.
12. The mean group scores from both questionnaires were analysed in SPSS using Analysis of Covariance (ANCOVA), using age as a covariate to adjust

for the age difference between the two groups, to determine whether the mean scores from the client and control groups were significantly different. These results formed the basis for the Section 1 discussion.

## **Section 2 Procedure – Qualitative Analysis**

1. Clients who met the inclusion criteria by scoring 4, 5 or 6 on *avoidant attachment* style and 4, 5 or 6 the early maladaptive schemas in the schema domain of *disconnectedness and rejection* were invited by letter a week later to participate in a taped session by completing the enclosed consent form 2 (Appendix 5), using the semi-structured interview (Appendix 9). The questions were specifically devised to be general with regard to relationships and open-ended in order not to direct the interviewees or prompt particular responses. The first eight who responded were included in the research provided they met the inclusion criteria. Three clients who met the criteria declined to participate.
2. Each client individually participated in an audio-taped, semi-structured interview with the researcher, held in the counselling rooms at the alcohol misuse tertiary service to ensure privacy. The interview lasted for approximately half an hour and consisted of their perceptions of relational experiences with alcohol and people,
3. Each client was offered time and space for de-briefing immediately afterwards, which lasted for approximately an hour, to discuss any issues and/or negative feelings arising from the interview.



4. The tapes were transcribed by the researcher (see separate confidential attachment) and analysed using *Interpretative Phenomenological Analysis (IPA)* (Smith, Jarman & Osbourne, 1999).
5. IPA necessitated reading and re-reading of the transcripts individually, so that the researcher was completely immersed in the narrative. Ideas and questions arising, including recurrent thoughts and feelings were noted and themes generated from the text.
6. The interlinked themes were then clustered into relevant super-ordinate themes. A table produced for each case study was then analysed and discussed (Appendix 21).
7. The individual case study tables were further analysed (Appendices 22 & 23) and integrated into one main table, highlighting recurrent similarities and differences, which formed the basis for the conclusion to the Section 2 discussion.

## Data Analysis

### Section 1

- Analysis of Covariance (Two-way Mixed Design) was used to examine the within-subject effect of the three dependent variables of *secure*, *avoidant* and *ambivalent attachment style* mean scores and the between-group effect of the independent variable of the two client and control groups, whilst removing the effect of the variable of age.
- Analysis of Covariance was used to examine the differences in the dependent variables of the five sub-scales of attachment style mean scores (*confidence* (in self and others), *need for approval*, *pre-occupation with relationships*, *discomfort with closeness* and *relationships as secondary*) and the five sub-scales of early maladaptive schema mean scores in the schema domain of *disconnection/rejection* (*abandonment/instability*, *mistrust/abuse*, *emotional deprivation*, *defectiveness/shame* and *social isolation/alienation*) between the independent variables of the two client and control groups whilst removing the effect of the variable of age.

### Section 2

Using IPA, the study explored eight alcohol dependent clients' perceptual experiences of themselves in relation to alcohol and other people within past and present relationships from transcribed semi-structured interviews conducted individually (Appendix 9). IPA was used, as arguably one of the basic requirements of qualitative research (McLeod, 2003). The approach was phenomenological, in that it focused upon the individual's subjective perspective

of their experience, rather than an objective account on the part of the researcher (Smith, Jarman and Osborn, 1999).

In this way, the researcher entered the client's perceptual world, through immersing herself in the language and interpreting the messages hidden within. Phenomenology analysed the client's spoken word to "*describe what lies behind language*" (McLeod, 2003). There is a culturally universal, inherently human requisite to seek meaning and understanding through social interaction; this is why IPA seemed so appropriate for the investigation.

### **Analysis Measures**

- **Attachment Style Questionnaire** (Feeney *et al.*, 1994) was a 40-item self-report measure (Appendices 10 & 11), assessing a person's attachment style within the three dimensions of *secure*, *avoidant* and *ambivalent attachment*, using a Likert Scale of 6.

The Likert Scale measured the degree to which an individual agreed or disagreed to statements presented in questionnaires. In this study a 6-point scale was used and a numerical value between 1 and 6 was given for each response. A mean score was then calculated according to the statements allocated for each dimension of attachment style (see Appendix 12).

Aspects of security of attachment style were divided into five sub-scales:

- *secure attachment* style was measured by *confidence* (in self and others).

- *avoidant attachment* style was measured by the combined mean scores of *discomfort with closeness* and *relationships as secondary*.
- *ambivalent attachment* style was measured by the combined mean scores of *preoccupation with relationships*, and *need for approval*.
- Feeney *et al.* (1994) reported reliability coefficients alphas for the five scales as .80, .84, .79, .76, and .76 respectively, indicating good reliability.
- Young and Brown's (2001) Schema Questionnaire (shortened version, Appendices 13 & 14) was a 25-item self-report measure, also with a Likert Scale of 6, assessing early maladaptive schemas in the domain of *disconnection and rejection*. The domain was divided into the five sub-scales of *abandonment/instability*, *mistrust/abuse*, *emotional deprivation*, *defectiveness/shame*, and *social isolation/alienation*.

The long version of Young's Schema questionnaire was a well-validated, clinical and research method of investigating core beliefs (Lee, Taylor & Dunn, 1999) but considered too lengthy at 205 items, hence the development of the shortened version. A comparative study between bulimics and controls revealed similar levels of internal consistency and reliability and discriminant validity in the two versions of the questionnaires (Waller, Meyer & Ohanian, 2001); the shortened version was therefore considered to be a valid measure. A similar study using psychiatric outpatients (Stopa, Thorne, Waters & Preston, 2001)

replicated these findings, with the conclusion that researchers could use the short form with confidence.

Although five domains can be tested within the questionnaire, the researcher decided to focus upon *disconnection/rejection* as it seemed to reflect the interpersonal problems of drinkers. Also, if all five domains had been included, it would have lengthened the items from 25 to 75, which may have inhibited participants from completing the longer questionnaire, when they had already undergone the 40-item attachment questionnaire. The emotional content of the whole schema questionnaire may also have elicited undue distress and the desire was to alleviate as much as possible negative affect to reduce the likelihood of exacerbating already problematic drinking.

- **CAGE Questionnaire** (Ewing, 1984), (Appendices 16 & 17), was a quick and easy four-item validated questionnaire, used in primary settings for identifying risk of possible alcohol dependency. This study used *CAGE* as inclusion criteria for the control group; only those participants scoring 0 or 1 were asked to complete the attachment style and schema questionnaires.
- **Severe Alcohol Dependence Questionnaire (SADQ)**, (Stockwell, Hodgson Edwards, Taylor & Rankin, 1979), (Appendix 18), was a validated questionnaire with a t-test-retest reliability of 0.85, used widely in the NHS Alcohol Services as an assessment tool to measure the severity of alcohol dependence. A score of 30+ was indicative of severe alcohol dependence. The investigation used the *SADQ* as inclusion

criteria for the alcohol dependent client group, where a score of 30+ was required.

### **Ethical Implications for the Study**

The current study was conducted at an NHS specialist tertiary service for severely alcohol dependent clients with complex needs. Due to the possible co-morbidity between severe alcohol dependence and mental health issues, these clients were potentially a vulnerable population; every effort was therefore made to protect them from exacerbating their current emotional and physical state and subsequently increasing their alcohol intake. Participating in research may have revealed negative feelings of anger and/or distress regarding their difficulty with or absence of meaningful relationships.

Consequently, all participants had the opportunity for de-briefing directly after the questionnaires and adequate time and attention was also given to those who were interviewed by the researcher to ensure that they were not unduly affected. Anonymity was ensured to protect clients' identity, in accordance with British Psychological Society's (2006) guidelines, by numbering questionnaires, and deleting potentially identifiable information from interviews.

## Section 1 – Quantitative Analysis

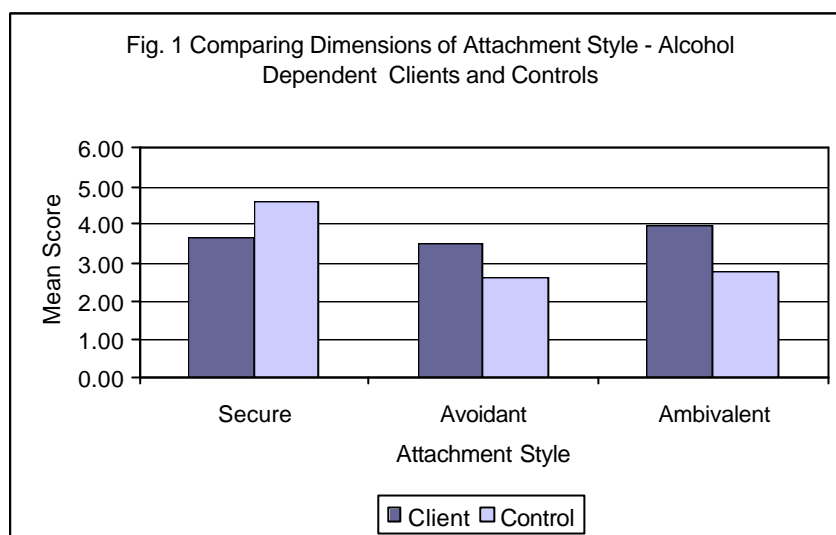
### Results

**Table 2: Comparing Age and Gender between Clients and Controls**

Category	Client				Control			
	Male		Female		Male		Female	
Gender	31	57%	23	43%	21	39%	33	61%
Mean Age	44		46		35		37	

Table 2 showed a between-group variance in age and gender. One-way Analysis of Variance revealed a significant effect of *age* between the two groups,  $F(1, 106) = 22.854, p = 0.000$ , but not of *gender*,  $F(1, 106) = 3.770, p = 0.055$ , although it was approaching significance. In order to reduce the degree of error of variance upon the data age was used as a covariate for further statistical analysis.

Descriptive analysis in the form of a histogram revealed a bell-shaped curve that suggested normality of distribution. This assumption of the data following the normal distribution allowed for the use of parametric statistical tests in the form of Analysis of covariance (ANCOVA). The observed power of the statistical test was sufficient in that it revealed a score of 1.000, indicating the sample size was adequate for research purposes.



Descriptive statistics in Fig. 1 showed a mean score difference in all three dimensions of attachment style, with the alcohol dependent client group scoring higher on average in *avoidant* and *ambivalent attachment style* and lower in *secure attachment style* than the control group.

After adjusting for between-group age variance using ANCOVA (Two-way Mixed Design) within-subjects effects revealed:

The main effect of attachment style was not significant, although it was approaching significance and therefore an effect cannot be ruled out,  $F(2, 210) = 2.827, p=0.061$ .

Similarly, the age by attachment interaction, although not significant, was approaching significance,  $F(2, 210) = 2.827, p=0.067$



The group by attachment interaction was significant,

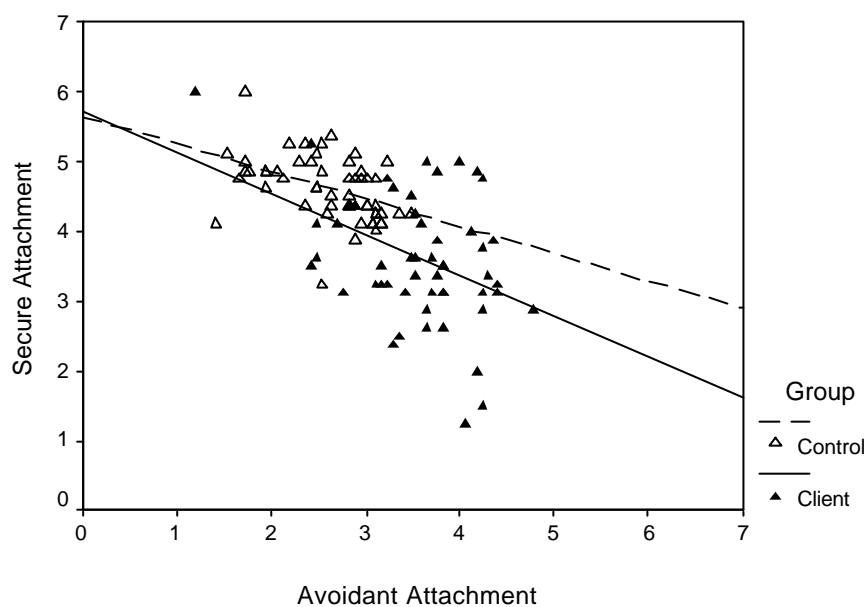
$$F(2, 210) = 71.604, p=0.000$$

The between-subjects effects revealed:

The main effect of attachment style was significant,

$$F(1, 105) = 25.934, p= 0.000$$

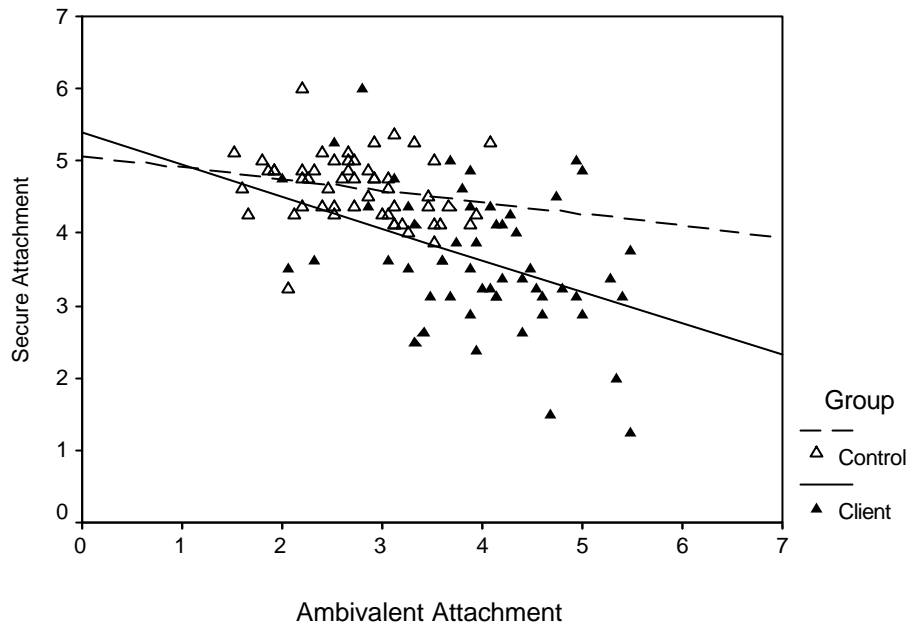
Fig.1a Relationship between Secure and  
Avoidant Attachment Style



There was a significant negative correlation between *secure* and *avoidant attachment style* in both the client ( $\rho = -.331, N = 54, p = 0.015, \text{two-tailed}$ ) and control groups ( $\rho = -.520, N = 54, p = 0.000, \text{two-tailed}$ ). Fig.1a showed a scatter plot of these results.

It can be seen that there were several outliers in the client group compared to one in the controls, indicating a greater individual variance within the alcohol dependent group than the control group. Clustering of points close to the regression line indicated a stronger negative correlation in the control group.

Fig.1b Relationship between Secure and  
Ambivalent Attachment Style

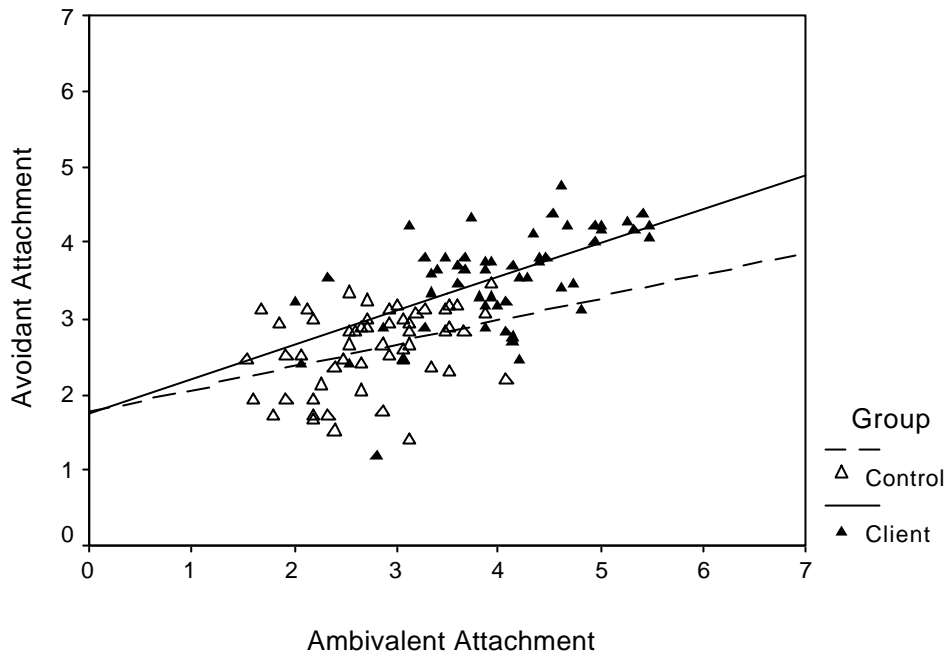


Similarly, there was a significant negative correlation between *secure* and *ambivalent attachment style* in both the client ( $\rho = -.362$ ,  $N = 54$ ,  $p = 0.007$ , two-tailed) and control groups ( $\rho = -.291$ ,  $N = 54$ ,  $p = 0.033$ , two-tailed).

Fig.1b showed a scatter plot of these results.

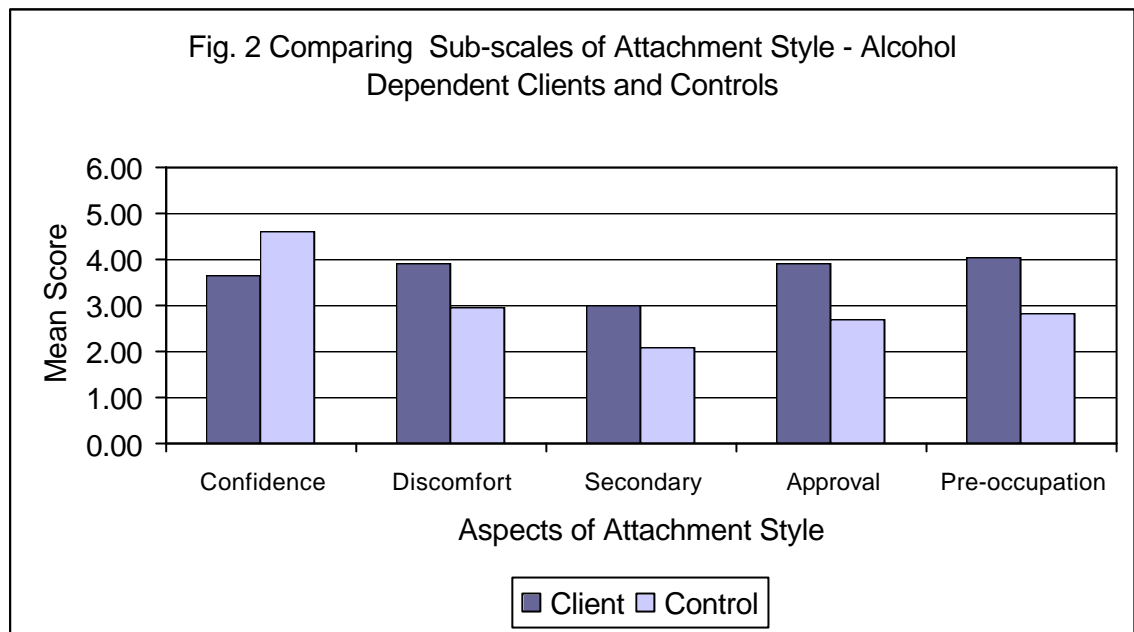
There were several outliers within the client group, compared to two in the control group, indicating greater individual variance within the alcohol dependent client group. Clustering of points close to the regression line indicated a comparatively stronger negative correlation in the control group.

Fig.1c Relationship between Avoidant and  
Ambivalent Attachment Style



In contrast, there was a significant positive correlation between *avoidant* and *ambivalent attachment style* in both the client ( $\rho = .539$ ,  $N = 54$ ,  $p = 0.000$ , two-tailed) and control groups ( $\rho = .362$ ,  $N = 54$ ,  $p = 0.007$ , two-tailed). Fig.1c showed a scatter plot of these results.

It can be seen that there was only one client outlier compared to several in the control group, indicating a greater individual variance within the control group. The points from the client group clustering closer to the regression line than the control group, indicated a comparatively stronger positive correlation.



Descriptive statistics in Fig. 2 showed a difference on all five sub-scales of attachment style, with the alcohol dependent client group scoring lower on average in *confidence* (secure attachment style) and higher in *discomfort with closeness and relationships as secondary* (indicating avoidant attachment style) and higher in *need for approval* and *pre-occupation with relationships* (indicating ambivalent attachment style) than the control group.

After adjusting for between-group age differences using ANCOVA, there was a significant difference in the mean scores on the attachment style sub-scale of *confidence*,  $F(1, 105) = 50.288, p = 0.000$ , which supported the original hypothesis that the alcohol dependent client group would score significantly lower on average in *confidence* than the control group.

In contrast, the client group scored significantly higher than the control group in the other four sub-scales. After adjusting for between-group age differences using ANCOVA, there was a significant difference in the mean scores in the

Attachment Style in the two sub-scales of *discomfort with closeness*,  $F(1, 105) = 34.433$ ,  $p = 0.000$ , and *relationships as secondary*,  $F(1, 105) = 30.720$ ,  $p = 0.000$ , whose combined mean scores define *avoidant attachment* style.

This result supported the original hypothesis that the alcohol dependent client group would score significantly higher than the control group in the sub-scales *discomfort with closeness* and *relationships as secondary* in the dimension of *avoidant attachment*.

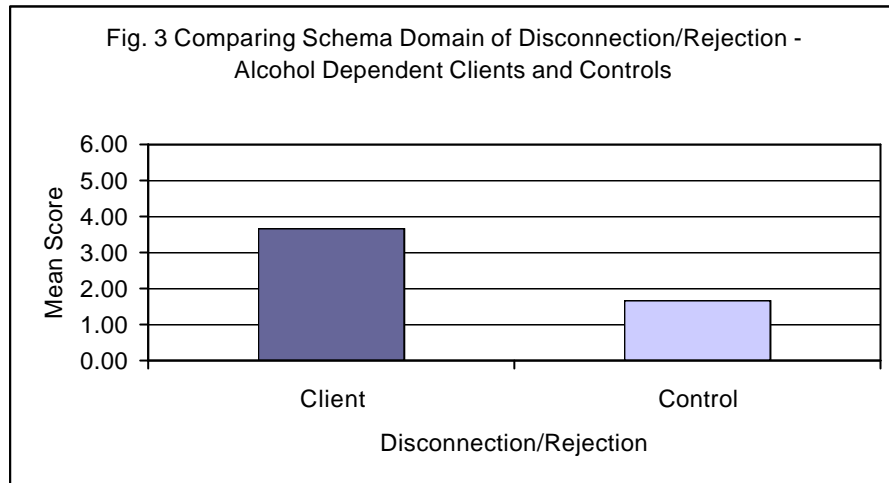
Similarly, there was a significant difference in the mean scores in the sub-scales *need for approval*,  $F(1, 105) = 58.035$ ,  $p = 0.000$  and *pre-occupation with relationships*,  $F(1, 105) = 64.007$ ,  $p = 0.000$ , whose combined mean scores define *ambivalent attachment* style.

The alcohol dependent client group scored significantly higher in the sub-scales *need for approval* and *pre-occupation with relationships* than the control group in the dimension of *ambivalent attachment*.

This result did not support the original hypothesis that the alcohol dependent client group would score significantly lower in *need for approval* and *pre-occupation with relationships* than the control group.

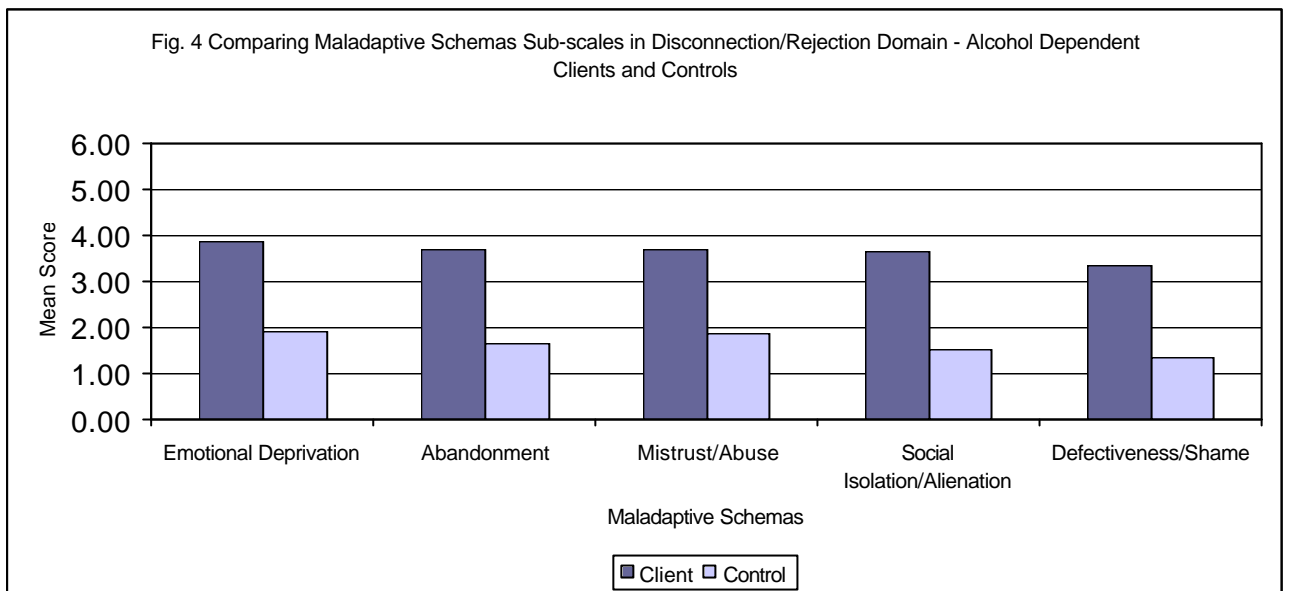
Alcohol dependent clients' pattern of significantly higher mean scores in *discomfort with closeness*, *relationships as secondary*, *need for approval* and *pre-occupation with relationships* and lower mean score on *confidence* was

indicative of a 'fearful avoidant' attachment style suggested by Feeney *et al.* (1994).



Descriptive statistics in Fig. 3 showed a between-group difference in the maladaptive schema domain of *disconnection/rejection*, with the alcohol dependent group scoring higher on average than the control group.

After adjusting for between-group age differences using ANCOVA, there was a significant difference in the mean scores on the maladaptive schema domain of *disconnection/rejection*,  $F(1, 105) = 112.788, p = 0.000$ , with the alcohol dependent client group scoring significantly higher on average than the control group.



Descriptive statistics in Fig. 4 showed the alcohol dependent group scoring higher than the control group in all five maladaptive schema sub-scales of *emotional deprivation, abandonment, mistrust/abuse, social isolation/alienation* and *defectiveness/shame* within the schema domain of *disconnection/rejection*.

After adjusting for between-group age differences using ANCOVA, there was a significant difference in the mean scores in all five maladaptive schema sub-scales within the domain of *disconnection/rejection*:

*Emotional deprivation*:  $F(1, 105) = 52.918, p = 0.000$

*Abandonment*:  $F(1, 105) = 60.386, p = 0.000$

*Mistrust/abuse*:  $F(1, 105) = 59.469, p = 0.000$

*Social isolation/alienation*:  $F(1, 105) = 71.023, p = 0.000$

*Defectiveness/shame*:  $F(1, 105) = 112.713, p = 0.000$

These results supported the original hypothesis that alcohol dependent clients would score significantly higher on average than the control group in all five maladaptive schema sub-scales of *emotional deprivation*, *abandonment/instability*, *mistrust/abuse*, *social isolation/alienation* and *defectiveness/shame* within the domain of *disconnection/rejection*.

According to Young (2006) a score of 5 or 6 in two or more of the five items of each maladaptive schema sub-scale in the Young's Schema Questionnaire (2001) implied a clinical significance to be aware of when working therapeutically with clients.

**Table 3: Group Comparison of Number of Participants Scoring 5 or 6 in Two or More Items in Maladaptive Schemas**

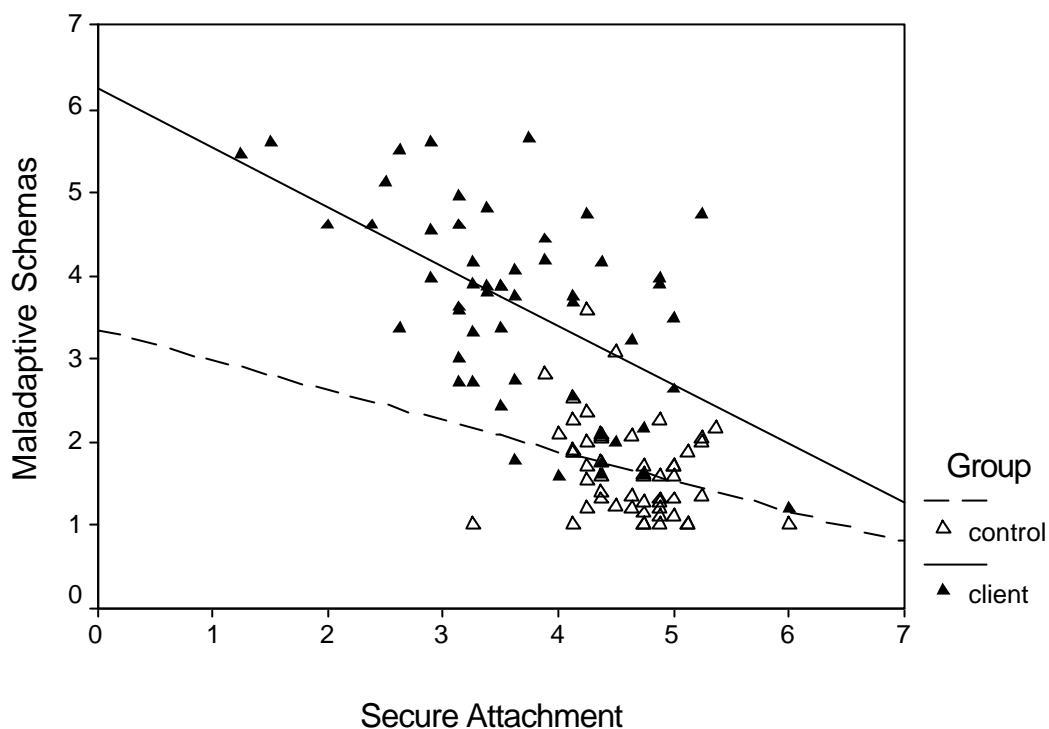
Categories	Emotional Deprivation		Abandonment		Mistrust/ Abuse		Social Isolation/ Alienation		Defectiveness/ Shame	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
<b>Clients</b>	31	57%	29	54%	34	63%	30	56%	25	46%
<b>Controls</b>	5	9%	1	2%	2	4%	0		0	

Table 3 recorded the number of participants with this clinical significance who scored 5 or 6 in two or more items out of five in the maladaptive schemas.

Clinical significance implied those who may require therapeutic interventions to address their unhelpful core beliefs. The results showed a far greater number in each category in the severely alcohol dependent client group (between 46 and 63% of participants dependent upon the individual sub-scales) compared to the control group (between 0 and 9% of participants).



Fig 5a: Relationship between Secure Attachment and Maladaptive Schemas

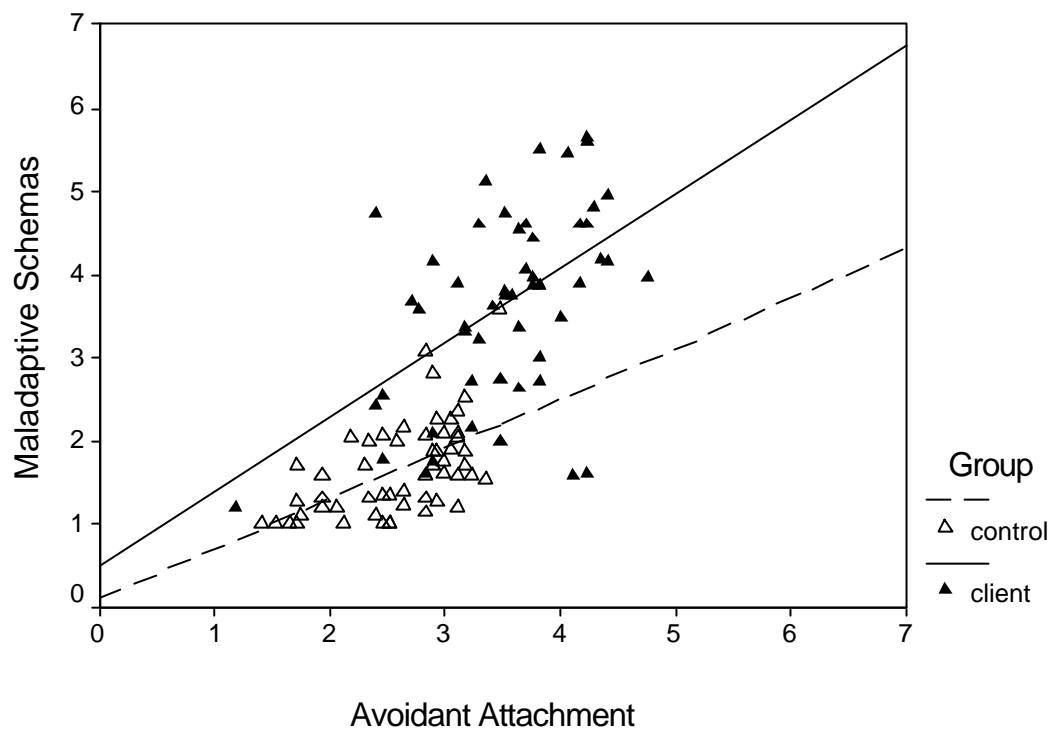


There was a significant negative correlation between *secure attachment style* and *maladaptive schemas* mean scores in both the client ( $\rho = -.502$ ,  $N = 54$ ,  $p = 0.000$ , two-tailed) and control groups ( $\rho = -.317$ ,  $N = 54$ ,  $p = 0.019$ , two-tailed). Fig. 5a showed a scatter plot of these results.

It can be seen that there were several outliers in the client group compared to three in the controls, indicating a greater individual variance within the alcohol dependent group than the control group. Clustering of points close to the regression line indicated a comparatively stronger negative correlation in the control group.

This indicated that if an individual scored more highly on secure attachment style, on average, he/she was more likely to exhibit a lower maladaptive schema score in the domain of *disconnection/rejection*.

Fig 5b: Relationship between Avoidant Attachment and Maladaptive Schemas

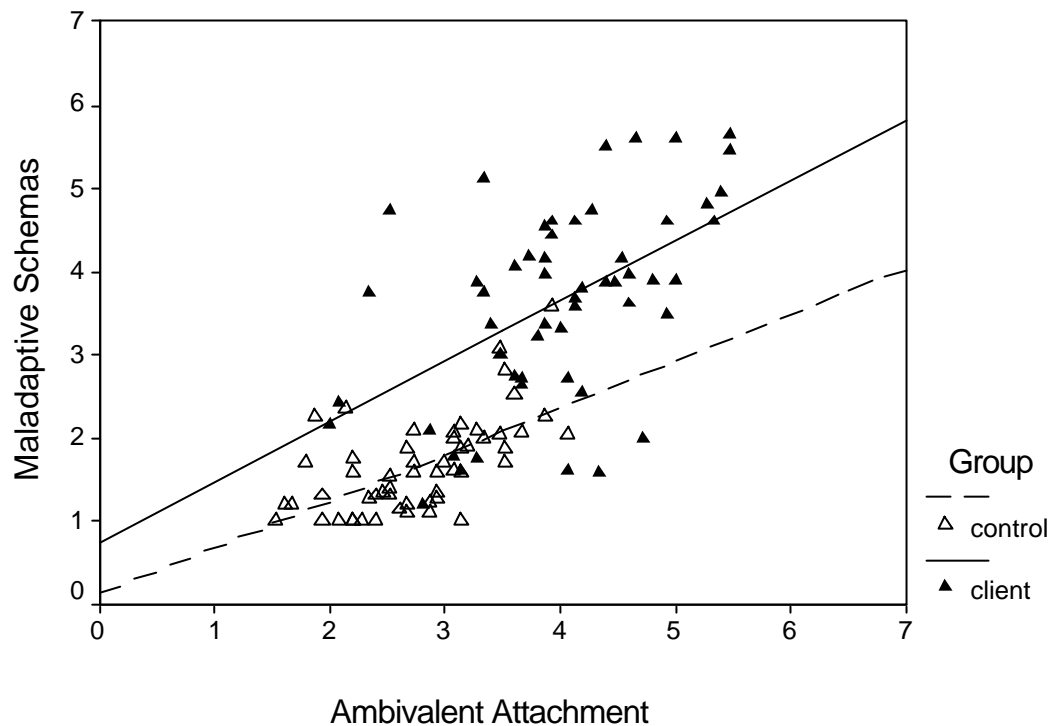


Conversely, there was a significant positive correlation between *avoidant attachment style* and *maladaptive schemas* mean scores in both the client ( $\rho = .500$ ,  $N = 108$ ,  $p = 0.000$ , two-tailed) and control groups ( $\rho = .571$ ,  $N = 54$ ,  $p = 0.000$ , two-tailed). Fig. 5b showed a scatter plot of these results.

It can be seen that there were several outliers in the client group compared to three in the controls, indicating a greater individual variance within the alcohol dependent group than the control group. Clustering of points close to the regression line indicated a stronger positive correlation in the control group.

These results indicated that the higher an individual scored on avoidant attachment style, on average, the more likely he/she was to exhibit a higher level of maladaptive schemas in the domain of *disconnection/rejection*.

Fig 5c: Relationship between Ambivalent Attachment and Maladaptive Schemas



Similarly, there was a significant positive correlation between *ambivalent attachment style* and *maladaptive schemas* mean scores in both the client ( $\rho = .510$ ,  $N = 54$ ,  $p = 0.000$ , two-tailed) and control groups ( $\rho = .612$ ,  $N = 54$ ,  $p = 0.000$ , two-tailed). Fig. 5c showed a scatter plot of these results.

It can be seen that there were several outliers in the client group compared to one in the controls, indicating a greater individual variance within the alcohol dependent group than the control group. Clustering of points close to the regression line indicated a stronger positive correlation in the control group.

These results indicated that the higher an individual scored on ambivalent attachment style, on average he/she was more likely to exhibit a higher level of maladaptive schemas in the domain of *disconnection/rejection*.

### **Summary**

Results showed that severely alcohol dependent clients showed on average similarly significantly higher scores in avoidant and ambivalent attachment style and significantly lower scores in secure attachment style than non-problematic drinkers. The positive correlations between ambivalent and avoidant attachment suggested a significantly higher level of 'fearful avoidant' style (Feeney *et al.*, 1994) in severely alcohol dependent clients than non-problematic drinkers.

Severely alcohol dependent clients also showed significantly higher scores in all five maladaptive schema sub-scales of *emotional deprivation*, *abandonment/instability*, *mistrust/abuse*, *social isolation/alienation* and *defectiveness/shame* suggested they held higher levels of maladaptive core beliefs within the domain of *disconnection/rejection* in comparison to non-problematic drinkers.

Significant positive correlations between both avoidant and ambivalent attachment and *disconnection/rejection* suggested a possible reciprocal relationship between the development of insecure attachment style and maladaptive schemas related to *disconnection/rejection*, although precedence could not be established.

## **Discussion for the First Study**

### **Introduction**

The current study investigated how early adverse experiences may influence attachment style and formation of core beliefs regarding negative perception of self and others (Young, 1999). The study compared severely alcohol dependent clients with non-problematic drinkers from an NHS service working population. From a psychosocial perspective, a significant difference in interpersonal relatedness may have implications for therapy, in terms of how such clients may or may not engage in services to address their alcohol-related difficulties. Therapists may need to address these issues using a more informed approach.

The aim of Section 1 of the current study was to reveal any statistically significant differences arising between the two groups in terms of security of attachment and related core beliefs and whether there was a relevant association between the two. However, a criticism of the current study could highlight the number of controls working in the caring profession, which may reflect a particular attachment style. Studies showed links between compulsive care giving, negative childhood experiences and clinical psychologists' insecure attachment (Leiper & Casares, 2000) and greater prevalence of 'narcissistic injury', namely harm to sense of self and feelings of inadequacy, in trainee counselling psychologists (Halewood & Tribe, 2003). Similarly, research showed significant differences in recalled adverse early experiences and 'unresolved reparation' related to childhood in student nurses compared to controls. It suggests that those people whose needs were not met are attracted

to the helping professions and are in the familiar place of sublimating their own needs to help others (Phillips, 1997).

Compulsive care giving may be a motivating factor in nurses' career choice (Phillips, 1997). It also suggested a possible higher propensity for insecure attachment style, in this study's control group, as many currently worked in the caring profession. Despite this possibility, significant differences in dimensions of secure, avoidant and ambivalent attachment were revealed, which suggested the deviations could have been greater if a different control group had been used, for example, workers in the civil service.

There was also a gender difference between the groups; this was mainly due to the prevalence of female workers within the health profession, particularly in caring roles, and the higher number of male alcohol dependent clients presenting to the service, which may have elicited a gender bias in the results. However, although approaching significance, the difference was not significant to warrant using gender as a covariate. Previous studies have not revealed a gender difference in attachment styles (Feeney & Noller, 1996).

The data initially showed there was a significant age difference between the two groups tested, with the alcohol dependent group aged approximately on average ten years older than the control group. This age gap necessitated the inclusion of age as a covariate in the analysis to eradicate any age-related bias; although previous research has suggested a relative stability of attachment over time (Main, Caplan & Cassidy, 1985) further studies of a longitudinal nature

were required to validate this premise (Cassidy & Shaver, 1999) and therefore it was considered by the researcher to be statistically relevant.

Interestingly, the 43 alcohol dependent clients who did not attend their initial assessments had a mean age of 30.5 years, which would have redressed the age imbalance.

The question was raised as to why the 43 severely alcohol dependent clients did not attend; it was possible that these individuals, in line with the initial research hypothesis, may have been on the extreme continuum of the avoidant attachment style and maladaptive schemas around disconnection and rejection that prevented them from engaging with the service. An alternative explanation was that they were not yet experiencing sufficient physical, alcohol-related health problems, which was often a motivational factor in the decision to attend. It was necessary, however, to acknowledge that a high number of potential participants were not included, which could have influenced the outcomes.

### **Hypothesis 1**

**Alcohol dependent individuals will score significantly higher on the dimension of *avoidant attachment style* and significantly lower on *secure attachment style* than non-problematic drinkers.**

The first research question asked in the study was whether alcohol dependent clients had a significantly greater likelihood of displaying an avoidant attachment style than the general population. Results supported the first hypothesis that alcohol dependent clients would score significantly higher on

the dimension of avoidant attachment style and significantly lower in secure attachment style than the control group. Results revealed statistical evidence for a greater likelihood for heavy drinkers to significantly differ from the general population in their degree of avoidant attachment and subsequent ability to develop and maintain close relationships. The question arose as from where this difference developed.

Attachment theory (Bowlby, 1969), based upon observational studies of separated and institutionalised children, suggested that absence, disruption to or denial of emotional bonding through maternal loss, rejection, deprivation, abuse and/or physical and emotional neglect resulted in the child's ambivalence towards, and reluctance or inability to form, intimate relationships later on in life, namely ambivalent or avoidant attachment.

Insecure attachment from early negative experiences and losses (Moncrieff *et al.*, 1996), such as 'childhood adversities of an interpersonal nature' (Mickelson *et al.*, 1997), was also suggested as a risk factor in alcohol misuse (Mirsal *et al.*, 2004). Similarly, a study of 155 alcohol-dependent clients seeking treatment implicated maternal dysfunction as a contributory factor (Langeland *et al.*, 2004). The evidence suggested that early childhood experiences were implicated in the development of later insecure attachment and associated adult alcohol dependence.

It was possible that the alcohol dependent clients in the current study experienced diverse childhood adversities and negative or inconsistent parenting that increased their vulnerability towards being insecurely attached.



This line of investigation was explored later in the Section 2 Discussion that explored clients' past and present subjective experiences of relationships, which informed the initial results.

How could insecure attachment contribute to alcohol dependence? A possible explanation was that alcohol dependence and insecure attachment seemed to interact symbiotically; perhaps drinking commenced initially as a maladaptive coping strategy to avoid negative affect regarding the perceived threat of relationships derived from anxiety-provoking early experiences. Intimacy avoidance may initially be a protective defence, which alcohol maintained, but ultimately also increased vulnerability in terms of social isolation and impoverished support and therefore increased the likelihood of excessive drinking. Thus, a cognitive, affective and behavioural pattern was established that subconsciously kept the drinker in the familiar, albeit uncomfortable and lonely place of emotional avoidance.

Within the two groups tested there was no significant difference between the attachment style scores, although it approached significance, suggesting that individuals tended to possess relatively similar levels of all three styles within their personality type. However, the between-group analysis revealed a significant effect of attachment style, which suggested that the variable of alcohol dependent individual versus controlled or non-drinker significantly affected differences in attachment style. Severe alcohol dependence did therefore appear to be strongly associated with higher levels of insecure attachment. This was supported in previous research (McNally *et al.*, 2003) that

revealed that insecurity around relationships and negative self-perception were implicated in a greater likelihood of alcohol misuse.

The current study suggested that non-problematic drinkers tended to have a more secure attachment style than severely alcohol dependent clients with complex needs, in terms of finding it relatively easy to get close to others and being comfortable with mutual dependency. There was relatively little concern about abandonment or emotional intimacy. In contrast, severely alcohol dependent clients' higher level of avoidant style implied they were relatively more uncomfortable being close to others than non-problematic drinkers and found it more difficult to trust people completely and allow themselves to rely on them. They were more anxious regarding emotional intimacy. Possibly, alcohol was a mediating factor in anxiety reduction. From these results, it was possible to suggest that in the interviews conducted, some severely alcohol dependent clients may reveal emotional difficulties with intimate relationships and issues around mistrust and a need for self-reliance.

Paradoxically, however, the severely alcohol dependent clients also displayed a significantly higher ambivalent attachment style and greater preoccupation with relationships than non-problematic drinkers, which suggested that they were concerned that others were reluctant to get as close as they would like and often worried that partners didn't really love or wouldn't want to stay with them. They worried that the excessive neediness in a relationship sometimes drove people away, resulting in a seeming self-fulfilling prophecy.

The current study supported the argument of Feeney *et al.* (1994) that attachment styles were not mutually exclusive, could have overlapping features and that individuals possessed characteristics of all three types. The seemingly dichotomous relationship between equally avoidant and ambivalent attachment styles suggested an internal conflict occurring within the severely alcohol dependent individuals; they oscillated between neediness and avoidance, wanting emotional intimacy, and rejecting it through fear of abandonment, which could be easily misinterpreted as dismissiveness and therefore perceived as avoidant attachment. This anxious confusion may be similarly replicated and externalised to engaging and then prematurely disengaging with therapeutic services.

This was statistically supported in a significant negative correlation occurring between secure and both avoidant and ambivalent attachment in both groups, although there were more outliers in the severely alcohol dependent group, suggesting a greater individual variance in the drinkers. This strong association suggested that on average, the more securely attached an individual was, the less likely he/she was to have the avoidant or ambivalent features as described above. In contrast, there was a strong positive correlation between avoidant and ambivalent attachment style, particularly with the severely alcohol dependent clients, which suggested that both avoidance and ambivalence in relation to emotional intimacy within close relationships were possibly implicated with severe alcohol dependence.

This strong, positive correlation also offered further support to Feeney, Noller and Hanrahan's (1994) overlapping dimensions of attachment style, and thus

querying Hazan and Shaver's (1994) previous forced-choice categories as an accurate measure of attachment. The severely alcohol dependent clients revealed similarly high scores for both ambivalent and avoidant dimensions of attachment style, which suggested the two were not mutually exclusive, that the idea of having an either/or concept for attachment style was too simplistic and that it was more likely a complex and seemingly conflicting set of beliefs and behaviours existed that belied how securely or insecurely attached an individual may be in their ability to relate with others.

## **Hypothesis 2**

**Alcohol dependent individuals will score significantly lower on the attachment style sub-scales of *confidence (in self and others)*, *need for approval*, and *preoccupation with relationships*, and significantly higher on *discomfort with closeness*, and *relationships as secondary* in Feeney, Noller and Hanrahan's (1994) Attachment Style Questionnaire (Appendices 10 & 11) than non-problematic drinkers.**

The second hypothesis explored the distinctive elements of attachment styles identified by Feeney *et al.* (1994), and suggested that severely alcohol dependent individuals would score significantly lower on the attachment style sub-scales of *confidence (in self and others)*, (*secure attachment*), *need for approval*, and *preoccupation with relationships (ambivalent attachment)*, and significantly higher on *discomfort with closeness*, and *relationships as secondary (avoidant attachment)* in the Attachment Style Questionnaire (Feeney *et al.*, 1994) than non-problematic drinkers.

Results showed that the second hypothesis was partially supported, in that severely alcohol dependent clients tended to be significantly less confident than non-problematic drinkers, which could stem from low self-esteem in connection with their drinking or it could be deep-rooted in childhood rejection; the causal effect was as yet difficult to establish. Poor self-concept was linked to substance misuse in anxious/ambivalent-attached adolescents (Schindler *et al.*, 2005), which suggested it was already present in childhood and that alcohol was more likely used to create a means of positive feeling of social inclusion that counterbalanced the feelings of worthlessness.

The severely alcohol dependent clients displayed a significantly greater tendency for both needing approval and spending more time being preoccupied with relationships, which suggested an attached importance to what others thought about them. This seemed to contradict the drinkers' seeming dismissiveness of relationships, in their significantly higher degree of discomfort with closeness and viewing relationships as secondary. It suggested a deeper complexity of interpersonal relatedness, in that they cared about how others perceived them and desired intimate relationships but possibly anxiety and low self-confidence prevented them from achieving their objective of emotional intimacy.

A possible explanation lay in the *'fearful avoidant'* style suggested by Feeney *et al.* (1994) that encompassed the paradox between alcohol misusers' seeming avoidance and conflicting need for relationships. A comparative study between adolescent drug users and controls (Schindler *et al.*, 2005) also revealed a

similar, predominantly fearful avoidant attachment style in drug users, in contrast to a prevalence of secure attachment in the non-clinical controls.

Recent research (Alford, Lyddon & Schreiber, 2006) revealed that fearful avoidant participants reported less positive affective experiences and dismissive avoidant individuals reported less affect directed towards connectedness, both of which could be argued to have negatively skewed the severely alcohol dependent clients' self-reporting. However, the study showed that insecure attachment was positively correlated with maladaptive core beliefs; they were both likely therefore to influence negative affect and so it was not surprising that recalled experiences revealed predominantly negative emotion and a lack of emotional connectedness.

The research implied a possible ongoing ambivalence related to emotional intimacy, which drove the preoccupation, rather than neediness. It also suggested that avoidance may be anxiety-related, rather than based upon dismissiveness, and that the two aspects of insecure attachment were not as dissimilar as first posited by forced-choice measures (Bartholomew & Horowitz, 1991).

### **Hypothesis 3**

**Alcohol dependent individuals will score significantly higher on the five sub-scales of the early maladaptive schemas of *abandonment/instability, mistrust/abuse, emotional deprivation, defectiveness/shame, and social isolation/alienation* in the domain of *disconnection and rejection* in**

**Young's Schema Inventory (shortened version) (Appendices 13 & 14) than non-problematic drinkers.**

The next question to be addressed in the study was whether severely alcohol dependent clients tended to have a higher level of maladaptive schemas in relation to the core domain of *disconnection and rejection* than non-problematic drinkers. These core beliefs appeared to encompass many alcohol clients' psychological and emotional difficulties regarding interpersonal relatedness and negative perception of self and others. Young *et al.* (2003) discovered that clients who possessed schemas in this domain, many of whom were likely to have personality disorder, tended to be the most psychologically damaged and found it difficult to form and maintain intimate and rewarding relationships. There was usually an early pattern of abusive, cold and rejecting parenting, with little stability or nurturing that could imply insecure attachment. Research has already established a high prevalence of personality disorder with concurrent alcohol misuse (Bernstein *et al.*, 1998; Bowden-Jones *et al.*, 2004); a further possible link with maladaptive schemas and alcohol dependence could therefore also be suggested.

Results in the current study revealed significantly higher scores for severely alcohol dependent drinkers than non-problematic drinkers in every sub-scale of *disconnection and rejection*, supporting the third hypothesis that severely alcohol dependent individuals would score significantly higher on all five sub-scales of the early maladaptive schemas of *abandonment/instability*, *mistrust/abuse*, *emotional deprivation*, *defectiveness/shame*, and *social isolation/alienation* in the domain of *disconnection and rejection* in Young's

Schema Inventory (shortened version, Young & Brown, 2001) than non-problematic drinkers.

The results had important implications for how individuals perceived themselves and others in relation to social interaction and their subsequent ability and willingness or otherwise to engage in intimate relationships. It also raised questions as to how these schemas developed, what maintained the unhelpful core beliefs regarding self and others and the part that alcohol played.

The current study suggested that severely alcohol dependent clients possessed more aspects of the *abandonment/instability* schema and were therefore significantly more likely to hold negative beliefs that people were essentially emotionally unreliable and unavailable than were non-problematic drinkers; their greater perception was that they would inevitably be abandoned, either through death or others finding someone better or more deserving. Clients' beliefs around expected rejection may therefore have inhibited forming and maintaining close relationships. Paradoxically, alcohol may have served to alleviate unpleasant feelings around abandonment but also simultaneously reinforced those fears, in that clients considered their drinking to be another reason for partners to leave. In reality, it was possible that partners did actually leave as a direct result of the clients' alcohol dependence, unwittingly creating a self-fulfilling prophecy of perceived abandonment.

Severely alcohol dependent clients scored significantly higher on the *mistrust/abuse* schema and were therefore also more likely to perceive others as basically self-oriented and who utilised abusive and hurtful means to



manipulate them. They could therefore be mistrustful of others' intentions and be hyper-vigilant regarding ulterior motives, which could potentially impede the development of emotional intimacy. The beliefs around severely alcohol dependent clients' mistrust and fear of being mistreated may be a consequence of the fellow drinkers with whom they tended to associate and the seemingly harsh, survival-based culture of needing to look after self at the risk of hurting others or it may have had origins in early childhood, abusive experiences.

Severely alcohol dependent clients possessed significantly higher levels of the *emotional deprivation* schema and were therefore more likely to have believed that their emotional needs would not be adequately met, either through nurture, protection or empathic connection than non-problematic drinkers. Severely alcohol dependent clients' perceptions of unmet needs may be understood in their seeming self-imposed lack of self regard that engendered its own prejudice and stigmatisation in services or raised the possibility of a more entrenched belief that began before the alcohol misuse.

The higher levels of *defectiveness/shame* schema reflected beliefs about self, and indicated that many severely alcohol dependent clients considered themselves to be significantly more unlovable through personal flaws and inadequacies, combined with a greater sense of shame and lack of self-worth than non-problematic drinkers. This could be related to their negative self-concept and defective sense of self, generated through excessive drinking, or it is possible that shame had deeper roots in adverse childhood experiences.

Severely alcohol dependent clients tended to display significantly greater *social isolation/alienation* schema scores than non-problematic drinkers and perceived themselves as being essentially different from the rest, on the periphery of a group and having had greater difficulty in engaging in communal activities. Anti-social behaviour through heavy drinking had the propensity to exacerbate isolation and alienation or an alternative explanation may lie in loneliness and a sense of felt difference that emanated in childhood and maintained feelings of isolation. Alcohol may have become a means of enabling social inclusion for those who felt excluded.

According to Young (2006) a score of five or six in two or more of the five items of each maladaptive schema sub-scale in the Young's Schema Questionnaire implied a clinical significance to be aware of when working therapeutically with clients. Results showed a far greater number in every category in the severely alcohol dependent client group (between 46 and 63% of participants dependent upon the individual sub-scales) compared to the relatively low scores of the control group (between 0 and 9% of participants). Results suggested many severely alcohol dependent clients were significantly more likely than non-problematic drinkers to hold quite resistant and maladaptive core beliefs that were clinically relevant and that would need to be addressed if therapy was to be effective in addressing their alcohol-related issues.

Statistically supported evidence from the current study suggested there were distinct and significant differences between severely alcohol dependent clients and non-problematic drinkers in the development and maintenance of negative and potentially destructive core beliefs regarding self and others and their

negative perception of relationships. The possible origins of these self-defeating patterns of negative thinking, affect and behaviour were discussed in Section 2.

There was a theoretical link between insecure attachment development in childhood and the formation of early maladaptive schemas. From an attachment perspective, Bowlby's (1969) 'internal working models' that developed from childhood to early adulthood formed the basis of how we perceived self and others in relation to the social context; if that situation was anxiety-provoking due to physical abuse or emotionally unrewarding in terms of lack of nurture or protection then it was unlikely that the child's perception of relationships would be positive or trusting. Young's Schema Theory redefined these models as 'early maladaptive schemas', namely, persistent, self-defeating learned patterns of cognition, affect and behaviour, arising from repeated individual experiences of unrequited childhood needs.

Young (1999) argued that temperament and individual personality characteristics interacted with a threatening, possibly hostile and rejecting family environment that engendered insecure attachment and an inability to express emotional and physical needs; he suggested that the inherently vulnerable child acquired maladaptive coping strategies, including alcohol misuse, to deal with unmet needs. This theory was also supported in a recent study of substance misusers, using the Young's Schema Questionnaire (short version) that found a similar higher prevalence of maladaptive schemas, particularly in the alcohol users (Brotchie *et al.*, 2004).

## **Associations Between Insecure Attachment and Maladaptive Schemas**

One research question arising from the current study was whether there was a significant association between security of attachment style and maladaptive schemas in relation to disconnection and rejection in support of Young's theory. The link between alcohol dependence, insecure attachment and early maladaptive schemas was corroborated in results that showed a negative correlation between secure attachment style and maladaptive schemas and a positive correlation between avoidant and ambivalent attachment style and maladaptive schemas. It implied that the more securely attached an individual was, the less likely they were to display unhelpful core beliefs around self and others, in relation to possible abuse, abandonment, isolation, rejection and negative self-perception.

However, it has to be acknowledged that there was a greater degree of individual variance in the severely alcohol dependent client group than the non-problematic drinkers, which suggested that not all insecurely attached chronic drinkers had correspondingly high maladaptive schemas. It is possible that they have developed different coping strategies to deal with ambivalence or avoidance of emotional intimacy.

Although as yet there has been relatively little research examining possible meaningful associations between Bowlby's internal working models of attachment and maladaptive schemas in alcohol dependence, Mason, Platts and Tyson (2005) discovered a positive correlation between insecure attachment and early maladaptive schemas in mental health service users, with 81% having an insecure attachment style. The current study therefore

replicated previous research outcomes regarding the possible link between insecure attachment and maladaptive schemas and mental health service users in alcohol misusers. As it is widely recognised that many severely alcohol dependent clients had the 'dual diagnosis' label of mental illness co-morbidity (Rassool, 2002) it was possible to suggest that they had a similarly greater propensity for associated attachment issues and corresponding negative and self-defeating core beliefs than non-problematic drinkers.

### **Insecure Attachment, Maladaptive Schemas and Implications for Therapy**

The final question asked was what might be the implications for counselling psychologists' therapeutic approaches when working with severely alcohol dependent clients in the light of the results revealed, i.e. that the majority of heavy drinkers tended to possess a higher, combined avoidant and ambivalent attachment style and associated higher levels of maladaptive schemas than non-problematic drinkers.

The current study revealed severely alcohol dependent clients possessed more aspects of the *abandonment/instability* schema and were therefore significantly more likely to believe that people were essentially emotionally unreliable and unavailable than non-problematic drinkers and that they would inevitably be abandoned, either through death or others finding someone better or more deserving. Clients' maladaptive beliefs around expected rejection could therefore become an issue in the therapeutic relationship, for example in terms of cancelling appointments or taking leave.

Severely alcohol dependent clients revealed a higher level of *mistrust/abuse* schemas and were therefore more likely to regard others as self-motivated who used abusive and hurtful means to control them. Mistrust of others' intentions could result in misinterpretation and misunderstanding, inhibiting the development of a trusting relationship; hyper-vigilance around ulterior motives could also potentially impede the progress of the therapeutic alliance.

Schemas around emotional deprivation may have implications for therapy, in that severely dependent drinkers, through their perceived undeservedness, might attend with the expectation to be disappointed, to the point that unwittingly they might engineer a self-fulfilling prophecy of unfulfilled expectation and rejection through sporadic attendance or non-attendance at services.

Schemas around defectiveness and shame might negatively impact upon the therapeutic relationship, in that they felt unworthy of the time and attention given to them. Clients' non-attendance may be justified to themselves in terms of relinquishing their place in their belief that someone more deserving might make better use of it.

Clients with maladaptive schemas around social isolation and alienation who were used to finding themselves either excluded or on the social periphery may find being the centre of attention in a counselling environment an unfamiliar place; it could feel threatening and possibly anxiety provoking. Emphasis would need to be placed upon building a sense of emotional connectedness and engendering a feeling of safety and security within the therapeutic relationship.

The outcomes suggested a possible re-evaluation of therapy in alcohol specialist services. Disputing resistant and deeply entrenched, self-defeating core beliefs and replacing them with more positive schemas by exploring underlying childhood issues may require longer-term therapy, to complement current alcohol misuse interventions (Brotchie *et al.*, 2004).

The current study's results advocated a screening procedure to be implemented by alcohol workers at initial assessment, using the Attachment Style Questionnaire (Feeney *et al.*, 1994) and Young's Schema Questionnaire (Young & Brown, 2001). It could identify those with fearful avoidant attachment and maladaptive schema characteristics, at increased risk of psychological damage through hostile and critical parenting (Young *et al.*, 2003) and who were at risk of not engaging in or prematurely disengaging from therapy. Similarly, from the perspective of the individual possessing entrenched core beliefs related to disconnectedness and rejection, their experiences of relationships may be perceived as abusive, unrewarding and to be avoided; they were unlikely therefore to place themselves in an unfamiliar and potentially threatening situation unless they felt safe and supported (Young, 2006). If workers were better informed in terms of psychological thinking of how these vulnerable clients were likely to behave during engagement they could respond more appropriately.

It was possible to suggest that from an attachment perspective, for the therapeutic process to be effective the therapist needed to offer a stable and secure base from which the insecurely attached alcohol dependent client may

explore unresolved issues related to their negative past childhood experiences. Young *et al.* (2003) argued that such clients required 'limited re-parenting' so that they may experience a mutually rewarding intimate relationship, possibly for the first time. In this way, the therapist took on the role of 'nurturing and supportive parent' who initially encouraged a form of dependence in the process of establishing a secure attachment; as the client began to trust in that relationship an enabling process occurred of the client experiencing a more validating sense of self and the capacity to socially engage in a more positive and productive way; the eventual outcome was personal autonomy and independence.

Only when a positive and empathic therapeutic alliance had been established could the work upon unhelpful and self-defeating patterns of thinking and feeling that kept them locked into the cycle of alcohol dependence begin. Young advocated the need for longer-term therapy to address the maladaptive schemas around disconnection and rejection, which were suggested to be the most resistant and also the most psychologically damaging, particularly for those with personality disorder, which was prevalent in alcohol misuse (Bowden-Jones *et al.*, 2004). A recent study (Giesen-Bloo *et al.*, 2006) revealed a significant benefit of schema-based therapy in comparison to psychodynamically based, transference-focused psychotherapy in personality disordered patients, which suggested its effectiveness may be repeated in severely alcohol dependent clients.

Currently, CBT intervention and motivational interviewing strategies were used widely in alcohol services and have been shown to be effective, in terms of



reducing excessive drinking, relapse prevention and cost-effectiveness (Babor & Higgins-Biddle, 2001); however, long-term successful outcomes were questionable as relapse within twelve months was likely to occur (Wutzke *et al.*, 2002). Research suggested that CBT acted as an effective intervention for addressing behavioural change in hazardous and harmful drinkers (NTA, 2006), particularly with those clients whose excessive drinking had developed from specific and identifiable environmental stressors, such as bereavement, unemployment or divorce. However, as the current study showed, it was possible that more pervasive and diffuse, underlying causes of severe alcohol dependence, such as prolonged childhood abuse and neglect suggested to be the precursors of insecure attachment and subsequent maladaptive schema formation, could not always be adequately explored by CBT alone and required a more in-depth approach.

In general, the majority of severely alcohol dependent clients also displayed symptoms of anxiety and depression. Recent research comparing 80 alcohol dependent hospitalised clients with a control group of 60 with no history of alcohol use and matched according to age and gender, discovered a positive correlation with anxiety and affective symptoms in the alcohol misusers. It highlighted the preference for an integrated plan of care for alcohol dependent clients presenting with anxiety and depression, tackling both issues simultaneously in order to achieve an effective outcome (Mirsal *et al.*, 2004).

Currently, some mental health and alcohol specialist services in the UK tended to operate relatively autonomously with communication between involved health professionals only occurring during patient crisis. This unhelpful experience

could mirror for the severely alcohol dependent client the inconsistent and inadequate parenting received in childhood. A more pro-active and collaborative way of working that reflected 'good parenting' may be effective in retaining avoidant clients in alcohol services.

In terms of prevention work, a review of the developmental history and course of adolescent use disorders suggested childhood abuse, impoverished parental involvement and co-morbid psychopathology were possible precursors to adolescent drinking and adult alcohol dependence, particularly if drinking began around the age of 13 (Pitkanen *et al.*, 2005). As adolescence appeared to be a crucial time in terms of the progression of alcohol misuse, it suggested the need for early, multi-faceted, psychosocial interventions for young people, possibly using an integrative treatment program, combining family and community-based treatments (Henggeler, Schoenwalk, Borduin, Rowland & Cunningham, 1998).

Early interventions using attachment style and schema assessment may highlight vulnerable teenagers at risk who need more intensive therapeutic input. Additional social and emotional support and promoting of positive attachments may alleviate the risk factor of social isolation and alienation and developing later adult alcohol dependence. It may also begin to challenge earlier the negative perceptions around self and others that reinforced the pervasive maladaptive schemas related to disconnection and rejection.

In order to examine more closely how severely alcohol dependent clients' early formative experiences of interpersonal relatedness may have shaped the subsequent development and maintenance of fearful avoidant attachment and

maladaptive schemas, it was necessary to investigate their subjective memories concerning close relationships. This was conducted using Interpretative Phenomenological Analysis of eight taped individual interviews to see what contributory factors may emerge from their recollections of self and others and the interpersonal, dynamic process occurring that may have predisposed some children to the risk of relatively early alcohol misuse and later severe dependence. The results were explored next in the Section 2 discussion before a final summary and conclusions were drawn.

## **Section 2 – Qualitative Analysis**

### **Introduction to Interpretational Phenomenological Analysis**

#### **(IPA, Smith & Osborn, 2003)**

The development of IPA as a sound theoretical and procedural framework for conducting qualitative analysis over the past decade has occurred predominantly in the field of health but is increasingly used in mainstream psychology (Smith, 2004). A recent review undertaken of 52 articles revealed its breadth of scope and flexibility in application in a wide diversity of research areas (Brocki & Wearden, 2006). IPA's epistemological position was essentially phenomenological, in that it was concerned with individuals' experiences and perceptions of events and situations, which were then subject to the researcher's interpretation.

However, to differentiate IPA from other forms of phenomenological exploration, its theoretical origins lay in the 'critical realism' approach (Bhaskar, 1978) and social cognition model (Fiske & Taylor, 1991), that suggested that although reality existed in an unchanging and abiding form apart from human conceptualisation, people experienced distinct aspects of reality and therefore attached different meanings, reflected in their language and actions (Fade, 2004). The researcher was therefore aware that knowledge gained from this type of research cannot be completely objective-driven and perspective-free, and acknowledged the influential presence of subconscious thought and emotional processes of the individuals interviewed. This included the researcher's own experiences that may subconsciously affect the research

direction, that questioned how neutrality and objectivity may be achieved, which may be seen as a limitation to IPA.

The strength of IPA was that it was essentially participant-centred and enabled the individual's self-reflection through narrating their story (Smith, Flowers & Osborn, 1997). The open-ended questioning of the semi-structured interview enabled unexpected details to emerge that could not be discovered merely through questionnaires. It therefore complemented the quantitative approach used in this study by adding a depth and richness of subjective, narrative material that elucidated upon the measurable outcomes (Senior, Smith, Michie & Marteau, 2002).

There were two fundamental aims to IPA research:

1. To enter into the participant's world and discern how they make sense of their experiences. This complex and interactive process endeavoured to analyse that experience. It was partially and intellectually constructed through researcher and participant symbiotic interaction; the outcome was therefore a similar but understandably incomplete perspective to that of the participant (Larkin, Watts & Clifton, 2006).
2. To interpret that individual, experiential perspective more fully by examining the 'person-in-context', that is, embedding the person contextually within family, social, physical and cultural environments (Heidegger, 1985) and linking the experiences to psychological theory. A critical evaluation was provided of the person endeavouring to find meaning in their experiences.

Smith (2004) characterised IPA as having three defining features:

**Idiographic** – each participant's interview was systematically analysed and a table of themes individually constructed; only when the researcher had achieved closure did the next analysis commence. Cross-referencing for similarities and differences occurred at the end.

**Inductive** – unlike quantitative research, IPA made no attempt to limit itself by establishing hypotheses at the outset but merely had a loose rationale. In this way, through its flexibility of approach, unlikely and unpredicted themes could emerge.

**Interrogative** – the themes and patterns that were elicited did not exist in isolation but were linked to theoretical knowledge of mainstream psychology through critical evaluation and discussion.

Historically, phenomenology was the study of human experience situated within particular contexts. The phenomenological perspective stated that it was not possible to isolate or divide people's experiences from the objects and subjects of their immediate environment, which all have presence and temporal meaning; this meaning represented their reality (Husserl, 1859-1938).

The phenomenological approach aimed to investigate the participant's perceptual, lived experience whilst acknowledging that this dynamic process did not occur in isolation; it was inevitably influenced by the researcher's preconceptions, expectations and assumptions in relation to the participant and

the research and the degree of inter-relatedness between researcher and participant. It was imperative therefore for the researcher to be fully cognisant of the potential for researcher bias and to develop and maintain continuous reflexivity during the process.

Despite the researcher's attempts to capture the quintessence of an individual's experience, it can simply be accessed indirectly through the vehicle of language. IPA, therefore, depended upon language to provide representational validity. However, it was suggested that language was a constructive rather than a descriptive process in terms of reality. Language could not just describe experience, because the vocabulary used inevitably constructed a distinctive and individual version of that experience; one situation may be described quite differently by those witnessing the event, according to external influences such as situational factors or internal, individual personality characteristics and core beliefs (Gergen, 1999). Participants' subtle, personal variations of their recollections and their ability to communicate may also influence the researcher's implicit understanding of their expressed life events.

Phenomenological analysis was therefore limited to an interpretation of the participant's experience (Willig, 2001). It was also limited by the individual participant's abilities to accurately verbalise their thoughts and emotions. However, the strength of IPA was that it offered an insight, not only into the perceptual but also the contextual world of the individual, that questionnaires alone could not do. IPA served as a particularly useful vehicle in the current study for exploring people's perceptions of themselves in relation to others and alcohol within their experiences of intimate relationships.

## **Reflexive Process of IPA**

In the current study on severe alcohol dependence and avoidant attachment, the focus was upon how individuals established and maintained intimate relationships and what may inhibit or prevent that process from occurring. The hypothesis supported in the initial quantitative analysis was that severely alcohol dependent clients may be more susceptible to insecure attachment, and that there may be a connection between associated maladaptive schemas that reinforced difficulty with emotional intimacy. The difficulty lay in trying to separate from and leave behind the original hypotheses and quantitative analysis results and remain as open-minded as possible regarding people's subjective experiences. Inevitably, there was some implicit and subconscious connection in an endeavour to explain the initial results, which may limit the findings. However, the non-directiveness of the semi-structured interview questions prevented any deliberately engineered client responses on the part of the researcher.

The purpose of the qualitative aspect of the current study was to elicit emergent themes, from early childhood memories of relatedness to the present time, that might enable a deeper understanding of the underlying issues alcohol clients might have in forming relationships. It was important in the interviews for me as the researcher to gain insight into how severely alcohol dependent clients experienced their sense of 'self', how they related to others and how they thought others perceived them. This necessitated sensitive exploration of past and present relationships.



Often severely alcohol dependent clients described feelings of unimportance or invisibility indicating to me that they were often labelled by their problem. Their identity tended to be neglected or lost as they were continually being epitomised in health services by their drinking and alcohol-related issues. In this research they were allowed a 'voice' possibly for the first time in their lives, as their perceptions of pain, loss and sadness regarding past and present relationships were narrated. I was privileged as a researcher to be a part of that emotional journey.

I had five years' experiences of counselling alcohol dependent clients from which this research proposal originated. It was therefore possible that implicit attributional bias from my preformed ideas and expectations influenced the study's development and subconsciously informed the direction of the IPA analysis. A criticism was that the results from the attachment style and schema questionnaires undoubtedly may have influenced the direction and the focus of the emergent themes. Nevertheless, I have endeavoured to maintain awareness of such implications throughout the process. To ensure objectivity, I had no prior knowledge or contact with the participants, other than their completion of the questionnaires.

As each person had a valuable and important story to tell, experiences of the eight participants interviewed were initially analysed individually (see Appendix 21 Memos) before the general discussion regarding the super-ordinate themes of convergence and divergence occurred. In accordance with BPS (2006) guidelines regarding confidentiality, names were changed and any potentially identifying information was removed.

It was acknowledged that in the interviews my probing capacity as a researcher was possibly inhibited by the ethical consideration to invoke as little discomfort or distress as possible whilst conducting the process. Although severely alcohol dependent clients interviewed could have been questioned further to extract more detailed information, for example in relation to Carl's involvement in his father's death, ethical constraints demanded the need for sensitivity coupled with the desire not to exacerbate distress in potentially vulnerable clients.

Although I neglected to keep a reflective diary during the research journey, a necessary and important part of the reflexive process was exploring and evaluating the emotional impact of engaging with often distressing material; this was achieved through regular supervision and personal therapy.

## **IPA Summary**

Individual Tables of Themes and the descriptive, theoretical memos (see Appendix 21) drawn from the tables were analysed, from which a Master Table of Super-ordinate and Sub-ordinate Themes (see Table 4, page 109) was developed. Using the Master Table, the transcripts were analysed to determine how often themes were cited (see Table 5, page 110).

Four super-ordinate themes were identified:

1. *Development of mistrust in childhood.*
2. *Loss and aloneness.*
3. *Implications for self.*
4. *Implications for therapy.*

The super-ordinate and sub-themes were incorporated into a diagram (see Figure 6, page 111).

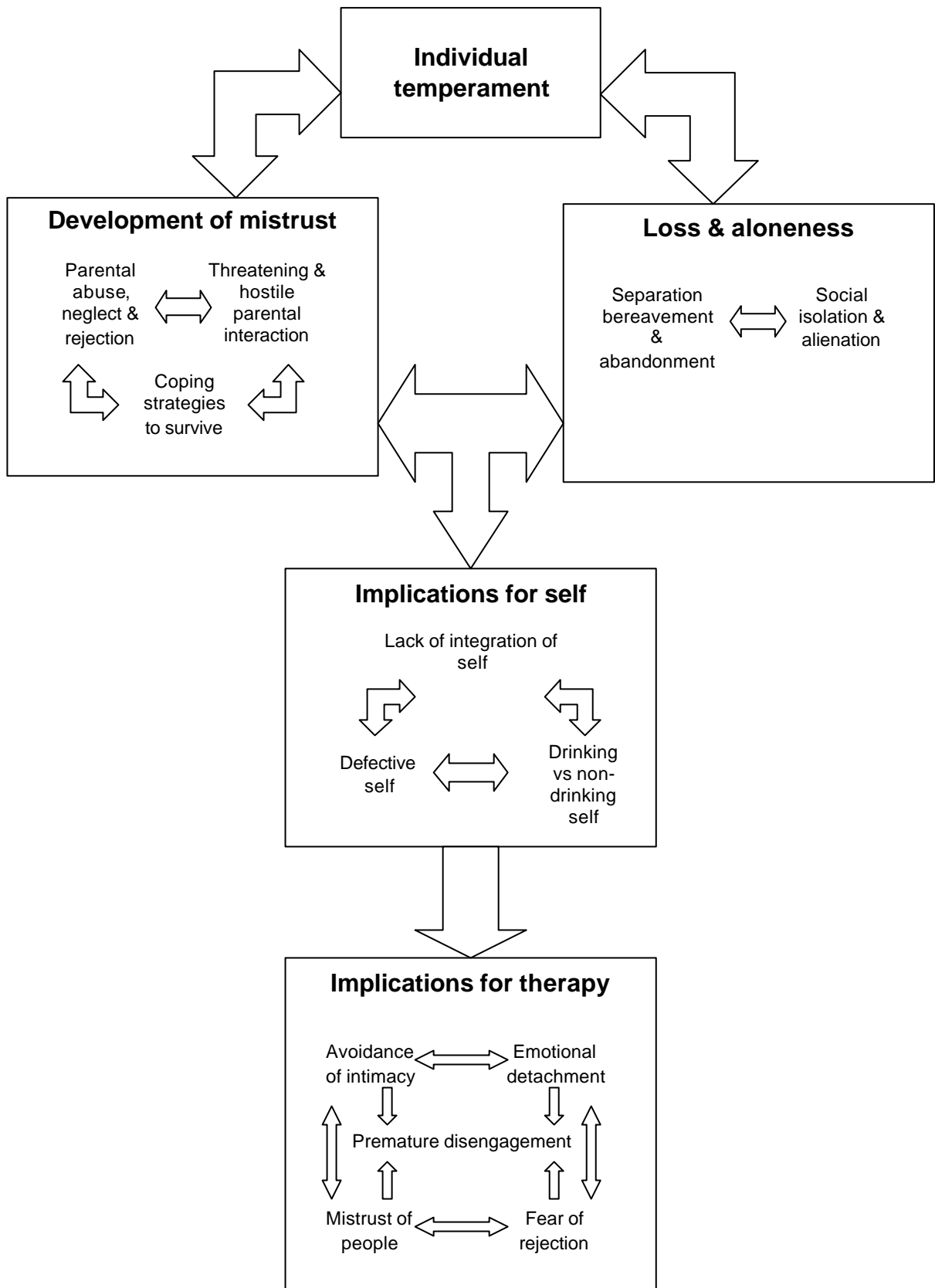
**Table 4: Master Table of Super-ordinate and Sub-ordinate Themes**

Themes	Quotes from Interviews
<b>Development of mistrust in childhood</b>	
1. Parental abuse, neglect and rejection	"Mum told me she didn't want me" "Physical abuse, mental abuse, starved..."
2. Threatening and hostile parental interaction	"They was always arguing all the while" "They would just start scrapping"
3. Coping strategies to survive	"I end up cutting myself" "But I can't remember it"
<b>Loss and aloneness</b>	
4. Separation, bereavement and abandonment	"Now I've got nothing" "They wasn't with me; we were separated"
5. Social isolation and alienation	"People just tend to stay away" "I don't really see anybody; nobody comes here"
<b>Implications for self</b>	
6. Lack of integration of self	"I don't really know" "In both I'm not really being myself"
7. Defective self	"I'm not good enough" "As a pisshead"
8. Drinking versus non-drinking self	"Drinking, I am awful, really awful" "I am quite kind and considerate to people when I am sober"
<b>Implications for therapy</b>	
9. Avoidance of intimacy	"It has stopped me getting close" "I try to keep myself away from people..."
10. Emotional detachment	"That's where I've got the big scars from" "She used to hit me with the pots"
11. Mistrust of people	"There isn't many people I feel I can trust" "They're being friendly for a reason"
12. Fear of rejection	"I was the one who wasn't wanted" "When I was little I was put in a home"

**Table 5: Master Table Indicating how often Super-ordinate Themes were Cited in Individual Transcripts**

Themes	Susan	Tim	Jean	Lydia	Paul	Carl	Brenda	Stan
<b>Development of mistrust in childhood</b>								
1. Parental abuse, neglect and rejection	8	6	6	1	5	16	4	6
2. Threatening and hostile parental interaction	5	7	3	5	1	1	1	4
3. Coping strategies to survive	3	5	4	2	6	3	4	9
<b>Loss and aloneness</b>								
4. Separation, bereavement and abandonment	1	4	3	9	3	2	5	10
5. Social isolation and alienation	7	3	3	4	3	3	9	9
<b>Implications for self</b>								
6. Lack of integration of self	1	3	4	3	4	2	7	6
7. Defective self	2	5	3	6	5	5	6	5
8. Drinking versus non-drinking self	6	3	3	12	5	2	2	5
<b>Implications for therapy</b>								
9. Avoidance of intimacy	5	5	2	1	3	6	8	5
10. Emotional detachment	4	5	1	2	6	6	4	7
11. Mistrust of people	6	4	1	1	7	1	3	2
12. Fear of rejection	3	2	2	3	4	3	6	6

Figure 6: Inter-relationship between Super-ordinate Themes



Within Figure 6 an additional text box was added. Although not identified as a super-ordinate theme, the personal construct of individual temperament was included in the diagram because biological factors such as genetic predisposition and inherent personality traits were considered as contributory influences upon parental interaction, as were birth order within the family (Green, 2003).

Theorists who implicated insecure attachment in the effect of child-parent inter-relatedness upon personal development and possible later adult psychopathology (Bowlby, 1969; Linehan, 1993 & Young, 2003) all acknowledged the combined role of heritable characteristics and environmental influences within their models. As the current study explored the nature of severe alcohol dependence from an attachment perspective, inclusion of internal as well as external factors within Figure 6 was therefore considered a necessary prerequisite to provide a succinct, bio-psychosocial evaluation. However, it was not investigated in the current study, merely acknowledged as a contributory factor, as it would be difficult to distinguish between biological predisposition and environmental influences, such as learned behaviours.

### **Development of mistrust in childhood**

Of the themes analysed, the concept of mistrust emerging from negative childhood experiences was fundamental to close relationship formation and maintenance, in that it seemed to shape not only how the individual negatively perceived self, others and relationships but also inhibited the capacity for later decision-making and positive life choices. The development of mistrust was sub-divided into intrinsically linked, sub-ordinate themes, such as the potentially

destructive impact of parental abuse, neglect and rejection upon the child's self-concept and interpersonal relatedness.

Threatening and aggressive inter-parental interaction prevented the child from trusting in that relationship as a stable and secure base from which to seek support in times of perceived threat; ironically, parents became the source of danger and to be avoided rather than approached. Differing coping strategies, such as alcohol misuse, initially were developed to survive such an unpredictable and hostile environment, which then became possibly maladaptive in adulthood.

### **Loss and aloneness**

This super-ordinate theme of loss and aloneness highlighted the issues around individual, perceived separateness and felt difference, which tended to be the legacy of unresolved, childhood negative experiences. The sub-ordinate themes were separation, bereavement and abandonment and social isolation and alienation. Loss took several forms and could temporarily occur, as in separation due to illness, or had the permanence of death or perceived abandonment, such as in divorce. Isolation appeared to exist at three levels: the physical aloneness, as friends and family withdrew through the alcohol dependent individual's anti-social behaviours; the psychological inability or unwillingness to interact socially, due to lack of self-confidence, low self-esteem or fear of abandonment; and the emotional aspect of feeling ashamed and embarrassed that was also self-isolating.



### **Implications for self**

The two super-ordinate themes previously described had possible serious implications for the individual's sense of self, both in terms of self-esteem development and ability to combine self-concept and others' perception of them into a clear and positive self-identity. The sub-ordinate themes subsequently developed that appeared to create difficulties for the individuals interviewed were lack of integration of self, defective self and the contrasting split between the drinking versus the non-drinking self.

### **Implications for therapy**

The final super-ordinate theme identified contributory factors arising from the analysis that could inhibit the therapeutic relationship and possibly sabotage positive outcomes. The sub-ordinate themes identified were avoidance of intimacy, emotional detachment, mistrust of people generally and fear of rejection, which could potentially create psychological barriers to eliciting and receiving help.

Each super-ordinate and their corresponding sub-ordinate themes were analysed in turn, using evidence from the transcripts, to explore what aspects of participants' early experiences of interpersonal inter-relatedness may have contributed to fearful avoidant attachment and maladaptive schemas around disconnection and rejection revealed earlier in the investigation. It also assisted in informing therapeutic implications for psychologists working with severely alcohol dependent clients.

## **Discussion for the Second Study**

Each super-ordinate and sub-ordinate theme (Table 4) was interpreted in turn, using examples of individual client experiences from their transcripts and linking them to identified recurrent thematic patterns within the dialogues and theoretical analysis and explanation.

### **Development of mistrust in childhood**

This super-ordinate theme suggested an internal, cognitive and affective process occurring that denoted a gradual progression of realisation and disappointment that expectations were unlikely to be fulfilled, due to the perception that people close to you could not be relied upon to meet the basic requirements and that emotional and physical needs were likely to remain unmet. Repeated, negative, interpersonal experiences shaped the formation of maladaptive belief systems and internal working models of self, others and relationships. Three sub-ordinate themes were identified that seemed to contribute to the development of mistrust in formative years and the continuance within adulthood and varying defensive, coping strategies were developed to deal with the degree of negative affect encountered.

#### **1. Parental abuse, neglect and rejection**

Parents as the primary care givers in an infant's life were likely to have the greatest influence upon a child's emotional well-being and personal development and their ability later on to form positive relationships (Bowlby, 1969). Regular, abusive encounters had the capacity to leave a child vulnerable to negative perceptions regarding self and others. Research suggested that the

greater the number of adverse childhood experiences, the higher the risk of developing adult alcohol problems (Dube *et al.*, 2002).

In the current study, the interviews analysed revealed different forms of childhood abuse to varying degrees, some intentional and others a product of circumstance and unfortunate life events, such as death of a parent or divorce. Nonetheless, abuse and neglect in whatever guise by those who were supposed to protect and nurture, it seemed, had the potential to be psychologically damaging in creating and maintaining mistrust of others. Physical abuse by an unpredictable and out of control parent engendered similarly uncontrollable and enduring feelings of helplessness and anxiety that may well have been mediated by alcohol in later years (Howe, 2005). Carl recalled traumatic instances that starkly encompassed all aspects of abuse, neglect and rejection:

*“Physical abuse, mental abuse, starved”. (Carl, line 150)*

In Carl's case, he seemed to angrily hold both parents equally responsible in their cruelty and neglect:

*“They were both drinking; they were both blowing all the money. And there were six kids, don't forget, yeah? We always used to go without for weeks, never had anything”. (Carl, lines 158-161)*

Tim revealed a similar story that incorporated extreme bullying and controlling behaviour, but that was inflicted solely by his mother:

*“I’ve been beaten with odd things like fishing rods you know, I used to have black marks on my back where I was hit with sticks. She used to hit me with the pots; I was beaten with those. My sister was slapped until she wet herself.”*  
(Tim, lines 118-121)

In contrast, Brenda’s siblings appeared to be the main perpetrators, inflicting psychological and physical abuse in the form of abandonment, imprisonment and physical pain, with seemingly little, if any consequences to their actions, suggesting parental paucity of care and concern for Brenda’s needs for protection:

*“K... was spiteful; she’s still spiteful now with me. You know a holly tree; she used to go and get the leaves off and stick them in me, that sort of thing, I think. Um, I remember once they shut me in the airing cupboard, K... shut me in so I couldn’t get out. Um, they left me in the park on a swing. Um, I couldn’t get out; it was one of them with the bar”.* (Brenda, lines 216-220)

An image was conjured of the child Brenda as a helpless and passive victim, invisible to those around her; it was a negative identity that she seemed to absorb and which appeared to be similarly repeated in adulthood with her needs being ignored and not met:

*“I just sat on the bench outside A... crying and nobody asked me, it was a panic attack. And all I could think of was: “I need a drink”. It’s not a very nice thing, is it, really? It’s like a security blanket, I think. Um, it was horrible, ‘cos all I could*

*think of was; "Get off the bus, go straight to the building society then straight back", but I couldn't get back, do you know what I mean? And I thought: "Well, I need to go in somewhere". But I didn't want to go in the shops, so I just sat there on the bench, crying, and no-one took no notice". (Brenda, lines 105-112)*

In her panic, Brenda re-experienced the thoughts and feelings of her childhood and consequently her distress was more acute, increasing the need for alcohol to suppress her overwhelming emotions.

Psychological abuse seemed to be more insidiously pervasive in its inference, eroding self worth and confidence but creating sufficient ambiguity and confusion that was subsequently processed and internalised. The child was therefore viewed as the problem. Stan personalised his parents' apparent neglect of his needs into his naughtiness that necessitated their imprisonment of him, rather than just being a lively little boy who needed attention:

*"They'd spend half the time playing snooker and that, like. I'd wake them up early in the morning, 'cos of me being young and I wanted to get up and watch cartoons and that, and then it was like: "Go away, Stan, we're tired". And I would be like: "But I want to get up" 'cos they used to lock me in the room, like, not because I misbehaved, because I was young, like, and I didn't have a lock I used to go downstairs and 'trash' the entire living room". (Stan, lines 293-299)*

Supportive evidence of developed negative core beliefs regarding 'self' and 'others' was shown in studies exploring self-reporting by adult children of alcoholic parents that suggested predominant patterns of avoidant and

anxious/ambivalent attachment style and avoidance of intimate relationships was largely due to inability to trust and consummate fear of rejection (Kelley *et al.*, 2004; Kelley *et al.*, 2005). Three of the eight participants experienced explicit maternal rejection from birth that engendered feelings of worthlessness and a clear sense of being in the way. Jean's very existence was a cause for seeming dismissal and imbues in her a sense of self-blame and guilt for being there and nothing more:

*"My Mum told me she didn't want me. She was 40 when she had me and if it wasn't for me they could have bought a shop and lived by the seaside".*

*(Jean, lines 111-113)*

Paul was outwardly rejected for being the wrong gender and although he was initially unaware of it, the felt difference that he intuitively felt throughout his childhood was implicit in its destructive nature upon his self-worth:

*"When I was born there was a chance I was going to die and my Auntie went up to my Mother and said, "Look, there's a chance he may not live; what are you going to call him?" And my mother's response was, "If it's a him I am not interested". (Paul, lines 488-492)*

Rejection left a sense of confusion and bewilderment as the child struggled to comprehend his experiences of the lack of relatedness with his mother:

*"I don't know why, I can't explain it. It was just there and that's all I can remember". (Paul, lines 547-549)*

However, Carl was vehement in his memory of being treated less favourably by his mother in relation to his siblings:

*“Well, we all got it in a way, I suppose, but it was me more than anybody, ‘cos I was the one who wasn’t wanted”. (Carl, lines 191-192)*

When Carl’s perception was queried, he clarified with stark reality that was in his mind undeniable, as his mother outwardly rejected him in the company of others, to his shame:

*“She’s told it to people in front of me in the pub”. (Carl, line 200)*

Such humiliation undermined the capacity to trust and constructed a wall of self-reliance as protection. Susan’s more discreet emotional neglect had a similar effect of feeling rejected indirectly and created within her a sense of invisibility and in her words *“unwanted”* that evoked visible and barely containable distress. Although it happened over thirty years ago, she relived in the present the pain and disappointment:

*“Let me get my breath. “Here you are, Mum, here’s my report card”, “Oh, OK, put it on the table”, never looked at it, so when I’d finished, when it was time for the report, books they was then, not the cards, I’d just take it back, put it on the table and just forget about it. I thought, they won’t look through it, nor my Dad, they never did’. (Susan, lines 204-208)*

Bowlby (1980) focused upon maternal deprivation as disruption of affectional bonds and evidence in this study, similarly identified by Fleming *et al.* (1998), suggested this was a contributory factor to insecure attachment, as an image emerged of some over-controlling, critical, emotionally unavailable and manipulative mothers. They seemed to evoke fear and confusion in their offspring who as adults were still seeking to comprehend such seemingly abusive and unreasonable behaviour:

*“She was a very dominant woman”. (Tim, line 103)*

*“Basically, my mother did a ‘divide and conquer”. (Jean, lines 77-78)*

*“She said, “You wouldn’t believe where you used to hide, every time you heard a knock on the door and you thought it was your mother”. You wouldn’t believe me if I told you. I used to hide under my Nan’s skirt out of the way I’d hide. Yeah”. (Carl, lines 170-173)*

*“I suppose it was all jealousy on my Mother’s behalf, I don’t know”. (Carl, lines 231-232)*

That three of the mothers in the interviews were heavy drinkers suggested a possible lack of maternal emotional attunement and an inability to respond adequately and appropriately to their children’s needs (Howe, 2005), creating a further source of anxiety within the child:

*“Basically, my Mum was a drinker”. (Brenda, line 133)*



*"I reckon I take after my Mum 'cos she used to have two litres of sherry a night".  
(Stan, lines 430-431)*

*"They were both drinking; they were both blowing all the money". (Carl, lines  
158-159)*

Inadequate and abusive parenting prevailed, as it seemed that parental needs were placed before those of the child and any expression of need was met with dismissiveness or hostility. What should be a stable and secure base ironically became in itself a threatening and fearful place to be avoided rather than approached for help. Personal accounts of lived experiences recounted a common theme of repeated parental aggression, neglect and rejection that suggested increased risk of developing maladaptive cognitive and affective consequences for the children involved. Often, physically abused children also displayed 'hostile attributional bias', a tendency to perceive negative intent in others' actions, irrespective of whether it was real or not (Howe, 2005). Thus, seeds for suspicion and mistrust were set in early childhood.

The development of an impoverished self-concept combined with negation of existence engendered and internalised feelings of worthlessness, self-blame and guilt. Through parental unavailability and unreliability, the belief developed that the child was not worthy of his/her needs being met and therefore expectation was low of others being either supportive or helpful. Thus, the internal, cognitive template was set for future relationships, in terms of perceived threat and unavailability.

## **2. Threatening and hostile parental interaction**

Although the effect of parent-child interaction has been well researched in terms of evidence of security of attachment (Cassidy & Shaver, 1999), few studies have investigated the possible negative consequences of inter-parental conflict upon children's emotional well being and their subsequent attitudes towards and ability to form and maintain relationships. However, the current study revealed subjective evidence of persistent, verbal and physical abuse between parents witnessed by the children as confused spectators caught in the crossfire of an emotional battlefield; such an experience elicited anxiety and fear, as the family environment, which ought to be a protective and safe space, became an unfriendly and unpredictable place to inhabit.

It may be suggested that the child felt helpless and vulnerable when faced with seemingly out of control parents who seemed intent on hurting one another (Howe, 2005). The perception that one or other parent may be physically harmed or may leave aroused fear around possible abandonment. It was suggested that this state of childhood high arousal and hyper-vigilance became 'hard-wired' into the brain (Green, 2003) and could persist into later years; alcohol possibly acted as an emotional 'dampener' to control increased emotional dysregulation. The child was placed in the uncomfortable and unrelenting predicament of having to repress needs and feelings for fear of exacerbating or becoming the target of the hostility (Howe, 2005).

Being caught in the conflict between his parents over his mother's increasing, smoking-related ill-health was explored through Stan's eyes as a child, as an argument that he witnessed between his parents seemed to precede his

mother's death and his perceived abandonment. Thus Stan's imagined fears of being left alone were realised:

*"That caused a little argument because my Dad was looking after her, like. There was only 2 out of the pack and, em, he was like: "When did you buy them?" And she goes: "Three days ago". "Where?" And so we went round to the shop where she bought it from and said: "Don't serve her fags anymore". Then the next day I went to school 'cos she was starting to get better, and so I went to school and, and sometime in mid-afternoon, er, Dad came to pick us up. All my classmates knew before me that my Mum had died". (Stan, lines 338-345)*

Stan's fears were further exacerbated by the anxiety that his father could also choose to leave in this poignant excerpt that portrayed Stan's perceived helplessness in this sad and desperate situation where all around him seemed to be disintegrating:

*"I felt sorry for my Dad that day, looking out the window, going: "That's it, I can't go on anymore"". (Stan, lines 360-362)*

As a nine year-old boy, Stan had to repress his grief and loss in order to support his father and hopefully prevent him from leaving. In Stan's eyes, relationships were fraught with discord and his experiences had taught him that arguments were usually a fundamental part of relating:

*"You can't be in a relationship if you don't argue". (Stan, lines 311-312)*

It seemed that conflict could take several forms. In Susan's case her memories were of constant fighting between her parents that aroused both frustration and confusion as she struggled to comprehend their relationship, which seemed to oscillate between two polarised extremes of heightened conflict, the only point of connectedness or avoidance and physical separation. Susan unfavourably compared them to squabbling children as she examined their relationship with a seeming fatalistic resignation from an adult perspective, but as a young child it would have been anxiety provoking and unsettling to the extent that she sought refuge:

*"I used to go upstairs in my bedroom, in me and my sister W... 's bedroom to get a bit of peace and quiet so I could do my homework in peace because they was always arguing like two children. They still argue now and they are in their 70s. Yeah. My Dad has to sleep, well he sleeps on the settee downstairs and my mother goes to bed. She won't let him in the bed. Even now, after all these years. It was a weird upbringing, to say the least but, er, it's one of those things". (Susan, lines 233-240)*

Similarly, Tim powerfully described an unpredictable and sometimes violent family environment as "hostile" (Tim, line 111) and like Susan, as an adult he acknowledged the strangeness of the situation, which as a child was likely to have been fearful: "It was a very strange set up". (Tim, line 117)

*"It used to get physical a lot. Um, I can remember when I was a kid I saw, they would just start scrapping whilst we were round at the table". (Tim, lines 115-117)*

Lydia also used the words “*a lot of hostility*” (Lydia, line 134) as she emphasised not only the conflict but also the oppressive effect upon her of the tension between them:

*“Not very good, they were always arguing. My Dad would, um, do his own thing, basically, er, he’d be out late as a chef, um, not very much time for us or my Mum at all. I remember it being quite, quite strained”.* (Lydia, lines 128-130)

The word ‘*hostility*’ originated from the Latin meaning: ‘*stranger, enemy*’ (Soanes & Stevenson, 2005), which suggested the strength of negative feeling and estrangement within these relationships that was seemingly transferred to the children. Jean’s experience, however, was of a more subtle passive-aggressive type, suggesting the relationship was based upon implicit avoidance of emotion, but which seemed to invoke in her similar anxiety, confusion and feeling unsafe:

*“I don’t think they loved each other at all. There was never any arguments or fighting, but there was never any affection”.* (Jean, lines 120-121)

It was known that at least five parents were heavy drinkers, which was likely to have been a source of conflict, heightened emotion and disinhibited behaviour, negatively affecting the social interaction between both partners and children. The lack of emotional attunement between parent and child may have contributed to the development of insecure attachment and compulsive self-reliance within a critical and perilous environment where needs were not likely to have been met (Howe, 2005). Clients’ recalled negative experiences of

interpersonal relatedness suggested consequent core beliefs regarding emotional deprivation and the expectation of unmet needs, combined with schemas around mistrust of others and fear of abuse might well have developed in such children and prevailed as adults.

Of the eight participants, six recalled an atmosphere of parental, high emotional hostility and verbally and/or physically abusive behaviour, which suggested their negative templates for people's interpersonal relatedness was not conducive towards establishing positive and rewarding relationships themselves in adulthood, which may have contributed to their fearful avoidance of emotional intimacy later on (Bowlby, 1969).

Subsequently, their internal working model of how others communicated and acted towards each other was one of perceived threat and negativity or emotional avoidance and suggested a maladaptive avoidant or aggressive approach to social interaction, which was possibly learned relatively early on in childhood, to be repeated in later adult relationships. They all struggled to recall close peer friendships, both in child and later years, which supported research implicating these negative early experiences as crucial within their later social development (Wood *et al.*, 2004).

### **3. Coping strategies to survive**

According to Young *et al.* (2003) the early maladaptive schemas that seemed to prevail at a higher level in alcohol dependent clients than in the general population identified in Section 1 elicited powerful and sometimes overwhelming

emotions that needed to be managed. Individuals in the interviews seemed to develop various coping styles to deal with these potentially threatening feelings that could be categorised in terms of avoidant, over-compensatory or surrendering responses.

Of the eight people interviewed, one woman was in a current long-term relationship, three women had engaged in recurring, abusive patterns of relating, three men had not been involved in an intimate relationship at all or for a long period of time and one man in his sixties had been engaging in seemingly inappropriate relationships with young girls. This suggested a difficulty in forming and maintaining positive, intimate relationships. It was possible that early experiences of betrayal, abuse and abandonment within family dynamics left a legacy of mistrust and disappointment that required defensive coping strategies.

*"I won't let them in". (Susan, line 66)* reflected Susan's avoidant strategy of keeping almost everyone at arm's length in her belief that closeness resulted in betrayal: *"They have all betrayed me". (Susan, lines 115-116)*

Avoidance of intimacy tended to be linked to reliance merely upon superficial relationships, often where alcohol was the only mediating factor and source of connectedness:

*"The only people I end up knowing are people very similar to me". (Carl, line 30)*

Avoidant strategies seemingly allowed the person to maintain emotional and physical distances, creating a sense of perceived control. The importance of the need to feel in control was reflected in Carl's admission that he would deliberately go against people's wishes in order not to experience that negative emotion of feeling helpless:

*"Nobody says, "You can't do that", because if somebody tells me I shouldn't do that, I'll go and do it. I'll do exactly the opposite. And that's how I've always been. People can ask me, but not tell me". (Carl, lines 128-131)*

Sadly, avoidance also maintained the learned belief that intimate relationships were essentially threatening and anxiety provoking and therefore the pattern of avoidance was reinforced and engendered a feeling of misattributed safety.

Another avoidant strategy was to minimise or intellectually justify the abusive or neglectful experiences in order to contain the feelings of distress (Fraley & Shaver, 1997). It seemed that Susan felt guilty about expressing her sadness, to the point that she struggled to express her views, as if she had no entitlement to such feelings. This was echoed in her outward dismissal of the comparative treatment as insignificant, and yet the strength of inner emotion was apparent:

*"Just different little things, just silly little things but I thought well, they used to buy M... things and I used to think, well, it wasn't...; it wasn't just that, at mealtimes and everything. It was just different little things, like. I mean this was a long time ago. But it was just different. It was the feeling". (Susan, lines 187-191)*



Tim rationalised his abusive childhood by positively reframing it as beneficial to his politeness in adulthood that was appreciated by those who knew him:

*“People have commented on my manners, ‘cos I was brought up to be very well-mannered, you know, which has stayed with me to this day, like, ‘cos it was a very strict upbringing and I think some people find that refreshing in this day and age, you know’.* (Tim, lines 151-154)

An extreme form of subconscious avoidance was the person’s seeming difficulty in or reluctance to reflect upon traumatic experiences concerning loss, abuse and separation, possibly to regulate their distress. Fraley and Shaver (1997) suggested that avoidant attached individuals had acquired defence mechanisms to redirect their attention away from anxiety-inducing triggers:

*“I don’t remember, too much but what I do remember it was quite strained really between them”.* (Lydia, lines 135-136)

*“Well I wouldn’t know because I can’t even remember none of that. But according to my Auntie and my Nan and my Uncle I used to get battered”.* (Carl, lines 177-178)

*“I don’t remember that because I was only little”.* (Brenda, line 148)

Another survival coping style existed in the form of over-compensatory strategies such as compliance to offset the perceived sense of difference and unacceptability (Young *et al.*, 2003):

*"I just try and be ordinary, I try to be as nice as can". (Tim, line 141)*

There seemed to be a compulsive need to fit in, in order to feel included, which was demonstrated in several of the clients' interviews. Jean appeared to display a 'chameleon'-like effect by blending in to whichever group she happened to be with at the time:

*"To some people I'm not a drinker; to other people I'm one of the girls. I drink and have totally different relationships with those people. And in both I'm not really being myself". (Jean, lines 29-31)*

Paul assumed a surrogate grand-parenting role that allowed him a feeling of respectability and status to deflect from his lack of self-respect and low self-esteem:

*"I was just like a Granddad to her, literally". (Paul, line 456)*

Another over-compensatory strategy was in the form of compulsive care giving to gain the attention denied them, fill the emptiness inside and deflect from the uncomfortable inner feelings of rejection. The person developed a helping role to feel needed and accepted that became an intrinsic part of their identity. Jean thus became a surrogate 'parent' to the vulnerable women she supported as she seemingly attempted to meet their various needs and in doing so compensated for what she was denied as a child, which possibly eased her emotional pain:

*"I'm very helpful. If anyone needs a hand, then they know I'm there. I'm a 'sorter outer' of other people's problems, emotional and you know, actual, getting the rent paid or whatever they have to do. I baby-sit for them any of the evenings, so they might go out". (Jean, lines 144-147)*

Paul's apparent care giving was more complex as he endeavoured to attain the role as seemingly doting Granddad to a group of similarly disaffected and neglected girls. However, his possible ulterior motives appeared more sinister as he revealed that he condoned un-boundaried behaviour such as smoking and was also due to appear in court on a charge of taking indecent photographs of them. Paul's role as helper could be deemed almost sacrificial in terms of his well being:

*"I've always been there for people even if it's meant my own worth being put outside". (Paul, lines 621-622)*

Parentification of the child in the form of compulsive care giving could occur (West & Keller, 1991). With Stan, his helping role began very early on in his life, with both parents either emotionally unavailable or physically incapacitated:

*"I've always been the, em, like, bloke, like; since my Mum died it's always been me who does like the jobs and that. So even though, before, like, she died it was me who'd do the shopping and that because my Dad's like, disabled, like". (Stan, lines 422-425)*

Possibly, his assuming a caring, parental role to keep the family together reduced Stan's anxieties and felt lack of control around parental illness and his schemas related to feared abandonment. This was a familiar place that Stan found himself in as an adult, helping people out wherever he could:

*"I like the way I think, well I think I'm easy to get on with, like, em, I think I'm good to help, 'cos I help people. A lady round the corner, I do her shopping and that when she 'phones, like, and, er, that's about it really. I just think I'm all right to get on with and I'm good at helping people. I don't mind". (Stan, lines 457-461)*

For some people the compulsive care giving continued through adulthood as it deflected from their low self-esteem and schemas of defectiveness and shame; their worth and identity were seemingly intrinsically linked to their role:

*"It's a strange thing to say but he's the only person I know, and I care for him. It's a 24-hour job, you know". (Brenda, lines 86-87)*

Individual needs were put to one side and the perceived invisibility continued, which was a familiar, albeit uncomfortable place to inhabit.

Individuals used a surrendering coping style, in that they perpetually re-enacted repetitive and abusive patterns of relating that reinforced their low self-esteem and sense of worthlessness and the internal working models of self and others, that they will continue to be abused, betrayed and abandoned. This resulted in

a self-fulfilling prophecy of successive, broken and discarded relationships, as shown in the participants' narratives:

*"I feel like I have tried my best over the years, not one night stands with different partners and they have all betrayed me by either taking money out my purse, that was the last one, he was by far, I think he was the worst one". (Susan, lines 114-117)*

*"I have had relationships in the past and most of those have been drinkers". (Lydia, lines 67-68)*

Although Lydia was only in her early thirties, she had a history of negative experiences of abandonment in relationships; her coping responses were to surrender to her schemas around abandonment by choosing partners who were unreliable, such as drinkers and gamblers. Unwittingly, it was possible that she re-enacted her father's abandonment of her in her adult relationships:

*"They have got two different fathers; I was married twice, so they are with their fathers". (Lydia, lines 79-80)*

Other maladaptive, surrendering coping strategies also occurred, as Susan and Stan vividly portrayed in their described self-harming. Internal, emotional hurt was transferred to physical pain in the form of visible cutting that served as a distraction from the real source of distress:

*“When I lose my temper I have to take it out on myself otherwise I know I’ll hurt someone else again, and I don’t want to do that”. (Stan, lines 209-211)*

With Stan, his self-harming seemed to be either directly related to feelings of extreme anger related to the loss of his mother or distress regarding perceived abandonment in emotional relationships. Similarly, Susan eased her resentment and disappointment related to her parents’ disregard of her achievements by self-harming. Both appeared to try and release negative affect by pain transference, and possibly as a communication of their suffering to the world, but it seemed to remain un-noticed:

*“That was one of the reasons I started doing this when I was about 13, 14 (client showed scars on her arms), cutting myself, because I felt so resentful and they was always arguing all the while and I was trying to do my best at school”. (Susan, lines 229-233)*

Alcohol appeared to act as a mediating factor in all the coping strategies, in that it aided compliance and enabled people to feel socially accepted:

*“It weren’t peer pressure it was just trying to fit in, do you know what I mean?”. (Stan, lines 49-50)*

Alcohol seemed to act as a confidence-giver with most of the people interviewed that helped them to socially integrate, instead of being on the social periphery:

*“I feel able to express myself more, open up a little bit more, more confidence, and be able to speak to people, because in relationships with anybody I am very shy. I just tend to sit back and listen, rather than get involved. Drink did help me to overcome those fears of, of meeting people and talking to them. It just gives me a bit more confidence, I think”. (Lydia, lines 35-39)*

Paradoxically, as alcohol dependence progressed, it also had the capacity to isolate and alienate, thus defeating the original objective and placing them in that lonely place they experienced as a child, feeling lost and vulnerable:

*“I tend to shut myself away. I don’t like people, you know, I don’t like people to see that side of me”. (Tim, lines 30-32)*

Increasing reliance upon alcohol exacerbated the felt difference experienced by many of the participants that initially created their estrangement from peers in childhood and which was insidiously repeated in their adult lives in terms of social exclusion. Through drinking, Brenda tended to re-enact the abandonment and separation she experienced as a child:

*“Well, like I say I don’t really see anybody; nobody comes here so...” (Brenda, lines 47-48)*

Alcohol also had a temporary, sublimating effect, enabling them to forget about past and present traumas for a while, and therefore fulfilled an important purpose in ameliorating high anxiety arousal and low affect triggered by past abusive memories. Although often health professionals identified alcohol

dependence as a maladaptive coping strategy it also had to be acknowledged that for the clients alcohol had perceived positive benefits that they were reluctant to relinquish, which had implications for therapy.

### **Loss and aloneness**

According to Bowlby (1980), childhood separation and loss have a negative impact upon emotional bonding and security of attachment. The absence of a supportive and nurturing relationship with care givers leaves a legacy of intensity of feeling when experiencing loss in adulthood. The gradual, learned ability to cope with separation and loss occurred at an early age. If the child had the stable and secure base of protective, nurturing primary care givers to return to when threat was perceived, he/she became more confident and self-reliant in his/her ability to explore the environment and tolerated separation in the knowledge that safety was present and available and that being united was a positive and rewarding experience. However, if that protection was inconsistent or non-existent or the care giver had become the source of threat, then anxiety was likely to be experienced more acutely in times of loss in the insecurely attached child, as comfort had not been made available to them and neither was there any expectation from the child of parental care and concern.

Compulsive self-reliance was an avoidant coping response employed to manage the feelings of disappointment and protect against anxiety (Young *et al.*, 2003). This defence strategy also taught the child that help was neither forthcoming nor to be expected. However, through continuing experiences of insecure attachment, the child had not been given the coping mechanisms to manage separation and loss, leaving him/her more vulnerable to such



experiences in later life (Howe, 2005). This was evident in the participants interviewed, who revealed diverse experiences of early separation, bereavement and abandonment that influenced their negative, internal working model sense of self, others and relationships.

#### **4. Separation, bereavement and abandonment**

- **Separation**

Early childhood separation from primary care givers could disrupt the emotional bonds and inhibited the formation of secure attachment and had been shown to contribute towards later alcohol misuse (Hope, Power & Rodgers, 1998).

Brenda not only experienced possible emotional distancing from inconsistent and neglectful parenting that rendered her helpless in the hands of her abusive siblings but also physical separation from her family at a very early age, due to illness:

*“They wasn’t with me; we were separated”. (Brenda, line 159)*

This experience of separation combined with childhood feelings of sensed abandonment could possibly be a contributory factor to Brenda’s present chronic anxiety and panic, particularly around feeling alone. She believed that her childhood experiences negatively affected her current mental state:

*“I think a lot of things, a lot of things when I was younger, then into my teenage years I think have affected me up here” (Pointing to her head). (Brenda, lines 231-233)*

Bowlby (1980) maintained that early childhood separation negatively influenced levels of emotional connectedness and ability to form secure attachments later on. Memories of parental absence evoked powerful feelings, which were re-enacted when experiencing loss in adulthood. Loss occurred in different forms; divorce was one of them and perhaps the effect was underestimated from a child's perspective, despite the acknowledgement that the adults' relationship was hostile and unrewarding. Lydia's separation from her father through divorce when she was quite young and the geographical distancing further inhibited them from an emotionally intimate relationship. A feeling of impotence over events that changed her life irrevocably evoked a sense of perceived helplessness that continued into adulthood:

*"My Mum and Dad got divorced, um, um, when I was about 9, I think, um, and then my sister, my mum and I all went to live with my Grandma in N..."*. (Lydia, lines 108-110)

Sadly, Lydia's childhood experiences of separation were re-enacted in the loss of her own children through her drinking, and repeated, generational patterns of insecure attachment were potentially promulgated (Main *et al.*, 1985):

*"When they were taken away I was a mess"*. (Lydia, line 80)

Loss also occurred through imposed segregation, as in Jean's case, when she was socially excluded by her mother's seemingly critical and controlling behaviour. The feelings of humiliation and confusion that became internalised into a negative self-perception remained unspoken, although the resentment in

Jean's voice was noticeable. It was possible that the phrase "*never good enough*" that referred to her friends in the text also implicated her defective sense of self:

*"Nobody. No. No, I wasn't allowed to have friends. Friends were never good enough, always something wrong with them. I wasn't allowed to go to their house; they weren't allowed to come to my house". (Jean, lines 84-86)*

The experience of aloneness evoked in Jean a 'felt difference' that was similar to Brenda's in terms of their enforced separation leading to almost a perception of being punished for their existence that invoked schemas of worthlessness and shame and became internalised to form an integral part of their identity.

- **Bereavement**

Bowlby (1980) suggested that avoidant attached children who suffered the death of a parent were likely to suppress attachment-related feelings and risk suffering from psychological and physical ill-health problems later on in life.

Stan's traumatic, childhood loss of his mother was accentuated by the knowledge that everyone else knew before him that his mother had died and he was excluded and isolated through feeling essentially different from everyone else:

*"My teacher told them, like, so that when I went back, like, they wouldn't, it was kind of like treading on eggshells round me, if you know what I mean, trying not to say nothing wrong or anything". (Stan, lines 349-351)*

The pain of childhood, unresolved loss negatively impacting upon adult life experiences was reflected in Stan's unleashed anger when his friends unwittingly mentioned his Mum, with the consequence of being self-isolating and increasing his sense of aloneness:

*"I try to keep myself away from people because I put one, when I was younger, I put one of my best mates in hospital 'cos he, he was joking about, it was an accident, because he'd forgot my Mum had died, and because he said something about my Mum, so, like, 'cos I lost my temper because he said it, I grabbed him, picked him up upside down, slamming his head off the concrete".*  
(Stan, lines 200-205)

Stan's seeming emotional neediness in intimate relationships exposed his fear of further, uncontrollable loss and the need to self-harm when they ended, to transfer the emotional to physical pain, thus stemming the flow of distressing memories of his Mum's death and their parting.

From a schema theory perspective (Young *et al.*, 2003) Tim's formative experiences of a physically abusive childhood led him to believe that relationships were essentially threatening or emotionally hurtful, reinforced by later multiple losses and the core belief of perceived abandonment maintained and re-enacted in those recurrent losses. Tim therefore tended to contain his feelings of emotional deprivation by avoiding intimate relationships. It was possible that Tim's childhood abusive and isolating experiences at the hands of his mother and subsequent lack of social support left him increasingly vulnerable to bereavement and multiple losses as an adult:

*“Um, my partner died ten years ago and this left me with two sons. Um, they instantly took my youngest son off me and put him into care and then, er, two years ago my eldest son died of a heroin overdose so for most of the time I had a family and now I’ve got nothing”. (Tim, lines 78-82)*

Carl’s perceived responsibility for his father’s death after an argument exacerbated his sense of aloneness and ‘felt difference’ that also maintained his low self-worth and current estrangement from his family. The only emotional connectedness he experienced was with a young man who had lived the same trauma:

*“In a way we’ve got a similar thing between us, so he understands one way, and I understand the way he is, because he actually had a fight with his Dad and he died as well”. (Carl, lines 81-84)*

Their seemingly shameful act appeared to be a closely guarded secret that Carl was not prepared to discuss in the interview, as he swiftly deflected the conversation to a different topic:

*“I did to him, and he talks to me about what happened, but we don’t tell anybody else about it. The staff know but they don’t care anyway, as long as they get their £160 a week they ain’t bothered about no-one. Rent is all they want”. (Carl, lines 105-108)*

The deflection suggested Carl’s involvement in his father’s death was an emotive subject upon which Carl was neither prepared nor equipped to

elaborate, possibly because it put him in touch with emotions he would rather keep at a distance. His compulsive self-reliance and defensive exclusion (Bowlby, 1980) prevented Carl from accessing his distress because his internal working model of others and relationships was based upon fear, threat and rejection. His experiences had taught him that people were not to be trusted with intimate feelings and therefore they remained deeply hidden.

- **Abandonment**

The sense of “*not being good enough*” echoed by Lydia was possibly a childhood perception from her negative experiences of being left by her father, which was repeated in her own relationship and which reinforced her lack of self-worth:

*“I was left on my own with a young baby”. (Lydia, line 30)*

## **5. Social isolation and alienation**

According to Schema theory, individuals employed various strategies to avoid triggering painful and distressing memories, which included avoidance of emotional intimacy and subsequent self-imposed social isolation. With severely alcohol dependent clients, alienation appeared to exist at three distinct levels. Geographical aloneness developed as friends and family withdrew through the alcohol dependent individual’s unacceptable and anti-social behaviours or their lack of social engagement. Psychological isolation engendered from an inability or unwillingness to interact socially was often due to lack of self-confidence or low self-esteem, accumulated from years of abuse. Abuse alienated the child, in that they could not confide in others; they felt different and inferior, as if it was

their fault that the abuse happened, which inhibited them from seeking emotional intimacy (Lisak, 1994). Fear of abandonment also played an important part in their reluctance to engage in emotional intimacy, which increased their sense of isolation. The negative emotional aspect of feeling humiliated, ashamed and embarrassed through parental criticism and rejection and subsequently developed schemas around defectiveness and shame were also self-isolating.

It could be suggested that Susan's avoidant attachment and fear of intimacy evolved from early childhood experiences of parental rejection and coldness. This left her with anxiety and distress from unmet needs that became repressed and internalised due to parental emotional unavailability (Bowlby, 1969). It was difficult to ascertain to whether Susan was alluding to her alcohol dependence or her abusive relationship in this extract, both of which had the capacity to cause imprisonment, one self-imposed for her own protection, the other inflicted by her partner, as she relived her alienation and isolation:

*"You lose most of your friends. Your family don't want to come and see you. Nothing, it's just like you're isolated". (Susan, lines 288-289)*

Susan's inner, perceived worthlessness and feeling unwanted seemed to stem from her perception of being ignored and not valued as a child. It appeared to create a vulnerability and fear of rejection in her that perpetuated the belief that she was somehow deserving of her partner's physical and emotional abuse that prevented her from leaving and kept her trapped and isolated:

*“All the feelings for him, you know, because he would keep my prisoner, like I was stupid, you know and I couldn’t get out of that situation, I couldn’t”. (Susan, lines 277-279)*

Ironically, her abusive relationship reinforced her feelings of inferiority and worthlessness and continued the repeating patterns of neglect from childhood. Similarly, Tim’s traumatic childhood experiences placed him in a state of fearful helplessness, realising that the people closest to you could be a source of physical threat and that people could not be trusted:

*“Um, well I’ve only got one friend at the moment. Um, I feel close to him. Um, (long pause) that’s about it, there’s nobody else, nobody else”. (Tim, lines 61-62)*

Physically abused children’s mental model of ‘self’ tends to be lacking in self-worth and undeserving of nurturing and protection, and stoically accepting that care and protection were not available. Thus, emotional detachment and self-containment prevailed, which sometimes resembled dismissiveness or lack of empathy, as anxiety was present but suppressed (Howe, 2005). Tim appeared to gain control through separating himself from people who harmed him; it felt as if his isolation was self-imposed for his own protection from a perceived hostile and threatening environment but the alienation also had the effect of increasing his vulnerability. There was very much a sense of complete aloneness and fragility with Tim:



*"I'm in my third property now, er, because of bullying by neighbours, you know, um, that's the reason I think I'm picked on by neighbours. Um, the main reason is because I can't fight them because of my disability so, um, that side of it is very negative. The saying is true, you know, people just bump into you and push you to one side so, you know, you know, it's very negative". (Tim, lines 52-57)*

Lydia's alienation tended to be very much related to her drinking:

*"People just tend to stay away". (Lydia, line 48)*

Insecurely attached individuals whose needs were unmet in childhood tended to be fearful of expressing them in intimate relationships, as their expectation was low. Unresolved issues were likely to remain buried until they were triggered. Possibly the anger unleashed through alcohol was linked to powerful, repressed emotions around her felt abandonment as a child that Lydia had been unable to previously express. Events that triggered such similar feelings of rejection evoked anxieties that were also ameliorated by alcohol. Thus Lydia's drinking behaviour risked alienation from partners, friends and family and entrapped her in the isolation she most feared:

*"Sober, I think everybody would say I am a nice person, um, very kind, not selfish, er, but drinking, I am awful, really awful. People just can't stand being around me, listening to me repeating myself, getting all irate and I can't deal with it". (Lydia, lines 56-59)*

The sense of childhood felt difference was associated with feelings of inferiority that prevented the person from engaging in close relationships. Brenda's fear of rejection and abandonment conjured from her early experiences maintained her self-imposed isolation and fuelled the belief that no one cared. Despite the reassurances of her friend who extolled her virtues, Brenda found it hard to believe in her sense of self worth, which had diminished over the years and was further reinforced by her alcohol dependence:

*"Well, like I say I don't really see anybody; nobody comes here so...". (Brenda, lines 47-48)*

Carl's stigmatised sense of shame and humiliation from his parents' systematic and prolonged physical and psychological abuse persisted into adulthood, as he internalised a fight with his father that was accidentally fatal into self-blaming responsibility that became another felt difference and alienating factor, resulting in estrangement from his family:

*"I've not seen any of them". (Carl, line 142)*

Carl held a shameful secret that could only be shared by one who had lived the same experience and their emotional connectedness was maintained through that guilt:

*"I understand where he's coming from and he understands me. In a way we've got a similar thing between us, so he understands one way, and I understand*

*the way he is, because he actually had a fight with his Dad and he died as well".*  
(Carl, lines 80-84)

Alcohol possibly assisted in repressing negative feelings and traumatic memories but also subconsciously served the purpose of further isolation and alienation from people, lest they discovered his secret.

### **Implications for self**

#### **6. Lack of integration of self**

Research (Kinard, 1980) supported the notion that physically abused children had issues regarding self-concept and struggled with a sense of self-identity. All of the participants in the current study revealed an immaturely developed identity and exhibited a diffuseness of self that had been linked to substance misuse in early adulthood (Bishop, Macy-Lewis, Schneklath, Puswella & Struessel, 1997). This lack of integration of self appeared to have its roots in being critically dismissed or ignored or treated with hostility and contempt that left the child with little or no sense of value or positive identity.

The emotional need for attention and comfort was seemingly stifled due to the parental lack of responsiveness or punishment that engendered a compulsive self-reliance that hid an inhibited neediness. Ambivalence and anxiety was fostered that created a sense of confusion and uncertainty within the child, forcing him/her to be hyper-vigilant against further, unwelcome attention and desire not to antagonise further possible hurt. The child learned to conform by

repressing his/her own needs and becoming compliant and self-effacing, constructing a passive identity that aroused minimal hostility.

This malleability of self tended to be transferred into adulthood, as the individual endeavoured to fit in socially by developing transient roles or identities to suit the situation. Brenda seemed to find it difficult to contemplate the possibility that others did not perceive her in the same negative light and that they held a dissimilar view:

*"I don't want to look like a fool. Because I don't like myself, I don't think anybody else would". (Brenda, lines 252-252)*

This inability to imagine others' perception of themselves occurred in several of the participants who could not begin to comprehend how others perceived them, as if it was a difficult question to which they really struggled to respond:

*"I don't know about that. You should be really asking them. Perhaps what I just said really, about being honest with people, I think they do appreciate that". (Tim, lines 149-151)*

This suggested a degree of social incompetence that prevented participants from empathic responses with regard to emotional content. Stan's sense of self was very much entwined with that of his mother, but only to the extent that he related his identity to that of his mother in terms of her destructive drinking and smoking behaviours, rather than emotional connectedness.

*“Er, I think I’m closer to my Mum because, er, I was closer because I, I think that was how I’ve turned out this way because I was closer to my Mum, but I don’t really know why I was closer to my Mum”. (Stan, lines 434-437)*

Stan appeared to have difficulty separating his identity from his mother’s, which suggested that the separation-individuation phase identified in psycho-analytical theory necessary in childhood for personal development had not occurred, resulting in Stan’s confusion around his self-concept. An immaturely developed identity and diffuseness of self has been linked to substance misuse in early adulthood (Bishop *et al.*, 1997). In response to her childhood environment of emotional deprivation, Jean seemed to develop a compliant attitude to minimise the perceived threat of further rejection by adapting a blending in effect with whichever social group she inhabited but acknowledging that she had little sense of who she really was, suggesting a diffuseness of identity:

*“They might think you’re a bit weak or.... The way they relate to you. Different people relate to me in different ways, they see me as a different person. To some people I’m not a drinker; to other people I’m one of the girls. I drink and have totally different relationships with those people. And in both I’m not really being myself”. (Jean, lines 27-31)*

Participants seemed to display similar characteristics to those with personality disorder that was prevalent in alcohol dependence. It suggested personality organisation stemmed from pathological internalised value systems and identity formation (identity diffusion), primitive defence strategies and reduced ability to evaluate and act upon interpersonal interaction, especially within the

emotionally intimate relationship (Lenzenweger & Clarkin, 2005). The sense of self was poorly integrated due to predominantly negative and abusive experiences from primary care givers and the therefore gradual realisation of both positive and negative aspects perceived in the same person did not occur. Thus, confusion and uncertainty regarding self-identity prevailed.

## **7. Defective self**

Alcohol dependence invoked a stigmatised, public image of inferiority and weakness, to which the participants seemed to actively subscribe. A major feature of the interviews was the derogatory self-perception and inability to consider positive aspects of self from their own or others' perspective, with the exception of Jean. Perhaps her adult experience of a long-term, secure, intimate relationship with her partner managed to moderate those negative feelings and challenge her self-concept. Research suggested that the experience of a positive and nurturing adult relationship could offset the negative effect of childhood insecure attachment (Bretherton, 1992). Jean's stable family base of husband and children appeared to act as a mediating factor upon her sense of security: "*My husband, my children*" (131).

For the others, it was as if the self-abasement was firmly established and inculcated into their identity, and could possibly be attributed to pervasive, critical and abusive parenting that repeatedly instilled the message of worthlessness and incompetence from an early age.

It could also be suggested that suppressed anger unable to be expressed towards the primary care giver was turned inwards and internalised into

defensive self-blaming (Cassidy & Shaver, 1999) and implying a defective sense of self that alcohol dependence further reinforced into a self-punishing cognitive, affective and behavioural cycle:

*“I feel quite guilty for the things that I’ve done, um, in the past, like, you know. I could have got well for my children and a lot of guilt issues now around me thinking that I’m not good enough to do things that I’d like to do”. (Lydia, lines 153-157)*

Unresolved anger became self-directed and aimed at others who appeared judgmental and rejecting in their punitive attitude that mirrored Carl’s childhood abusive experiences:

*“As a pisshead, straight to the point, yeah. I mean, I’m known for it round B... I’m known for it in S..., I’m known for it in W..., I’m known for it everywhere. That’s all they think, the same thing, “He’s a pisshead”.”. (Carl, line 64-66)*

Carl seemed to oscillate between anger and acceptance of the self-denigratory label that was bestowed upon him. The anger appeared to exist around his perceived invisibility, in the fact that others seemed to see no further than the alcohol:

*“They don’t see anything else; all they see is the same thing. They never saw anything else at all”. (Carl, lines 70-71)*

Carl also portrayed a sadness and loneliness, that his seemingly lost identity was epitomised by his alcohol dependence. Carl reflected an emptiness of self that had possibly been filled by his role as a drinker. The diminishment of positive attributes seemed to prevent participants such as Paul from accessing any good personal qualities, either that they or others could identify:

*“If you had asked me, had I one redeeming feature I would say no”. (Paul, lines 566-567)*

Paul resignedly took on the mantle of alcoholic, possibly because, according to attachment theory, it was part of his internal working model of how he believed himself to be and due to his childhood experiences of rejection and inferiority by means of his gender, and also how others negatively perceived him:

*“People I know just see me as an ‘alchy’”. (Paul, line 136)*

Brenda inwardly wrestled with the idea of being worthwhile and accepted but it was evidently such a struggle for her to acknowledge a positive self-attribute that she immediately retracted the statement in embarrassed confusion, as if she had no right to even contemplate such a notion:

*“I’d like to think I’m a nice person, um, (Pause) but I really can’t see it myself. I know I am but it’s sort of like, I dunno”. (Brenda, lines 267-269)*

Like Lydia, Brenda was continually self-punishing in her feelings of self-blame and was anxiously hyper-vigilant and emotionally attuned to signs of rejection:



*“And my friend, but she’s disappeared for a few days; I dunno why, and that makes me feel I’ve done something, but I don’t think I have. But, like, I’m always on a guilt trip, so...”. (Brenda, lines 76-78)*

It could be suggested that the development of a defective sense of self began early on through childhood experiences of abuse, critical hostility and rejection that had the potential to eradicate self worth or a sense of feeling valued or wanted, which was integrated into a low self concept. This negative self-perception was maintained by alcohol dependence that reinforced the maladaptive core beliefs around self and also invoked the uncomfortably familiar patterns of critical appraisal from others.

## **8. Drinking versus non-drinking self**

Lack of assimilation of identity was reflected in the seeming, distinct separateness between drinking and non-drinking self in participants. In some, alcohol seemed to create a split ‘Jekyll and Hyde’ personality:

*“Sober, I think everybody would say I am a nice person, um, very kind, not selfish, er, but drinking, I am awful, really awful”. (Lydia, lines 56-57)*

It was possible to suggest that alcohol’s disinhibiting effect released negative emotion related to unresolved, unmet needs. Ironically, in Lydia’s case, her unleashed, uncontrollable anger merely served to reinforce and realise her fears around abandonment. In contrast, there appeared to be no positive side to

Carl who wore the label of drinker that seemed to encapsulate his negative identity and there was no sense of his existence without alcohol:

*“They think, well, you know what they’re saying as they walk up the road with the cans in your pocket and your hand or bags or wherever you’ve got ‘em. You know what they’re saying, “Pissed up again”. You know exactly what they’re saying. I could go and write the script for them if they want’ . (Carl, lines 41-45)*

I felt that Carl’s perception of how others saw him was inseparable from his own, which supported the notion of diffuseness of identity.

Ironically, initially alcohol appeared have a positive effect by imbuing some individuals with a self-confidence that had previously eluded them, enabling a feeling of social inclusion and lessening the sense of felt difference previously experienced:

*“I’ve noticed, em, like, I have got on with people a lot better, like, since I’ve been drinking because before I used to be moody but not mood swings, like, I’d be, like, the really quiet one and, like, just give one word answers, but I’ve noticed that since I’ve been drinking I’ve been more talkative, so, er, and I’ve made a lot more friends”. (Stan, lines 59-63)*

Similarly, Tim enjoyed the initial feeling of temporary mood swing of empowerment and perceived control within the metamorphosis from quiet introvert to someone who exuded confidence and personality:

*“Um, it gave me a lot of confidence, um, so without it I wasn’t happy, you know, very shy around people. It gave me the ability to come out of my shell, um, be a bit of a ‘Jack the Lad’ and do a lot of things you wouldn’t have dreamt of doing, you know. There always seemed to be a negative side of it, after the initial, and that’s the way of it now”. (Tim, lines 10-15)*

However, Tim also acknowledged the temporary mood changes were unsustainable and that the long-term insidiously destructive effect of alcohol merely eroded the negative self-concept further.

Brenda’s low self-worth accumulated from childhood abuse and neglect was epitomised in her self-denigratory description that she believed incorporated others’ negative perception. It was suggested that these entrenched maladaptive beliefs related to self and others began far earlier than the alcohol dependence, and that alcohol merely served to support and maintain the maladaptive schemas related to defectiveness and shame:

*“Oh, here’s the drunk coming”. (Brenda, line 65)*

Some of the participants in the current study, such as Lydia and Susan, appeared to clearly distinguish between the positive and negative aspects of drinking versus non-drinking selves; Tim and Stan identified how drinking brought forth temporarily elements of themselves that they longed for, a sense of inclusion and acceptance, of being, whereas others’ identity was so intrinsically linked to their image of the ‘alcoholic’ self that a sober self was unimaginable and possibly unattainable. To remove the alcohol dependence

could imply the eradication of self, which would be a difficult if not impossible concept to grasp.

## **Implications for therapy**

### **9. Avoidance of intimacy**

Severe alcohol dependence suggested a greater degree of avoidant attachment style that placed importance of relationships as secondary and emphasised discomfort with closeness. A possible explanation derived from the current study was adverse childhood experiences of close relationships and past attempted expression of needs were met with either hostility or rejection or both, instilling in the child the belief that emotional intimacy was fraught with peril and best avoided. This internal working model of negative interpersonal relatedness and subsequent self-containment was carried into adulthood and created an issue for the intimate, therapeutic relationship (Bowlby, 1969):

*"I suppose with present relationships as well, it has stopped me getting close to people. Um, I fear it happening again, talking about it". (Tim, lines 87-89)*

Tim's accumulative, negative experiences of early rejection, hurt and loss that continued as an adult resulted in his building an impenetrable, psychological barrier as protective defence against further pain and distress. Similarly with Carl, his avoidance of emotional intimacy protected him from the shame that people could discover his secret and his shameful self could be revealed:

*"We grew up together since we was two, but I never see him now, I never seen him for 18 years. I haven't seen none of them, none of my friends". (Carl, lines 136-138)*

Carl avoided discussing the death of his father, which was very personal, in the interview and it is possible to suggest he might continue those safety-seeking, avoidant strategies in the counselling room unless he felt safe and contained.

Susan recalled painful details of her last, close relationship that was both extremely abusive and controlling:

*"I wouldn't listen to him. I wish I had of done now. I wouldn't have been like this, two broken noses, broken ribs, covered in bruises". (Susan, lines 271-272)*

Her experiences invoked wariness of intimacy and a resistance against any aspect of perceived controlling by the therapist.

Clients' sense of shame and felt stupidity at their helplessness, exacerbated by their negative self perception, erected an emotional barrier that inhibited them from entering into the therapeutic alliance and working effectively. The intimacy required could be initially threatening and anxiety provoking and necessitated a safe space created by a gradual, genuine and empathic approach based upon unconditional, positive regard (Rogers, 1951), so that the client felt in control.

## **10. Emotional detachment**

Emotional detachment was a protective defensive mechanism to avoid distress, known in Schema Therapy as the '*detached protector mode*' by disconnecting

the cognitive, rationalising aspect from the feeling-laden element of lived experience (Young *et al.*, 2003). Carl discussed traumatic childhood abuse with seeming nonchalance as if unaffected by the experience, but acknowledged intellectually that his mother almost certainly would have been imprisoned for the abuse and neglect served against him and his siblings:

*“If they had these same laws now, in my day, my mother would have done a lot of time. She would”. (Carl, lines 208-209)*

Research suggests that the physically abused child attempted to minimise reflecting and mentalising through fear of unleashing uncontrollable feelings (Howe, 2005). It was as if Carl had severed the emotional aspect of his experiences as a survival strategy, possibly to prevent overwhelming emotions of anger and despair. Children who have been subjected to chronic physical abuse have been shown to display inhibited affect, emotional detachment and estrangement (Kolko, 1996). Similarly, Stan described the death of his mother with apparent emotional detachment that was learned as a child, as he focused upon his TV programme to deflect from his grief that threatened to engulf him. Stan’s need for self-reliance invoked an initially protective coping mechanism that could become maladaptive in the therapeutic environment, when the therapy involved engaging in reconnecting painful and distressing thoughts and feelings:

*“Well, to tell the truth when my Mum died all I wanted to do was watch ‘Hangar 17’. I don’t know why”. (Stan, lines 355-356)*

Emotional detachment was sometimes maintained by minimisation of trauma to avoid eliciting repressed, unpleasant memories. Tim reframed his physically abusive and frightening childhood experiences at the hands of his mother into a seemingly more positive experience that later imbued him with good manners and behaviour:

*“It was a very strict upbringing”. (Tim, line 153)*

Emotional detachment appeared to be a learned survival strategy that initially acted as protective defence for the child, but then became maladaptive in adulthood, as the individual presented as seemingly dismissive and uncaring, but was really afraid of emotional intimacy. The therapist needed to gradually break down the psychological barrier of detachment to integrate feelings and thoughts from past, unresolved issues.

### **11. Mistrust of people**

Childhood experiences of intermittent or neglectful care by those who were deemed to be the nurturing protectors in an unpredictable and sometimes hostile environment engendered in the child an inability to trust others. Their internal working model of relationships was one of disappointment and unfulfilled expectation, which evoked compulsive self-reliance and self-containment as internal defences against further rejection. Often, physically abused children display ‘hostile attributional bias’, a tendency to perceive negative intent in others’ actions, irrespective of whether it is real or not (Howe, 2005).

The participants recalled few childhood friends or close relationships whilst they were growing up. A study identified a positive correlation between insecure attachment and later peer rejection, which suggested the importance early on of attachment type (Wood *et al.*, 2004). Insecurely attached children who had models of intimacy avoidance or inconsistency or an expectancy of relational conflict exhibited non-compliant, annoying, sometimes aggressive behaviour that mirrored their experiences and expectations of relationships, resulting in peer rejection. It was possible the participants experienced similar difficulties in their developing years.

Often, mistrust through fear of further abuse was reinforced when adult relationships created a self-fulfilling prophecy by repeating those early negative experiences as the vulnerable adult with perceived worthlessness and low self-esteem felt that he/she was undeserving of care and concern. Susan found it difficult to trust people after repeated abuse and betrayal that isolated her from the possibility of experiencing a positive and rewarding relationship. Thus, the cycle of mistrust, avoidance and alienation was perpetuated, with little likelihood of change:

*“There isn’t many people that I feel I can trust”. (Susan, line 92)*

Mistrust created a challenge for the therapist to facilitate a trusting and safe environment where for perhaps the first time a client could experience a positive attachment towards another individual. Inevitably, the client would be initially hyper-vigilant for possible ulterior motives and suspicious of warmth and interest, an unfamiliar concept:



*“Well, I can get on with people but I don’t see anybody. Um, I don’t like people, but I think that’s me generally, I find it difficult to (Sigh). I’d like to think I can get on with people but then I always think there’s, that they’re being friendly for a reason, you know, that there’s something behind it”. (Brenda, lines 36-39)*

Similarly, Paul felt that he had been mistreated over the years and that abuse was a familiar if uncomfortable place to inhabit:

*“I’ve only had three real friends. You know, that’s true. Um, most of the others that I have been with have been abusing me”. (Paul, lines 44-46)*

Establishing trust within the therapeutic relationship was a gradual process. Awareness of the need for consistency was also required when working with clients that had continually experienced threatening unpredictability. Clients possessing the maladaptive schema of mistrust and abuse might be attuned to the possibility of betrayal and disappointment and a schema-based approach could assist in challenging these unhelpful core beliefs.

## **12. Fear of rejection**

A higher level of fearful avoidant attachment style revealed in severely alcohol dependent clients suggested an internal conflict between needing yet dismissing emotional intimacy due to fear of rejection (Feeney & Noller, 1996). Stan struggled with the dynamics of the intimate relationship because possibly he was unsure how to manage interpersonal relatedness. His confusing experiences had been based upon perceived abandonment and conflict and unwittingly Stan seemingly engineered rejection through his emotional

neediness that possibly stemmed from the early death of his Mum and lack of nurturing from his father who paradoxically relied upon the child Stan for emotional support:

*“It turned out because I was too clingy, I don’t want to lose her so it affects me in that way”. (Stan, lines 186-188)*

Lydia also revealed an almost desperate, emotional clinginess, as if she needed to remain close to him, otherwise he could disappear:

*“My partner is, I’m very, very, very close to. He has helped me out so much and he is understanding me as well”. (Lydia, lines 65-67)*

Fear of rejection due to perceived worthlessness was an immensely powerful and sometimes destructive force, in that it kept people trapped in abusive relationships. Sadly, Susan negatively misattributed her helpless vulnerability into stupidity, which fitted with her internal working model of criticism and neglect and reinforced her core beliefs around fear of not being wanted:

*“That went a long time before, um, they put him in prison. All the feelings for him, you know, because he would keep my prisoner, like I was stupid, you know and I couldn’t get out of that situation, I couldn’t”. (Susan, lines 276-279)*

Fear of rejection was also potentially a destructive force within the therapeutic setting, with the possibility that the client, fearing abandonment, would subconsciously sabotage the relationship by intermittent or non-attendance and

consequently be discharged from the service unless the therapist was aware of the implicit, dynamic process occurring.

## Section 3 – Integrated Analysis

### Discussion

Previous research suggested that predisposition towards alcohol dependence and avoidant attachment may be linked to external, environmental factors such as adverse childhood experiences of interpersonal relationships (Bernstein *et al.*, 1998; Dube *et al.*, 2002). Such experiences present risk factors for mental health co-morbidity and dual diagnosis (Evans & Sullivan, 2001) positively correlated with anxiety, depression (Mirsal *et al.*, 2004) and personality disorder (Bernstein *et al.*, 1998; Bowden-Jones *et al.*, 2004) and maladaptive core beliefs development (Brotchie *et al.*, 2004). However, causality was difficult to establish due to several, confounding variables and methodological limitations.

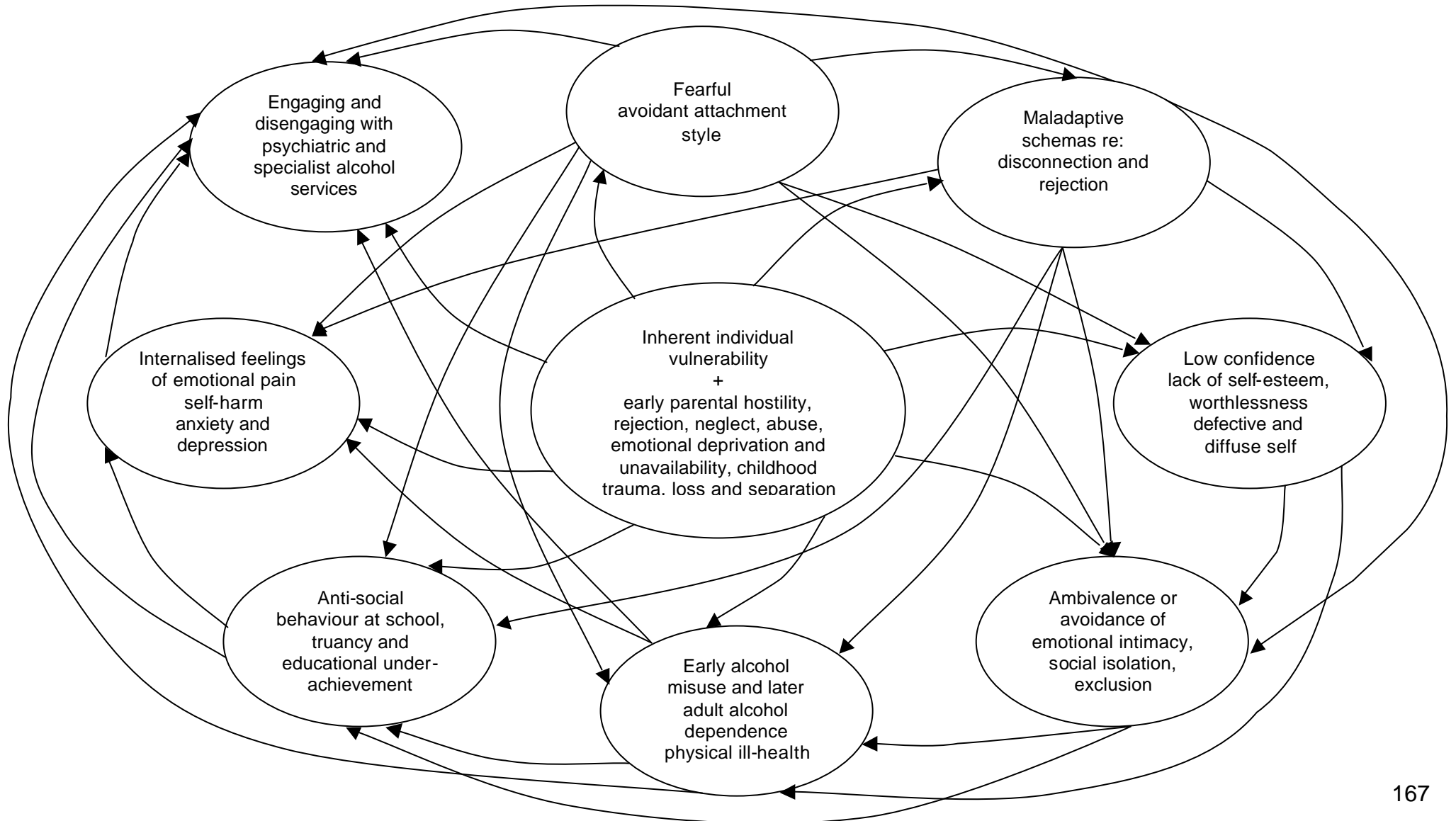
The aim of the current study was to investigate, from a psychosocial perspective (see Figure 7, page 167), associations between avoidant attachment style and early maladaptive schemas related to disconnection and rejection. It explored possible aetiological factors of adverse childhood experiences in severely alcohol dependent clients that might inhibit emotional intimacy and social interaction and whether this group significantly differed from non-problematic drinkers. Figure 7 portrayed the inextricably linked, inherent individual traits viewed and external influences of parental abuse (Bowlby, 1969; Young *et al.*, 2003) as central to the radiating and interwoven, emotional, psychological and behavioural difficulties that may ensue.

Often, one aspect may impact upon several others in a dynamic cycle of events and experiences. Interestingly, at first glance the diagram seemed to have an enmeshed, 'organic' feel, as if acting as a metaphor for the brain's neural

network system and possibly reflecting the neurological disruption and disorganisation that long-term abuse can create (Green, 2003). It highlighted the multi-faceted effects of early negative social interaction upon insecure attachment.

The current study analysed past and present, subjective experiences of eight severely alcohol dependent clients with regard to interpersonal relatedness to identify what cognitive, affective and behavioural aspects of insecure attachment and core beliefs posed a risk of developing and maintaining alcohol misuse. The outcome of the current study revealed implications for therapy in specialist alcohol services.

**Figure 7: Bio-psychosocial Interrelatedness of Contributory Factors to Alcohol Dependence**



Results of an Attachment Style Questionnaire (Feeney *et al.*, 1994) from the comparative study between 54 alcohol dependent clients and a control group of 54 NHS workers revealed those with severe alcohol dependence were more likely to possess significantly higher aspects of both avoidant and ambivalent attachment and lower levels of secure attachment on average than non-problematic drinkers. The similar results for both insecure attachment characteristics implied a possible ambivalence related to emotional intimacy, which drove preoccupation with relationships, rather than neediness (Feeney *et al.*, 1994).

Similar results also suggested that avoidance may be anxiety-related, rather than based upon dismissiveness, and that the two aspects of insecure attachment were not as dissimilar as first posited by forced-choice measures (Bartholomew & Horowitz, 1991). This mutual reciprocity and overlapping of dimensions suggested a 'fearful avoidant' attachment style in some severely alcohol dependant clients identified by Feeney and Noller (1996) that reflected an internal conflict between needing yet resisting emotional intimacy through fear of rejection or further hurt, which may be misattributed to dismissiveness.

The Attachment Style Questionnaire (Feeney *et al.*, 1994) used was developed from Bowlby's (1969) research on attachment, involving separated and institutionalised children, who theorised that absence, disruption to or denial of emotional bonding through maternal loss, rejection, deprivation, abuse and/or physical and emotional neglect resulted in the child's ambivalence towards, and reluctance or inability to form, intimate relationships later on in life, namely insecure attachment.

Research has shown that physically abused children tended to be avoidantly attached and neglected children showed anxious/ambivalent attachment styles (Finzi, Cohen, Sapir & Weizman, 2000). IPA analysis conducted using eight severely alcohol dependent clients' interviews, with self-reported childhood experiences showing common themes around varying degrees of parental physical and psychological abuse, emotional deprivation and neglect: "*Physical abuse, mental abuse, starved*". (Carl, line 150), supported the combined dimensions of alcohol dependent clients' avoidant and ambivalent attachment style, revealed in the current study.

In three clients' relived experiences, explicit maternal rejection was also recalled: "*My Mum told me she didn't want me.*" (Jean, line 111). This was also supported in a study of severely alcohol dependent clients that implicated maternal dysfunction as a factor and revealed a complex relationship between childhood abuse, associative PTSD and co-morbid and affective anxiety disorders (Allen, 2001; Langeland *et al.*, 2004). The current study clearly suggests severely alcohol dependent clients' childhood parental adversity and rejection as aetiological factors for the formation of insecure attachment and maintenance of maladaptive schemas.

Themes of temporary and permanent separation and loss during childhood due to illness, bereavement or divorce and unforeseeable behaviour that oscillated between mutual aggression and emotional avoidance between parents also implied a pervasive and insidious influence upon the formation of fearful avoidant attachment style. The unpredictable and hostile nature of both parent-



child and parent-parent interaction appeared to invoke anxiety, perceived helplessness and hyper-vigilance guarding against threat.

Bowlby (1980) suggested that internal working models of self, others and relationships developed, through repetitive experiences and became long lasting and relatively stable, mental representations of attachment relationships as the child became an adult. This unconscious processing formed familiar cognitive, affective and behavioural patterns that were increasingly resistant to change.

Young *et al.* (2003) redefined these models as 'early maladaptive schemas', namely, repetitive, self-defeating learned patterns of cognition and behaviour, arising from unrequited childhood needs. Young (1999) argued that temperament and individual personality characteristics interacted with a threatening, possibly hostile and rejecting environment; he suggested that the inherently vulnerable child acquired maladaptive coping strategies to deal with these unmet needs; this could include alcohol misuse.

Young's Schema Questionnaire (shortened version, Young & Brown, 2001) was used to assess core beliefs around perceived mistrust and abuse, emotional deprivation, abandonment/instability, defectiveness and shame and social isolation/alienation. Severely alcohol dependent clients scored significantly higher on average in all five schemas than non-problematic drinkers, suggesting they were unlikely to believe their needs would be met, due to past abuse and betrayal from others' ulterior motives, others' lack of care and concern and

clients' own perceived worthlessness and felt difference that alienated them: "*It was just different. It was the feeling*" (Susan, line 191).

Young *et al.* (2003) argued that clients who possessed schemas in the domain of disconnection and rejection tended to be the most psychologically damaged and found it really difficult to form and maintain intimate and rewarding relationships. There was usually an early pattern of abusive, cold and rejecting parenting, with little stability or nurturing, which was highlighted in the client interviews: "*I thought, they won't look through it, nor my Dad, they never did*" (Susan, line 208). Unavailable and inconsistent parenting may well have been exacerbated by at least five parents acknowledged in the interviews as alcohol misusers, which research suggested contributed to insecurity of attachment style in adult children of drinkers (Kelley *et al.*, 2005): "*They were both drinking; they were both blowing all the money*" (Carl, lines 158-159).

However, a longitudinal study comparing vulnerable and matched samples of adolescents revealed the influence of a positive and nurturing family environment, irrespective of parents' alcohol intake, as a moderator of peer inclination to drink excessively; absence of supportive parental input presented a risk factor of abusing alcohol (Nash, McQueen & Bray, 2005). With the clients interviewed, it was apparent that neglectful and abusive parenting seemed to coincide with alcohol misuse and that both appeared to be risk factors in developing severe alcohol dependence.

A strong, positive association between severely alcohol dependent clients' fearful avoidant attachment style and higher level of maladaptive schemas in

the domain of disconnection and rejection suggested possible psychosocial, contributory factors towards development and maintenance of negative core beliefs that exacerbated avoidance of intimacy.

In the current study, distorted perceptions around mistrust of relationships in general, fear of abuse, rejection and abandonment, negative affect around defectiveness and shame and feeling isolated and alienated seemed to prevail at a significantly higher level on average in severely alcohol dependent clients than non-problematic drinkers. However, individual variance suggested that this was not necessarily true for all clients.

A bio-psychosocial approach linked adverse childhood experiences and the possible negative effect of such trauma upon later ability to engage with and maintain emotional intimacy within relationships to the brain's development (Green, 2003; Stien & Kendall, 2004). This theory was supported by a review (Glaser, 2000) that explored the effects of child abuse and neglect upon the brain's biological structure, development and function. It argued that chronic stress induced by prolonged child maltreatment could result in perpetual hyper-arousal by the autonomic nervous system.

Severe alcohol dependence could be explained by the activation of 'flight/fight' responses, whereby an insecurely attached child subjected to the fearful presence of perpetual abuse and uncertainty within the family, vividly described in the client interviews, developed a hyper-vigilant arousal system and was consequently biologically 'hard-wired' from an early age to expect threat. The child therefore became more vulnerable and attuned to anxiety-provoking

situations. An earlier critical review (Stewart, 1996) explored the link between alcohol misuse, exposure to trauma and subsequent PTSD symptoms, particularly in relation to childhood physical and/or sexual abuse. This was further supported in recent research that suggested a model of disruption to the right brain's developmental progress, due to early abuse, that impaired the coping mechanisms to deal with relational stress, resulting in emotional dysregulation and PTSD-type symptomatology (Schore, 2002; Stien & Kendall, 2004; Teicher *et al.*, 2003 ).

A reasonable explanation was that initially alcohol reduced or controlled unpleasant and intrusive PTSD symptoms, but which then developed into a further problem to be treated. The emotional regulatory system was thus impaired from early childhood; it is possible that in early and late teens, which was when the clients interviewed began their history of drinking, alcohol served to assist in reducing chronic, raised anxiety levels: "*I mean that's like I have been drinking since I was about 12*" (Stan, line 3). Stan's drinking from the age of 12 coincided with a longitudinal study that revealed that the younger the child was at onset of drinking, particularly at age 13 or younger, the greater likelihood of developing adult alcohol dependence (Pitkanen *et al.*, 2005).

It was possible to suggest that alcohol misuse ameliorated anxiety and negative affect triggered by traumatic and invalidating childhood experiences. A plausible model suggested that alcohol misuse was symptomatic of psychological disorder and acted as a buffer between childhood sexual and/or physical abuse and adult mental health problems, which were often linked to severe alcohol dependence (Thatcher *et al.*, 2005). It could be suggested that alcohol assisted

in moderating the emotional dysregulation commonly occurring with interpersonal difficulties and was possibly a form of self-medication for the clients interviewed to repress painful and distressing childhood memories of abuse and neglect.

Severely alcohol dependent clients' early recollections of negative interpersonal inter-relatedness appeared to have had a disruptive and inhibiting effect upon the child's developing sense of self, others and relationships. Repeated patterns of critical and rejecting behaviour seemed to engender a diffuse and negative sense of identity based upon instilled core beliefs of worthlessness and defectiveness: "*If you had asked me, had I one redeeming feature I would say no*" (Paul, lines 566-567). This was supported in a study of college drinkers, whereby a negative view of self and insecurity around relationships, in terms of feeling "*both inadequate and undeserving*" predicted greater likelihood of alcohol problems to cope with these negative cognitions and affect (McNally *et al.*, 2003).

A possible explanation for lack of identity could be found in disordered personality organisation, which can co-exist with severe alcohol dependence, and which stemmed from pathological internalised value systems and identity formation (identity diffusion), primitive defence strategies and reduced ability to evaluate and act upon interpersonal interaction, especially within the emotionally intimate relationship.

Herman (1982) suggested:

*“Repeated trauma in adult life erodes the structure of the personality already formed but repeated trauma in childhood forms and deforms the personality.”*

Herman (2001) believed personality disorder characteristics epitomised a specific type of post-traumatic stress disorder that implicated identity and relationship disruption through prolonged childhood abuse. The sense of self was poorly integrated due to negative and abusive experiences from primary care givers; the gradual realisation of both positive and negative aspects perceived in the same ‘object’ did not occur, resulting in a ‘splitting’ between the idealised (good) and the persecutory (bad) components.

All of the participants in section 2 of the current study revealed an immaturely developed identity and exhibited a diffuseness of self that has been linked to substance misuse in early adulthood (Bishop *et al.*, 1997). Intrinsically linked primitive defence mechanisms, such as projective identification, denial, idealisation, devaluation, omnipotence and omnipotent control maintained the splitting. These personality characteristics inhibited and distorted interpersonal relationships and the ability to estimate others’ motives and subsequent actions; it affected all aspects of social functioning, exacerbated by sporadic, intense emotional states (‘affect storms’) and impoverished impulse control, leaving the individual in a state of isolated confusion and uncertainty (Lenzenweger & Clarkin, 2005). This description epitomised the severely alcohol dependent clients interviewed with their seeming social incompetence, emotional dysregulation and interpersonal difficulties: *“When I lose my temper I have to*

*take it out on myself otherwise I know I'll hurt someone else again" (Stan, lines 209-210).*

The interviewed clients displayed difficulty in reading and interpreting others' beliefs as different from their own, similar to the 'theory of mind' social deficits observed in mild autistic impairment; however, this could also result from lack of positive and rewarding social interaction that may have merely left them socially inept. Difficulty in imagining others' perception of themselves occurred in all but one of the participants; they could not begin to comprehend how others saw them, as if it was an imponderable question to which they really struggled to respond. Crittendon (1995) maintained that physically abused children learned avoidant behaviour and inhibition of negative affect to placate the hostile and emotionally unavailable parent but not how to evoke nurturing and protective responses in others, nor at recognising it in intimate relationships in adulthood. This could lead to social incompetence and impoverished emotional intellect.

Negative core beliefs regarding 'self' and 'others' were replicated in studies exploring self-reporting by adult children of alcoholic parents that suggested predominant patterns of avoidant and anxious/ambivalent attachment style and avoidance of intimate relationships, due to inability to trust and consummate fear of rejection (Kelley *et al.*, 2005). The level of insecure attachment style does seem to play an important role in determining risk factors for self-perception and interpersonal relatedness, emotional and physical wellbeing, and developing substance misuse later on in life.

Insecure attachment style has been associated with attachment psychopathology, such as compulsive care seeking, angry withdrawal and compulsive self-reliance (Lapsley *et al.*, 2000). The severely alcohol dependent clients interviewed appeared to use avoidant, surrendering or over-compensatory coping strategies identified in Young's Schema Theory (Young *et al.*, 2003), initially as children to survive the seemingly critical and threatening environment, which then became maladaptive into adulthood; these included self-reliance and self-containment as learned, protective defences against expected disappointment and rejection. They tolerated similarly abusive adult relationships because they felt they deserved nothing more due to low self-confidence and perceived worthlessness and engaging in compliant and compulsive care giving behaviours respectively to negate feelings of low self-worth: "*I'm very helpful*" (Jean, line 144).

Alcohol seemed to play a dichotomous role, in that initially it served to deflect from the alcohol clients' felt difference and aloneness, allowing them a feeling of confidence that enabled them to engage socially. Alcohol enabled a degree of social inclusion and emotional connectedness, albeit superficial and temporary. However, as the alcohol dependence progressed, it merely increased the likelihood of being abused, neglected or betrayed in adult relationships and increased the sense of shame and defectiveness, thus reinforcing the maladaptive schemas around disconnection and rejection.

Fearful avoidant attachment style and maladaptive schemas in the domain of disconnection and rejection from abusive childhood experiences were deemed to have implications for therapy around severely alcohol dependant clients'



difficulty in maintaining a therapeutic relationship and the possibility of premature disengagement from services. Research queried the long-lasting benefit of CBT techniques (Wutzke *et al.*, 2002) for such vulnerable and avoidant clients whose entrenched beliefs may be resistant to change (Young *et al.*, 2003).

The current study advocated a screening procedure to ascertain those insecurely attached clients at risk of premature disengagement from services and who may require longer term, therapeutic interventions that incorporated a schema-based element to challenge and construct more adaptive core beliefs and effective coping mechanisms around interpersonal inter-relatedness. Thus clients began to experience feeling more in control than being controlled, which was threatening to them: *"Nobody says, "You can't do that", because if somebody tells me I shouldn't do that, I'll go and do it. I'll do exactly the opposite"* (Carl, lines 128-129).

Severely alcohol dependent clients may then begin to experience rather than avoid more rewarding and emotionally intimate relationships previously denied them and gain access to social and emotional support that may reduce the risk of repeated relapse and the 'revolving door' syndrome currently displayed in specialist alcohol services.

## **Research Issues Arising from the Study**

There were several issues for discussion arising from conducting the study.

Firstly, the acknowledgement of the difference between the two groups, in terms of the controls coming from a working population in comparison to the client group who were mostly unemployed. This had implications for the increased interpersonal skills, self-esteem, confidence and social network support that came with employment, which may have influenced the outcomes of the questionnaires. Equally, however, there is also the possibility that some people were unhappy, felt inadequate or undermined in their employment, which may have negatively affected their confidence or self-esteem. It would have been difficult to find a matched group, with the practical and ethical implications of interviewing, for example, people from unemployment agencies.

It could be argued that a number of control participants may have had access to prior knowledge of the research conducted on their work premises, which may have influenced their responses. This was ameliorated by approximately one quarter of the staff members having merely a basic outline of the research undertaken and the rest limited to the information sheet details as with the client group. Also, more than half of the control group were recruited through other NHS health care settings, and so it is unlikely that the controls were unduly influenced by prior knowledge. It would be useful to replicate the study using a more diverse population to compare insecurity of attachment between dependent drinkers and a control group consisting of civil service or private sector employees, for example.

The difference in the way the questionnaires were administered i.e. postal in the control group versus one-to-one individual interview with the client group was an area of concern. However, it was conducted this way out of necessity; it was important that the severely alcohol dependent clients, a potentially vulnerable group, had immediate access to de-briefing afterwards to ensure that any negative feelings or issues arising from the questionnaires were adequately discussed so that their alcohol problems were not further exacerbated by the research.

However, in the case of the control group of non-problematic drinkers working within an NHS mental health setting, the subject, i.e. alcohol misuse, was potentially a sensitive issue. In order for the questionnaires to be completed honestly and for those with serious alcohol concerns to be excluded from the study without fear of disclosure, postal replies ensuring anonymity were necessary. Face-to-face interviews may have made individuals more reluctant to participate or less honest in their disclosures regarding alcohol problems, thereby jeopardising the validity of the research outcomes.

A limitation of the current study was the decision to use the schemas in the domain of *disconnection/rejection* only despite previous research using alcohol misusers showed maladaptive schemas in *vulnerability to harm* in the domain of *impaired autonomy/performance*; *subjugation of needs* in the domain of *other-directedness*; and *emotional inhibition* in the domain of *over-vigilance and inhibition* (Brotchie *et al.*, 2004). Inclusion of the other domains may have given a more complete perspective of the diverse unhelpful core beliefs held by severely alcohol dependent clients with complex needs. The decision made was

both a practical and an ethical one, in order not to overload the clients with a 75-item schema questionnaire that was both physically, cognitively and emotionally demanding, when they had just completed a 40-item attachment style questionnaire. Further research was advised using the whole questionnaire to see whether similar results might occur as in the study by Brotchie *et al.* (2004).

The question arose over the co-morbid prevalence of anxiety and depression with severely alcohol dependent clients, which may have negatively biased the self-reporting of their subjective experiences in the current study. However, a study investigating the effect of mood responses upon Young's Schema Questionnaire showed significant differences in only three out of twenty five schemas (Stopa & Walters, 2005) suggesting that mood may not seriously affect the results.

Administering the Hospital Anxiety and Depression Scale (Zigmond & Snauth, 1983) (HADS, Appendix 19) questionnaire to all participants and using the scores as a covariate may have alleviated any variance evoked through current anxiety or depression-related negative perception. However, a third additional questionnaire may have made the task more onerous for clients and controls alike, and possibly created a greater resistance to participation.

With regard to the qualitative analysis, a limitation of the current study was the researcher's previous knowledge and experiences of working with this client population, with possible preformed expectations and conceptualisation of client experiences, which would have influenced researcher neutrality. It may be

advisable for the study to be replicated using a researcher who has had no previous contact or therapeutic experience of working with severely alcohol dependent clients to ensure researcher neutrality and to explore whether the IPA may have taken a different direction or focus.

From the results of the current study, it cannot be assumed that the interpersonal difficulties related to fearful attachment style and maladaptive schemas of *disconnection/rejection* necessarily preceded severe alcohol dependence without longitudinal studies to measure core beliefs in childhood before and then after excessive drinking. Such research would also require the development of a children's questionnaire to measure early maladaptive schemas.

Finally, the current study used participants who, through their engagement with a specialist tertiary service for substance misuse, were acknowledged to be severely alcohol dependent, many of whom had complex needs. The results, therefore, could not be generalised to all problematic drinkers. Further research needed to be conducted in primary and secondary services to see whether similar insecure attachment styles and maladaptive core beliefs also prevailed in hazardous, harmful or moderately dependent drinkers or whether the results were specific to this particularly vulnerable client group.

## **Summary and Conclusions**

Results of the comparative study showed similarly, significantly higher levels of avoidant and ambivalent and a significantly lower level of secure attachment style on average in alcohol dependent clients than non-problematic drinkers, suggesting possible fearful avoidant attachment style (Feeney & Noller, 1996). The individual's seeming internal conflict related to forming and maintaining close relationships that oscillated between apparent neediness and rejection. A strong, positive correlation between avoidant attachment and maladaptive schemas in the domain of disconnection and rejection supported the notion that negative core beliefs regarding self, others and relationships around mistrust/abuse, emotional deprivation, abandonment, defectiveness/shame and social isolation/alienation may reinforce insecurity of attachment and maintain avoidance of intimacy or vice versa. Severely alcohol dependent clients displayed higher levels of maladaptive schemas on average in all the five sub-categories than non-problematic drinkers.

IPA analysis of eight clients' interviews of their self-reported experiences of self and others in close relationships posited a possible aetiological explanation for the differences highlighted in the two groups. The study revealed painful, distressing and sometimes traumatic memories of parental, physical and psychological abuse, emotional deprivation and neglect and explicit maternal rejection that Bowlby (1969) argued predisposed individuals towards insecure attachment and difficulty establishing and maintaining close relationships. These negative and abusive patterns of relating were repeatedly re-enacted in adulthood.

A diffuse and defective sense of self was identified in the clients that seemed to increase their likelihood of avoidance of intimacy due to perceived worthlessness and fear of rejection or further hurt. The current study also highlighted hostile and threatening parent-parent interaction that seemed to engender anxiety and hyper-vigilance in the child, which may have continued into adolescence and adulthood. The study suggested that early alcohol misuse could have begun as a coping strategy initially to contain and control anxiety and negative affect related to childhood abuse and rejection.

It was argued that adverse childhood experiences may have predisposed severely alcohol dependent clients to avoidance of intimacy and social isolation through inability to trust, fear of abuse or betrayal and feelings of low self-esteem and worthlessness that may have preceded or been exacerbated by chronic, long-term, excessive drinking. Such negative core beliefs had implications for therapy. This study suggested that premature disengagement from alcohol services could be linked to social alienation through learned mistrust of others, fear of further hurt or rejection.

The current study advocated initial screening using Attachment Style (Feeney *et al.*, 1994) and Young's Schema (Young & Brown, 2001) questionnaires to identify those severely alcohol dependent clients most at risk of fearful avoidant attachment style and with maladaptive schemas around disconnection and rejection; it recommended the use of schema-based therapeutic interventions to challenge maladaptive core beliefs and replace them with more effective coping strategies to address the root causes of their severe alcohol dependence, which may lie in abusive and neglectful childhood experiences. Such therapeutic

interventions may require more trained, specialist psychologists in the field of severe alcohol dependence.

James (2001) raised concerns regarding the rise in schema-focused forms of therapy without adequate training or supervision in this area of general clinical work, and its inappropriate use within primary care with clients who have no previous psychiatric history. He highlighted the need for specialist training, which implied a greater role for counselling psychologists in tertiary services treating clients at the more severe end of the alcohol dependence continuum with complex needs.

Another issue to address was psychologists' consultancy work, in the provision of more training based upon psychological thinking and supervision for alcohol workers. This could include possible undisclosed childhood abuse by clients and how workers might emotionally contain such disclosures; instruction could also incorporate the interpersonal difficulties that arose from fearful avoidant attachment style and managing the sometimes frustrating oscillation between client neediness and rejection that occurred. Such collaborative working between practitioners with complementary skills could provide a more integrated and effective therapeutic approach to this group of particularly complex and challenging severely alcohol dependent clients in tertiary services.



## **Recommendations for Therapeutic Practice**

The study recommended that therapists developed an awareness of possible practical implications when working with severely alcohol dependent clients displaying possible fearful avoidant attachment and maladaptive schema related to disconnection and rejection, in order to avoid misinterpretation on behalf of both client and counsellor. For example, sporadic or non-attendance may be misattributed to indifference rather than fear of abuse, rejection or mistrust. Lack of self-worth or inexperience of an intimate relationship due to childhood emotional deprivation may provoke anxiety and prevent clients from attending sessions. These issues need to be openly addressed within sessions to enable clients to confront their fears and could only be achieved within an already established safe, trusting and supportive relationship but the dilemma was, how could this be achieved if the client did not attend?

Three possible avenues of exploration could be: firstly an initial assessment with the client, nurse or key worker and therapist together could provide continuity of care and also may assist in alleviating anxiety around meeting someone new. Secondly, telephone contact prior to the start of the therapeutic encounter could put the client at ease and facilitate the first session. Thirdly, seeing the client within their home environment and viewing them in context enabled the therapist to gain a more holistic picture of the client's predicament.

Although initial engagement with the client in therapy can occur, developing and maintaining the relationship was more problematic and DNA rates tended to be high. Therapists' frustrations at intermittent attendance needed to be aired within supervision to enable processing of what was actually occurring with the

client, in terms of oscillating between neediness and resistance linked to fearful avoidant attachment style (Feeney & Noller, 1996) and clients' perceived fear of abandonment. On a practical level, therapists could contact clients by telephone, to alleviate anxiety around not attending and to reassure them that they are worth investing in clinically. The therapist's limited re-parenting methods may engender initial client unease due to the unfamiliarity of experiencing a positive and empathic relationship, resulting in rejection (Young *et al.*, 2003). This may lead to feelings of inadequacy in the therapist and the transference of defectiveness. Working with severely alcohol dependent clients with complex needs demanded a degree of therapist robustness and self-awareness and a commitment to regular supervision where negative feelings may be freely discussed, to avoid 'burn-out'.

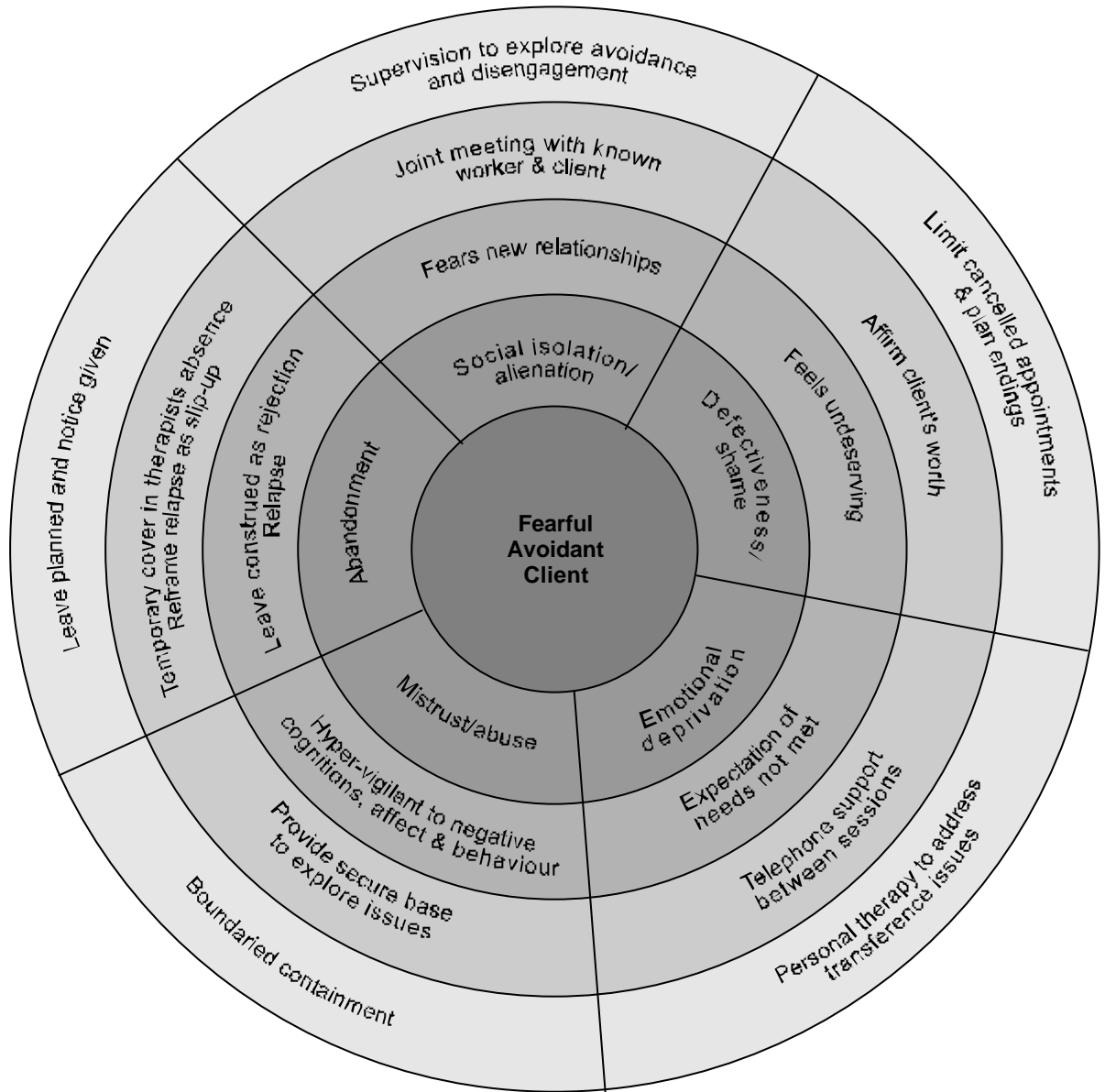
Similarly, therapists' cancellation of appointments may be misinterpreted by the client as rejection or that they were not worth seeing; their possible social incompetencies could inhibit them from understanding cancellation from the therapist's perspective. Annual leave may be perceived as abandonment and could result in relapse, which could sometimes feel as if the therapist was being punished and the client was being too needy, whereas the client may be missing the boundaried containment of the 'nurturing parent' to provide ongoing support. Perhaps a nurse or alcohol worker could provide temporary cover or act as a contact in the therapist's absence.

Counselling clients from an attachment perspective involved delving into often distressing, emotionally charged and painful areas, which might be both threatening and alien to clients who have repressed their emotions for so long

and who therefore had difficulty in managing such feelings. They relied upon the therapist to offer sufficient containment. It was not surprising, therefore that clients appeared more demanding or their drinking increased as a consequence of what was being discussed. The therapist needed to hold the tension between exploration and containment and also acknowledge that due to their relative social isolation, social networks were scarce and there was very little support for clients between sessions. Sometimes, additional telephone contact in between sessions might assist the client in sustaining emotional stability (see Figure 8).

Challenging entrenched maladaptive schemas that have been from the client's perspective a psychological support from childhood can also be an arduous and prolonged process and provoke resistance. Working with such individuals demanded patience and a belief in possible change in order to facilitate change. However, with all and particularly with avoidant attached clients, at the heart of schema and attachment work lies the empathic, supportive and genuine therapeutic relationship without which none of the above may be achieved. Insecurely attached, alcohol dependent clients may require more time initially to build upon that relationship, before in-depth therapy commenced.

**Figure 8: Implications for therapy synopsis**



## **Suggestions for Future Research**

Mental health and substance misuse services experience similar client intermittent attendance and disrupted contact with clinicians. Investigating a possible link between insecure attachment, maladaptive schemas and client disengagement with mental health services may be useful in identifying the interpersonal process occurring between client and clinician and establishing a more positive means of maintaining the client relationship.

Replicating studies involving a greater number of alcohol dependent clients and using the Young's Schema Questionnaire in its complete form could explore more fully the negative core beliefs involving all five schemas and not just *disconnection/rejection*, thus giving a more rounded picture of cognitive development in severe alcohol dependence. It may be advisable to use Young's Parenting Inventory (Young, 1994) in future studies to analyse in greater depth the effect of parental influences upon the development of fearful avoidant attachment.

The current study focused upon a particularly narrow group, namely severely alcohol dependent clients with co-existing complex needs, and therefore the results cannot necessarily be generalised to all problematic drinkers; replicating the research in those clients with hazardous, harmful drinking and those with moderate alcohol dependence may reveal qualitatively different or similar patterns of unhelpful core beliefs and insecure attachment style. Similar results may mean the introduction of schema-focused interventions in these groups also, to avoid the risk of developing later severe alcohol dependence.

Finally, early intervention work is proposed in the form of identifying attachment issues and using Young's schema-based therapeutic approach with identified adolescent drinkers that may decrease the likelihood of developing adult severe alcohol dependence.

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## Appendices

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## Appendix 1: Wolverhampton District LREC Confirmation Letter



### WOLVERHAMPTON DISTRICT LOCAL RESEARCH ETHICS COMMITTEE

Chairman: Mr. D. Little  
Consultant Obstetrician & Gynaecologist  
Tel: (01902) 444741 Fax: (01902) 444877

Administrator: Sandra Smith  
Wolverhampton City PCT, Coniston House  
Chapel Ash, Wolverhampton WV3 0XE  
e-mail: [sandra.smith@wolvespct.nhs.uk](mailto:sandra.smith@wolvespct.nhs.uk)

18 January 2006

Mrs Jane Cornwall  
Psychologist, Anchor Project  
2 St Michael's Court  
Victoria Street  
WEST BROMWICH  
B70 8ET

RECEIVED  
19 JAN 2006

Dear Mrs Cornwall

**Full title of study:** Alcohol dependence and avoidant attachment - implications for therapy  
**REC reference number:** 05/Q2701/85

Thank you for responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered by the Vice-Chair, Mr David Goda.

#### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol, and supporting documentation as revised.

#### Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

#### Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

#### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application		25 Nov 2005
Investigator CV		25 Nov 2005
Protocol	1	25 Oct 2005
Covering Letter, Anchor Project Sandwell Community Drug & Alcohol Team		14 Nov 2005 AXA Insurance

School of Applied Sciences - Psychology Division		31 Oct 2005
Interview Schedules/Topic Guides Preliminary Semi-structured Interview Schedule	1 (Appendix 7)	25 Nov 2005
Questionnaire CAGE for Control Group	1 (Appendices 8a, 8b)	25 Nov 2005
Questionnaire Participants	1 (Appendix 1a)	25 Nov 2005
Questionnaire Attachment style	1 (Appendix 1b)	25 Nov 2005
Questionnaire Young's (2003) Schema ) Participants' Questionnaire	1 (Appendices 2a, 2b))	25 Nov 2005
Questionnaire Severity of Alcohol Dependence	1 (Appendix 9)	25 Nov 2205
Questionnaire	CAGE 2	17 Dec 2005
Participant Information Sheet	2 Control Group	17 Dec 2005
Participant Information Sheet Alcohol clients	1 (Appendix 3)	25 Nov 2005
Participant Information Sheet Control Group	1 (Appendix 4)	25 Nov 2005
Participant Information Sheet	2 Alcohol Clients	17 Dec 2005
Participant Consent Form (x 2)	2 Alcohol Clients	17 Dec 2005
Participant Consent Form Control Group	1 (Appendix 6)	25 Nov 2005
Response to Request for Further Information		17 Dec 2005
Dept of Health 'Alcohol & Health' Leaflet		17 Dec 2005
Certificate of Professional Liability Insurance AXA Insurance		29 Nov 2005
Covering letter - researcher		17 Dec 2005

#### **Research governance approval**

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

#### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

<b>05/Q2701/85</b>	<b>Please quote this number on all correspondence</b>
--------------------	---

With the Committee's best wishes for the success of this project

Yours sincerely

Mr David Little  
Chair

Enc: *List of names and professions of members who were present at the meeting*  
*Standard approval conditions*  
*Site approval form*

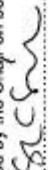
Cc: *Prof K Manktelow, Dr Nicola Hart, School of Applied Sciences, Psychology Division*  
*University of Wolverhampton*



Wolverhampton Local Research Ethics Committee

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	05/Q2701/85	Issue number:	1	Date of issue:	18 January 2006
Chief Investigator:	Mrs Jane Cornwall				
Full title of study:	Alcohol dependence and avoidant attachment-implications for therapy				
This study was given a favourable ethical opinion by Wolverhampton Local Research Ethics Committee on 18 January 2006. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.					
Principal Investigator	Post	Research site	Site assessor	Date of favourable opinion for this site	Notes <sup>(1)</sup>
Mrs Jane Cornwall	Psychologist	Anchor Project, 2 St Michael's Court Victoria Street, WEST BROMWICH B70 8ET	Wolverhampton Local Research Ethics Committee	18/01/2006	
Approved by the Chair on behalf of the REC:  (delete as applicable) ..... (Signature of Chair/Administrator) SANDRA SMITH ..... (Name)					

(1) The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension or termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.

## Appendix 2: Wolverhampton PCT Research and Development Forum

Wolverhampton City   
Primary Care Trust

Research and Development  
The Beeches  
Penn Hospital  
Penn Road  
Wolverhampton  
WV4 5HN

ivan.burchess@wolvespct.nhs.uk  
<http://www.wolverhamptonhealth.nhs.uk>

Project ID: 92

23/01/06

Mrs Jane Cornwall  
Anchor Project  
2 St Michael's Court  
Victoria Street  
West Bromwich  
B70 8ET

Dear Jane

**RE: Alcohol dependence and avoidance attachment- implications for therapy**

Thank you for supplying the Research and Development Department with the requested documentation. We are pleased to inform you that from a research point of view we are happy for you to undertake the research in line with the protocol you have submitted.

This permission covers the following Trusts

- Sandwell MH & SC NHS Trust

We must remind you that the National *Research Governance Framework for Health and Social Care* governs research in all NHS Trusts. As the Chief Investigator of the research, you are responsible for the conduct of the project in accordance with these guidelines, particularly in terms of ensuring that participants are properly treated, that data is protected and that adverse events are reported to us and the ethics committee who originally gave approval for the research.

At some point we are likely to audit your paperwork for this project and it is important that you keep everything secure, especially that relating to informed consent from participants in your research.

If there are any changes to your research, any difficult incidents or if you have queries about conducting the research, please inform R&D office immediately on 01902 446083.

Chairman: Terence MacKriel

Chief Executive: Jon Crockett

We look forward to hearing the outcomes of your research and receiving a copy of the final report. Good luck with the project.

Yours sincerely



Ivan Burchess  
Chair, Black Country Research Governance Network

cc: Catherine Dexter, Wolverhampton City PCT  
Carolyn Hurcom Sandwell MH &SC Trust

Enc: Research Governance Information Sheet

## Research Governance Information Sheet



Research issues  
to think about

### Monitoring

Projects, which are sponsored by Wolverhampton PCT, will be monitored for compliance with the Department of Health's Research Governance framework. Where Wolverhampton, PCT has, not acted, as sponsor it will be the responsibility of that organisation to take accountability of monitoring such projects.

To comply with the Department of Health's guidelines on Research Governance and Standards our Research & Development Department has values we expect researchers to abide by. This routine monitoring will specifically monitor researchers recording of informed consent and various relevant documents such as:

- Compliance with protocol verification
- Financial approval
- Consent procedures

It is therefore important you keep up to date with all your paperwork. The following issues have been summarised in order for you to fulfil our requirements.

### Health and Safety

It is important that the safety of participants, researchers and other staff involved in the research must be given priority at all times and health and safety regulations must be strictly observed (Research Governance Framework, 2003). If you feel for any reason that you or your participants are at risk of injury or threat you should notify your local ethics committee and R & D department. The Research & Development Framework (2003) suggests that all researchers (including on-trust personnel) involved in conducting research should receive Trust Health & Safety training/guidance. Training can be arranged for you through the Research and Development Co-ordinator.

### Data Protection

As a researcher you are responsible for ensuring informed consent for the collection of data by using patient/participants information sheet, which conforms to the Data Protection Act (1998). The purpose of this act is to protect personal information about living individuals. The Data Protection Act applies to all personal data. The most important part of the Data Protection Act rules for researchers are as follows:

- Informed consent

You must tell the participants what data will be collected and why

- Who will have access to the collected data
- How the data will be stored, keep data accurate, up date and as long as it is necessary
- Only collect what is necessary and relevant
- Whether it will be disclosed to a third party

---

Research Governance Information Sheet

If you process data without providing research participants with the answer to the above questions, there is a risk of acting unlawfully

**Informed Consent**

Informed consent is the process by which a fully informed patient can participate in choices about their health care. Consent must be given freely and not under any form of duress or undue influence from the researcher or family or friends.

The Department of Health's Research Governance framework state that all studies must have appropriate arrangements for obtaining consent. Patients/participants need sufficient information before they decide whether to give their consent.

However, if the subjects are not offered as much information as they need to make their decision, and in a form that is easy understood, their consent may not be valid.

**Clinical Trials**

If your study involves clinical trials you need to be aware of the European Directive for Clinical Trials (2004). As Principal Investigator it is your responsibility to ensure that the rights, safety and well being of the trial subjects are the most important consideration and should prevail over interests in science & society.

**Adverse Incidents**

As the lead researcher it is your responsibility to report any adverse incidents, which may occur during the study.

If you require any further support contact:

Dr. Sandra Squires

Research & Development Co-Coordinator

Tel: 01902-446087

e-mail: [sandra.squires@wolvespct.nhs.uk](mailto:sandra.squires@wolvespct.nhs.uk)

## Appendix 3: University of Wolverhampton RES20b Form (copy)



**RES 20B  
(October 2003)**

**School of Applied Sciences Ethics Committee: submission of project for approval**

To be completed by SEC:

Date Received:

Project No:

- **This form must be word processed – no handwritten forms can be considered**
- **ALL sections of this form must be completed**
- **No project may commence without authorisation from the School Ethics Committee**

### **CATEGORY B PROJECTS:**

There is identifiable risk to the participant's wellbeing, such as:

- significant physical intervention or physical stress.
- use of research materials which may bring about a degree of psychological stress or upset.
- use of instruments or tests involving sensitive issues.
- participants are recruited from vulnerable populations, such as those with a recognised clinical or psychological or similar condition. Vulnerability is partly determined in relation to the methods and content of the research project as well as an *a priori* assessment.

All Category B projects are assessed first at Divisional level and once approved are forwarded to the School Ethics Committee for individual consideration. Undergraduates are not permitted to carry out Category B projects.

<b>Title of Project:</b>	<b>Alcohol Dependence and Avoidant Attachment - Implications for Therapy</b>
<b>Name of Supervisor:</b> (for all student projects)	<b>Jane Benanti, Chartered Counselling Psychologist at Anchor Project, NHS Drugs &amp; Alcohol Service</b>
<b>Name of Investigator(s):</b>	<b>Jane Cornwall</b>
<b>Location of Research:</b> (Module code, MPhil/PhD, Staff)	<b>Practitioner Doctorate Counselling Psychology PS5011</b>
<b>Qualifications/Expertise of the investigator relevant to the submission:</b>	<b>2 years' experience as full-time counsellor for Aquarius Community Alcohol Team, Birmingham, and 1 year on trainee counselling psychologist placement at Anchor NHS Drugs &amp; Alcohol Service, West Bromwich.</b>

<b>Participants:</b> Please indicate the population and number of participants, the nature of the participant group and how they will be recruited.	<p><b>Group A: 50 clients with alcohol dependence referred to Anchor via health professionals or self, recruited at random via letter in conjunction with the initial assessment with alcohol nurses.</b></p> <p><b>Control Group: 50 people recruited at random by letter from the general population working in Primary Care.</b></p>
---	---

*Continued overleaf*

Please attach the following and tick the box provided to confirm that each has been included::

Rationale for and expected outcomes of the study	Ö
Details of method: materials, design and procedure	Ö
Information sheet* and informed consent form for participants <i>*to include appropriate safeguards for confidentiality and anonymity</i>	Ö
Details of how information will be held and disposed of	Ö
Details of if/how results will be fed back to participants	Ö
Letters requesting, or granting, consent from any collaborating institutions	Ö
Letters requesting, or granting, consent from head teacher or parents or equivalent, if participants are under the age of 16	N/a
<p>Is ethical approval required from any external body? YES (delete as appropriate)            If yes, which Committee? NHS Committee Sandwell Mental Health Care Trust</p> <p><i>NB. Where another ethics committee is involved, the research cannot be carried out until approval has been granted by both the School committee and the external committee.</i></p>	

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Investigator)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Supervisor)

Except in the case of staff research, all correspondence will be conducted through the supervisor.  
**FOR USE BY THE SCHOOL ETHICS COMMITTEE**

Divisional Approval Granted: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Chair of Divisional Ethics Committee)

School Approval Granted: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Chair of School Ethics Committee)

## **Appendix 4: Copy of Notes for Contributors**

**Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology)** is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports that support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

### **1. Circulation**

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.



## **2. Length**

Papers should normally be no more than 5,000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

## **3. Reviewing**

The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to the title page (and the text should be free of such clues as identifiable self-citations e.g. 'In our earlier work...')

## **4. Online submission process**

1) All manuscripts must be submitted online at <http://paptrap.edmgr.com>.

First-time users: click the REGISTER button from the menu and enter in your details as instructed. On successful registration, an email will be sent informing you of your user name and password. Please keep this email for future reference and proceed to LOGIN. (You do not need to re-register if your status changes e.g. author, reviewer or editor).

Registered users: click the LOGIN button from the menu and enter your user name and password for immediate access. Click 'Author Login'.

2) Follow the step-by-step instructions to submit your manuscript.

3) The submission must include the following as separate files:

Title page consisting of manuscript title, authors' full names and affiliations, name and address for corresponding author - **Editorial Manager Title Page for Manuscript Submission.**

Abstract

Full manuscript omitting authors' names and affiliations. Figures and tables can be attached separately if necessary.

4) If you require further help in submitting your manuscript, please consult the Tutorial for Authors - **Editorial Manager - Tutorial for Authors.**

Authors can log on at any time to check the status of the manuscript.

## **5. Manuscript requirements**

Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate page. The resolution of digital images must be at least 300 dpi.

For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, results.

Conclusions. **Review articles should use these headings: Purpose, Methods, Results, Conclusions: Psychology and Psychotherapy: Theory, Research and Practice - Structured Abstract Information.**

For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses.

In normal circumstances, effect size should be incorporated.

Authors are requested to avoid the use of sexist language.

Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations etc for which they do not own copyright.

For Guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association, Washington DC, USA (<http://www.apastyle.org>).

## **6. Brief reports**

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

## **7. Publication ethics**

Code of Conduct - Code of Conduct, Ethical Principles and Guidelines.

Principles of Publishing - Principles of Publishing.

## **8. Supplementary data**

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques.

The material should be submitted to the Editor together with the article, for simultaneous refereeing.

## **9. Post acceptance**

PDF page proofs are sent to authors via email for correction of print but not for rewriting or the introduction of new material. Authors will be provided with a PDF file of their article prior to publication.

## **10. Copyright**

To protect authors and journals against unauthorised reproduction of articles, The British Psychological Society requires copyright to be assigned to itself as publisher, on the express condition that authors may use their own material at any time without permission. On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form.

## **11. Checklist of requirements**

- Abstract (100-200 words).
- Title page (include title, authors' names, affiliations, full contact details).
- Full article text (double-spaced with numbered pages and anonymised).
- References (APA style). Authors are responsible for bibliographic accuracy and must check every reference in the manuscript and proof read again in the page proofs.
- Tables, figures, captions placed at the end of the article or attached as separate files.

## Appendix 5: Consent Forms

### Information and Consent Form 1 for Alcohol Clients

The purpose of this research project is to find out how people with alcohol problems form and maintain personal relationships.

This information will help to improve the counselling psychology service.

When you come for your assessment with the alcohol nurse and myself, we would help you to complete 2 tick-box questionnaires.

The questionnaires will be given a number rather than your name, to protect your identity and I will analyse the information myself.

I would be grateful if you could help in this research. If you are willing to help please tick the boxes below, sign the Consent form and return it in the envelope provided or hand it to your alcohol nurse.

Thank you.

I understand that:

- I will be helped to complete two questionnaires.
- The questionnaires will be given a number rather than my name, to protect my identity and the information will be analysed by the researcher Jane Cornwall.
- I can withdraw from the study at any time without giving a reason. This would not affect the care I receive now or in the future.
- Upon completion of the study I can receive a brief summary of the general outcomes of the report by e-mailing the researcher Jane Cornwall at *jcresearch@btinternet.com* but that no individual results can be given out.

#### Researcher:

Name.....

Signature.....

#### Participant:

Name.....

Signature.....

## Information and Consent Form 2 for Alcohol Clients' Interviews

The purpose of this research project is to find out how people with alcohol problems form and maintain personal relationships.

This information will help to improve the counselling psychology service.

You have been invited to take part in a tape-recorded interview, lasting approximately half an hour. The interview will be given a number rather than your name to protect your identity.

The interview will be typed and any names or identifying information will be removed to protect your identity. I will conduct the analysis myself.

I would be grateful if you could help in this research. If you are willing help please tick the boxes below, sign the form and return it in the envelope provided or hand it to your alcohol nurse. Thank you.

I understand that:

- I will be interviewed for up to half an hour on my past experiences of relationships.
- My interview will be tape-recorded.
- The written transcripts of my interview will be analysed by the researcher Jane Cornwall, and will be available to the supervisor and examiners.
- Confidentiality will be maintained and any identifying material will be removed from the final reports.
- Tapes and transcripts will be stored securely and anonymised, and tapes will either be returned to me or destroyed after examination of the research.
- I can withdraw from the study at any time without giving reasons. This will not affect my care now or in the future.
- Upon completion of the study I understand that I can receive a brief summary of the general outcomes of the report by e-mailing the researcher Jane Cornwall at *jcresearch@btinternet.com*, but that no individual results can be given out.

### Researcher:

Name.....

Signature.....

### Participant:

Name.....

Signature.....

## Appendix 6: Client Group Invitation Letter



Dean of School: Professor Patrick W J Robotham BSc PhD

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Telephone Codes  
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**Researcher and contact person: Jane Cornwall**

E-mail: [jcresearch@btinternet.com](mailto:jcresearch@btinternet.com)

Supervisor: Jane Benanti Chartered Counselling Psychologist

Dear

I am a Counselling Psychologist in training at the University of Wolverhampton, based at Anchor Project for my clinical practice.

The purpose of this research project is to find out how people with alcohol problems form and maintain personal relationships.

This information will help to improve the counselling psychology service.

When you come for your assessment with the alcohol nurse and myself, we would help you to complete 2 tick-box questionnaires.

At a later date you might be invited back for a tape-recorded interview to talk about your experience of personal relationships.

The questionnaires and interviews will be given a number rather than your name, to protect your identity and I will analyse the information myself.

I would be grateful if you could help in this research. If you are willing help please sign the Consent form and then return it in the envelope provided or hand it to your alcohol nurse.

You can withdraw from the study at any time without giving a reason. This would not affect the care you receive now or in the future.

If you have any queries please contact me, Jane Cornwall, at the Anchor Project, West Bromwich, telephone 0845 112 0100 or e-mail: [jcresearch@btinternet.com](mailto:jcresearch@btinternet.com).

Please keep this information sheet. Thank you for reading this.

Yours sincerely

A handwritten signature in cursive script that reads 'Jane Cornwall'.

Jane Cornwall  
(Counselling Psychologist in training)

Vice-Chancellor  
Professor Caroline Gipps MSc PhD ACSS FRSA





## Appendix 8: Alcohol and Health Information Sheet



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### Alcohol and health



Alcohol is something to be enjoyed and most of the time, drinking doesn't cause any problems. But drinking too much or at the wrong time can be harmful. The important thing is to know where the benefits end and the risks begin.

The Department of Health advises that men should not drink more than 3 - 4 units of alcohol per day, and women should drink no more than 2 - 3 units of alcohol per day. These daily benchmarks apply whether you drink every day, once or twice a week, or occasionally.

#### What is a unit of alcohol?

A unit of alcohol is 10ml of pure alcohol. Counting units of alcohol can help us to keep track of the amount we're drinking. The list below shows the number of units of alcohol in common drinks:-

- A pint of ordinary strength lager (Carling Black Label, Fosters) - 2 units
- A pint of strong lager (Stella Artois, Kronenbourg 1664) - 3 units
- A pint of bitter (John Smith's, Boddingtons) - 2 units
- A pint of ordinary strength cider (Dry Blackthorn, Strongbow) - 2 units
- A 175ml glass of red or white wine - around 2 units
- A pub measure of spirits - 1 unit
- An alcopop (e.g. Smirnoff Ice, Bacardi Breezer, WKD, Reef) - around 1.5 units

Remember that lagers and ciders sold in bottles are usually stronger than those sold on draught. The labels of some bottled drinks will tell you how many units of alcohol are in the bottle.

#### If you get drunk:

Avoid alcohol for 48 hours after an episode of drunkenness to give your body time to recover.

#### Different situations

There are some occasions when it makes sense to drink less than the daily benchmarks, or not to drink at all.

The Department of Health advises women who are trying to become pregnant or are at any stage of pregnancy, should not drink more than 1 or 2 units of alcohol once or twice a week, and should avoid episodes of intoxication.

**We advise people not to drink:**

- Before or when driving
- Before or when operating machinery and equipment
- Before or when using electrical equipment
- Before or when using ladders or working at heights
- When it might affect the quality of your work
- Before swimming or taking part in active sport
- Before or when taking certain medicines
- If a doctor or other health professional advises you to cut down or to stop drinking

**Finding it hard to stop**

Sometimes people feel that their own or someone else's drinking is getting out of control. If you are concerned, you should seek help in the first instance from your GP.

**As well as visiting your GP you might like to try:-**

Calling Drinkline. Drinkline is a free and confidential telephone helpline for people who need help and support with their own or someone else's drinking. The Drinkline number is 0800 917 8282 and lines are open 24 hours a day, seven days a week.

Taking the "Down your Drink" online programme, which tells drinkers what they need to know to stay drinking sensibly. The programme takes less than an hour a week over 6 weeks. It's free, confidential and part of the NHS.

**Sensible drinking**

NHS Direct Online provides advice on sensible drinking and information on other healthy lifestyle choices.

The Portman Group is an independent body, funded by the drinks industry, which supports sensible drinking.

**Alcohol and health**

Alcohol Concern, the main national agency on alcohol misuse, provides a range of factsheets and other materials which give information about alcohol and its effects on the body. The site also includes a search facility which visitors who are concerned about their own or someone else's drinking can use to find an alcohol agency in their local area.

## **Appendix 9: Clients' Semi-structured Interview**

Thank you for agreeing to be interviewed about your experiences regarding alcohol and forming relationships. In this context the word 'relationship' means contact with any others, such as family, friends, work colleagues, and not just romantic associations. Please reply as openly as you can, but do not feel obliged to answer any question you would rather not answer.

1. How long has alcohol been an issue for you?
2. Describe your early experiences of drinking.
3. In what way, if any, do you feel alcohol influences your relationships with others?
4. How do you feel alcohol influences how others might relate to you?
5. How do you think other people see you?
6. Is there anyone you feel currently close to?
7. What is it about that person that makes you feel close to them?
8. Is there anything about that relationship which you feel affects your drinking?
9. Tell me about the person or persons whom you were close to when you were growing up.
10. What was it about that person that made you feel close to them?
11. What do you like about yourself as a person?
12. What might others like about you?

Thank you very much for taking part in this research.

**Appendix 10: Participants' Questionnaire (Feeney, Noller & Hanrahan, 1994)**

Choose the answer which, to you, best matches the statement:

**Choices: Totally disagree (a), strongly disagree (b), slightly disagree (c), slightly agree (d), strongly agree (e), totally agree (f)**

Age                      Male                      Female                      (please circle)

No	Statement	Choice (please ring)
1	Overall, I am a worthwhile person	a b c d e f
2	I am easier to get to know than most people	a b c d e f
3	I feel confident that other people will be there for me when I need them	a b c d e f
4	I prefer to depend upon myself rather than other people	a b c d e f
5	I prefer to keep to myself	a b c d e f
6	To ask for help is to admit that you're a failure	a b c d e f
7	People's worth should be judged by what they achieve	a b c d e f
8	Achieving things is more important than building relationships	a b c d e f
9	Doing your best is more important than getting on with others	a b c d e f
10	If you've got a job to do, you should do it, no matter who gets hurt	a b c d e f
11	It's important to me that others like me	a b c d e f
12	It's important to me to avoid doing things that others won't like	a b c d e f
13	I find it hard to make a decision unless I know what other people think	a b c d e f

**Choices: Totally disagree (a), strongly disagree (b), slightly disagree (c), slightly agree (d), strongly agree (e), totally agree (f)**

No	Statement	Choice (please ring)
14	My relationships with others are generally superficial	a b c d e f
15	Sometimes I think I am no good at all	a b c d e f
16	I find it hard to trust other people	a b c d e f
17	I find it difficult to depend upon others	a b c d e f
18	I find that others are reluctant to get as close as I would like	a b c d e f
19	I find it relatively easy to get close to other people	a b c d e f
20	I find it easy to trust others	a b c d e f
21	I feel comfortable depending upon other people	a b c d e f
22	I worry that others won't care as much about me as I care about them	a b c d e f
23	I worry about people getting too close	a b c d e f
24	I worry that I won't measure up to other people	a b c d e f
25	I have mixed feelings about being close to others	a b c d e f
26	While I want to get close to others, I feel uneasy about it	a b c d e f
27	I wonder why people would want to be involved with me	a b c d e f
28	It's very important to me to have a close relationship	a b c d e f

Choices: Totally disagree (a), strongly disagree (b), slightly disagree (c), slightly agree (d), strongly agree (e), totally agree (f)

No.	Statement	Choice (please ring)
29	I worry a lot about my relationships	a b c d e f
30	I wonder how I would cope without someone to love me	a b c d e f
31	I feel confident about relating to others	a b c d e f
32	I often feel left out or alone	a b c d e f
33	I often worry that I do not really fit in with other people	a b c d e f
34	Other people have their own problems, so I don't bother them with mine	a b c d e f
35	When I talk over my problems with others, I generally feel ashamed or foolish	a b c d e f
36	I am too busy with other things to put much time into relationships	a b c d e f
37	If something is bothering me, others are generally aware and concerned	a b c d e f
38	I am confident that other people will like and respect me	a b c d e f
39	I get frustrated when others are not available when I need them	a b c d e f
40	Other people often disappoint me	a b c d e f

**Appendix 11: Attachment Style Questionnaire (researcher's copy)  
(Feeney, Noller & Hanrahan, 1994)**

Show much you agree with the following statements by rating them on this scale:

Totally disagree 1, strongly disagree 2, slightly disagree 3, slightly agree 4, strongly agree 5, totally agree 6

Score (please ring)	No	Statement	Factor
1 2 3 4 5 6	1	Overall, I am a worthwhile person	Confidence
1 2 3 4 5 6	2	I am easier to get to know than most people	Confidence
1 2 3 4 5 6	3	I feel confident that other people will be there for me when I need them	Confidence
1 2 3 4 5 6	4	I prefer to depend upon myself rather than other people	Discomfort with Closeness
1 2 3 4 5 6	5	I prefer to keep to myself	Discomfort
1 2 3 4 5 6	6	To ask for help is to admit that you're a failure	Relationships as Secondary (R as S)
1 2 3 4 5 6	7	People's worth should be judged by what they achieve	R as S
1 2 3 4 5 6	8	Achieving things is more important than building relationships	R as S
1 2 3 4 5 6	9	Doing your best is more important than getting on with others	R as S
1 2 3 4 5 6	10	If you've got a job to do, you should do it, no matter who gets hurt	R as S
1 2 3 4 5 6	11	It's important to me that others like me	Need for Approval (N for A)
1 2 3 4 5 6	12	It's important to me to avoid doing things that others won't like	N for A
1 2 3 4 5 6	13	I find it hard to make a decision unless I know what other people think	N for A
1 2 3 4 5 6	14	My relationships with others are generally superficial	R as S



1 2 3 4 5 6	15	Sometimes I think I am no good at all	N for A
1 2 3 4 5 6	16	I find it hard to trust other people	Discomfort with Closeness
1 2 3 4 5 6	18	I find that others are reluctant to get as close as I would like	Preoccupation with Relationships
1 2 3 4 5 6	19	I find it relatively easy to get close to other people	Confidence
1 2 3 4 5 6	20	I find it easy to trust others	Discomfort (reverse score)
1 2 3 4 5 6	21	I feel comfortable depending upon other people	Discomfort (reverse score)
1 2 3 4 5 6	22	I worry that others won't care as much about me as I care about them	Preoccupation
1 2 3 4 5 6	23	I worry about people getting too close	Discomfort
1 2 3 4 5 6	24	I worry that I won't measure up to other people	N for A
1 2 3 4 5 6	25	I have mixed feelings about being close to others	Discomfort
1 2 3 4 5 6	26	While I want to get close to others, I feel uneasy about it	Discomfort
1 2 3 4 5 6	27	I wonder why people would want to be involved with me	N for A
1 2 3 4 5 6	28	It's very important to me to have a close relationship	Preoccupation
1 2 3 4 5 6	29	I worry a lot about my relationships	Preoccupation
1 2 3 4 5 6	30	I wonder how I would cope without someone to love me	Preoccupation
1 2 3 4 5 6	31	I feel confident about relating to others	Confidence
1 2 3 4 5 6	32	I often feel left out or alone	Preoccupation (reverse score)
1 2 3 4 5 6	33	I often worry that I do not really fit in with other people	Confidence

1 2 3 4 5 6	34	Other people have their own problems, so I don't bother them with mine	Discomfort
1 2 3 4 5 6	35	When I talk over my problems with others, I generally feel ashamed or foolish	N for A
1 2 3 4 5 6	36	I am too busy with other things to put much time into relationships	R as S
1 2 3 4 5 6	37	If something is bothering me, others are generally aware and concerned	Confidence
1 2 3 4 5 6	38	I am confident that other people will like and respect me	Confidence
1 2 3 4 5 6	39	I get frustrated when others are not available when I need them	Preoccupation
1 2 3 4 5 6	40	Other people often disappoint me	Preoccupation

**Appendix 12: Attachment Style Sub-scale Mean Score Calculations (Feeney *et al.*, 1994)**

Sub-scale	Item number on Attachment Style Questionnaire	Calculation of mean score
Confidence	1, 2, 3, 19, 31, 33 (reverse score), 37, 38	Total scores for items listed and divide by 8 for mean score
Discomfort with Closeness	4, 5, 16, 17, 20 (reverse score), 21 (reverse score), 23, 25, 26, 34	Total scores for items listed and divide by 10 for mean score
Relationships as Secondary	6, 7, 8, 9, 10, 14, 36	Total scores for items listed and divide by 7 for mean score
Need for Approval	11, 12, 13, 15, 24, 27, 35	Total scores for items listed and divide by 7 for mean score
Pre-occupation with Relationships	18, 22, 28, 29, 30, 32, 39, 40	Total scores for items listed and divide by 8 for mean score

Mean score for *secure attachment* = 'Confidence'

Mean score for *avoidant attachment* = 'Discomfort with Closeness' + 'Relationships as Secondary' divided by 2

Mean score for *ambivalent attachment* = 'Need for Approval' + 'Pre-occupation with Relationships' divided by 2

## Appendix 13: Young's (2001) Schema Questionnaire Participants' Sheet

Number..... Age..... Male Female (please circle)

### INSTRUCTIONS:

Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it describes you. Where you are not sure, base your answer on what you emotionally feel, not on what you think to be true. Select the choice that best describes you and circle the most appropriate letter in the right-hand column.

### CHOICES:

a = Completely untrue of me

b = Mostly untrue of me

c = Slightly more true than untrue

d = Moderately true of me

e = Mostly true of me

f = Describes me perfectly

No	Statement	Choice (please ring)
1	Most of the time I haven't had someone to nurture me, share him/herself with me, or care deeply about everything that happens to me	a b c d e f
2	In general people have not been there to give me warmth holding and affection	a b c d e f
3	For much of my life I haven't felt that I am special to someone	a b c d e f
4	For the most part I have not had someone who really listens to me understands me or is tuned into my true needs and feelings	a b c d e f
5	I have rarely had a strong person to give me sound advice or direction when I'm not sure what to do	a b c d e f
6	I find myself clinging to people I'm close to because I'm afraid they will leave me	a b c d e f
7	I need other people so much that I worry about losing them	a b c d e f
8	I worry that people I feel close to will leave me or abandon me	a b c d e f

9	When I feel someone I care for pulling away from me I get desperate	a b c d e f
10	Sometimes I am so worried about people leaving me that I drive them away	a b c d e f
11	I feel that people will take advantage of me	a b c d e f
12	I feel that I cannot let my guard down in the presence of other people or else they will intentionally hurt me	a b c d e f
13	It is only a matter of time before someone betrays me	a b c d e f
14	I am quite suspicious of other people's motives	a b c d e f
15	I'm usually on the lookout for ulterior motives	a b c d e f
16	I don't fit in	a b c d e f
17	I'm fundamentally different from other people	a b c d e f
18	I don't belong; I am a loner	a b c d e f
19	I feel alienated from other people	a b c d e f
20	I always feel on the outside of groups	a b c d e f
21	No man/woman I desire could love me once he/she saw my defects	a b c d e f
22	No one I desire would want to stay close to me if he/she knew the real me	a b c d e f
23	I am unworthy of the love attention and respect of others	a b c d e f
24	I feel that I am not lovable	a b c d e f
25	I am too unacceptable in very basic ways to reveal myself to other people	a b c d e f

## Appendix 14: Young's (2001) Schema Questionnaire Researcher's Score Sheet

Number..... Age..... Male Female (please circle)

### INSTRUCTIONS:

Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it describes you. Where you are not sure, base your answer on what you emotionally feel, not on what you think to be true. Select the choice that best describes you and circle the most appropriate letter in the right-hand column.

### SCORES:

**Total Maximum Score for each category = 30**

**1 = a** = Completely untrue of me

**2 = b** = Mostly untrue of me

**3 = c** = Slightly more true than untrue

**4 = d** = Moderately true of me

**5 = e** = Mostly true of me

**6 = f** = Describes me perfectly

No	Statement	Choice and category (please ring)
1	Most of the time I haven't had someone to nurture me, share him/herself with me, or care deeply about everything that happens to me	a b c d e f emotional deprivation
2	In general people have not been there to give me warmth holding and affection	a b c d e f emotional deprivation
3	For much of my life I haven't felt that I am special to someone	a b c d e f emotional deprivation
4	For the most part I have not had someone who really listens to me understands me or is tuned into my true needs and feelings	a b c d e f emotional deprivation
5	I have rarely had a strong person to give me sound advice or direction when I'm not sure what to do	a b c d e f emotional deprivation
6	I find myself clinging to people I'm close to because I'm afraid they will leave me	a b c d e f abandonment/instability
7	I need other people so much that I worry about losing them	a b c d e f abandonment/instability

8	I worry that people I feel close to will leave me or abandon me	a b c d e f abandonment/instability
9	When I feel someone I care for pulling away from me I get desperate	a b c d e f abandonment/instability
10	Sometimes I am so worried about people leaving me that I drive them away	a b c d e f abandonment/instability
11	I feel that people will take advantage of me	a b c d e f mistrust/abuse
12	I feel that I cannot let my guard down in the presence of other people or else they will intentionally hurt me	a b c d e f mistrust/abuse
13	It is only a matter of time before someone betrays me	a b c d e f mistrust/abuse
14	I am quite suspicious of other people's motives	a b c d e f mistrust/abuse
15	I'm usually on the lookout for ulterior motives	a b c d e f mistrust/abuse
16	I don't fit in	a b c d e f social isolation
17	I'm fundamentally different from other people	a b c d e f social isolation
18	I don't belong; I am a loner	a b c d e f social isolation
19	I feel alienated from other people	a b c d e f social isolation
20	I always feel on the outside of groups	a b c d e f social isolation
21	No man/woman I desire could love me once he/she saw my defects	a b c d e f defectiveness/shame
22	No one I desire would want to stay close to me if he/she knew the real me	a b c d e f defectiveness/shame
23	I am unworthy of the love attention and respect of others	a b c d e f defectiveness/shame
24	I feel that I am not lovable	a b c d e f defectiveness/shame
25	I am too unacceptable in very basic ways to reveal myself to other people	a b c d e f defectiveness/shame

**Appendix 15: Maladaptive Schema Sub-scale Mean Score Calculations (Young, 2001)**

<b>Sub-scale</b>	<b>Item number on Young's Schema Questionnaire</b>	<b>Calculation of mean score</b>
Emotional Deprivation	1, 2, 3, 4,5	Total scores for items listed and divide by 5 for mean score
Mistrust/Abuse	6, 7, 8, 9, 10	Total scores for items listed and divide by 5 for mean score
Abandonment/Instability	11, 12, 13, 14, 15	Total scores for items listed and divide by 5 for mean score
Social Isolation/Alienation	16, 17, 18, 19, 20	Total scores for items listed and divide by 5 for mean score
Defectiveness/Shame	21, 22, 23, 24, 25	Total scores for items listed and divide by 5 for mean score

Mean Score for **Domain of Disconnection/Rejection** = Total mean scores for Emotional Deprivation + Mistrust/Abuse + Abandonment/Instability + Social Isolation/Alienation + Defectiveness/Shame divided by 5



## Appendix 16: CAGE Questionnaire (Researcher's copy)

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

### Scoring:

Item responses on the CAGE are scored 0 or 1 with a higher score an indication of alcohol problems. **A total score of 2 or greater is considered clinically significant.**

Developed by Dr. John Ewing, founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Chapel Hill, CAGE is an internationally used assessment instrument for identifying alcoholics. It is particularly popular with primary care givers. CAGE has been translated into several languages.

The CAGE questions can be used in the clinical setting using informal phrasing. It has been demonstrated that they are most effective when used as part of a general health history and should NOT be preceded by questions about how much or how frequently the patient drinks (see "Alcoholism: The Keys to the CAGE" by D.L. Steinweg and H. Worth, American Journal of Medicine 94: 520-523, May 1993).

The exact wording that can be used in research studies can be found in: JA Ewing *Detecting Alcoholism: The CAGE Questionnaire JAMA 252: 1905-1907, 1984.*

Researchers and clinicians who are publishing studies using the CAGE Questionnaire should cite the above reference. No other permission is necessary unless it is used in any profit-making endeavor in which case this Center would require to negotiate a payment.

## **Appendix 17: CAGE Questionnaire (Control Group)**

(JA Ewing, *Detecting Alcoholism: The CAGE Questionnaire JAMA 252: 1905-1907, 1984*)

Please circle the appropriate answer:

**1. Have you ever felt you should cut down on your drinking?**

YES/NO

**2. Have people annoyed you by criticizing your drinking?**

YES/NO

**3. Have you ever felt bad or guilty about your drinking?**

YES/NO

**4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?**

YES/NO

### **Guidelines:**

If you answer 'NO' to all or 3 of the questions please complete the further questionnaires.

If you answer 'YES' to 2 or more of the questions sometimes it can indicate an alcohol concern.

Please feel free to read the information sheet provided and if you are concerned contact your GP or Aquarius Community Alcohol team on 0121 525 9292 to discuss it further.

Thank you.

## Appendix 18: Severity of Alcohol Dependence Questionnaire

### Thank you for completing this form

Please answer all questions

We would like you to recall a recent month when you were drinking in a way which, for you, was fairly typical of a heavy drinking period. Please fill in the month and the year.

**MONTH..... YEAR.....**

We would like to know more about your drinking during this time and during other periods when your drinking experience was similar. We want to know when you experienced certain feelings.

Please reply to each statement by putting a circle round Almost Never or Sometimes or Often or Nearly Always after each question.

**Please indicate below the physical symptoms that you have experienced first thing in the morning during typical periods of heavy drinking.**

- |  |              |           |       |               |
|--|--------------|-----------|-------|---------------|
| 1. I wake up feeling sweaty  | Almost Never | Sometimes | Often | Nearly Always |
|  | 0            | 1         | 2     | 3             |
| 2. My hands shake first thing in the morning   | Almost Never | Sometimes | Often | Nearly Always |
|  | 0            | 1         | 2     | 3             |
| 3. My whole body shakes violently first thing in the morning if I don't have a drink | Almost Never | Sometimes | Often | Nearly Always |
|  | 0            | 1         | 2     | 3             |
| 4. I wake up absolutely drenched in sweat  | Almost Never | Sometimes | Often | Nearly Always |
|  | 0            | 1         | 2     | 3             |

**The following statements refer to moods and states of mind you may have experienced first thing in the morning during these periods of heavy drinking.**

- |    |  |              |           |       |               |
|----|--|--------------|-----------|-------|---------------|
| 5. | I dread waking up in the morning                             | Almost Never | Sometimes | Often | Nearly Always |
|    |  | 0            | 1         | 2     | 3             |
|    |  |              |           |       |               |
| 6. | I am frightened of meeting people first thing in the morning | Almost Never | Sometimes | Often | Nearly Always |
|    |  | 0            | 1         | 2     | 3             |
|    |  |              |           |       |               |
| 7. | I feel at the edge of despair when I first wake up           | Almost Never | Sometimes | Often | Nearly Always |
|    |  | 0            | 1         | 2     | 3             |
|    |  |              |           |       |               |
| 8. | I feel very frightened when I wake up                        | Almost Never | Sometimes | Often | Nearly Always |
|    |  | 0            | 1         | 2     | 3             |

**The following statements refer to morning drinking habits during the recent period when you were drinking heavily, and periods like it.**

- |     |   |           |       |               |  |
|-----|---|-----------|-------|---------------|--|
| 9.  | I like to have a morning drink  |           |       |               |  |
|     | Almost Never  | Sometimes | Often | Nearly Always |  |
|     | 0   | 1         | 2     | 3             |  |
| 10. | I always gulp my first few morning drinks down as quickly as possible |           |       |               |  |
|     | Almost Never  | Sometimes | Often | Nearly Always |  |
|     | 0   | 1         | 2     | 3             |  |
| 11. | I drink in the morning to get rid of the shakes                       |           |       |               |  |
|     | Almost Never  | Sometimes | Often | Nearly Always |  |
|     | 0   | 1         | 2     | 3             |  |
| 12. | I have a very strong craving for a drink when I wake up               |           |       |               |  |
|     | Almost Never  | Sometimes | Often | Nearly Always |  |
|     | 0   | 1         | 2     | 3             |  |

**The following statements refer to a degree of alcohol consumption during the recent period of heavy drinking and periods like it.**

13. I drink more than a quarter of bottle of spirits per day (4 doubles or 1 bottle of wine or 4 pints of beer/lager)
- |              |           |       |               |
|--------------|-----------|-------|---------------|
| Almost Never | Sometimes | Often | Nearly Always |
| 0            | 1         | 2     | 3             |
14. I drink more than half a bottle of spirits per day (8 doubles or 2 bottles of wine or 8 pints of beer/lager)
- |              |           |       |               |
|--------------|-----------|-------|---------------|
| Almost Never | Sometimes | Often | Nearly Always |
| 0            | 1         | 2     | 3             |
15. I drink more than one bottle of spirits per day (or 4 bottles of wine or 15 pints of beer/lager)
- |              |           |       |               |
|--------------|-----------|-------|---------------|
| Almost Never | Sometimes | Often | Nearly Always |
| 0            | 1         | 2     | 3             |
16. I drink more than two bottles of spirits per day (or 8 bottles of wine or 30 pints of beer/lager)
- |              |           |       |               |
|--------------|-----------|-------|---------------|
| Almost Never | Sometimes | Often | Nearly Always |
| 0            | 1         | 2     | 3             |

Imagine the following situation:

- (a) you have been completely off drink for a few weeks  
 (b) you then drink very heavily for two days

17. I would start to sweat
- |              |           |       |               |
|--------------|-----------|-------|---------------|
| Almost Never | Sometimes | Often | Nearly Always |
| 0            | 1         | 2     | 3             |
18. My hands would shake
- |              |           |       |               |
|--------------|-----------|-------|---------------|
| Almost Never | Sometimes | Often | Nearly Always |
| 0            | 1         | 2     | 3             |
19. My body would shake
- |              |           |       |               |
|--------------|-----------|-------|---------------|
| Almost Never | Sometimes | Often | Nearly Always |
| 0            | 1         | 2     | 3             |
20. I would be craving for a drink
- |              |           |       |               |
|--------------|-----------|-------|---------------|
| Almost Never | Sometimes | Often | Nearly Always |
| 0            | 1         | 2     | 3             |

## Appendix 19: Hospital Anxiety and Depression Scale (HADS)

Patients are asked to choose one response from the four given for each interview. They should give an immediate response and be dissuaded from thinking too long about their answers. The questions relating to anxiety are marked "A", and to depression "D". The score for each answer is given in the right column. Instruct the patient to answer how it currently describes their feelings.

- A I feel tense or 'wound up':
- |                                 |   |
|---------------------------------|---|
| Most of the time                | 3 |
| A lot of the time               | 2 |
| From time to time, occasionally | 1 |
| Not at all                      | 0 |
- D I still enjoy the things I used to enjoy:
- |                    |   |
|--------------------|---|
| Definitely as much | 0 |
| Not quite so much  | 1 |
| Only a little      | 2 |
| Hardly at all      | 3 |
- A I get a sort of frightened feeling as if something awful is about to happen:
- |                                   |   |
|-----------------------------------|---|
| Very definitely and quite badly   | 3 |
| Yes, but not too badly            | 2 |
| A little, but it doesn't worry me | 1 |
| Not at all                        | 0 |
- D I can laugh and see the funny side of things:
- |                            |   |
|----------------------------|---|
| As much as I always could  | 0 |
| Not quite so much now      | 1 |
| Definitely not so much now | 2 |
| Not at all                 | 3 |
- A Worrying thoughts go through my mind:
- |                                      |   |
|--------------------------------------|---|
| A great deal of the time             | 3 |
| A lot of the time                    | 2 |
| From time to time, but not too often | 1 |
| Only occasionally                    | 0 |

D I feel cheerful:	
Not at all	3
Not often	2
Sometimes	1
Most of the time	0
A I can sit at ease and feel relaxed:	
Definitely	0
Usually	1
Not Often	2
Not at all	3
D I feel as if I am slowed down:	
Nearly all the time	3
Very often	2
Sometimes	1
Not at all	0
A I get a sort of frightened feeling like 'butterflies' in the stomach:	
Not at all	0
Occasionally	1
Quite Often	2
Very Often	3
D I have lost interest in my appearance:	
Definitely	3
I don't take as much care as I should	2
I may not take quite as much care	1
I take just as much care as ever	0



- A I feel restless as I have to be on the move:
- |                  |   |
|------------------|---|
| Very much indeed | 3 |
| Quite a lot      | 2 |
| Not very much    | 1 |
| Not at all       | 0 |

- D I look forward with enjoyment to things:
- |                                |   |
|--------------------------------|---|
| As much as I ever did          | 0 |
| Rather less than I used to     | 1 |
| Definitely less than I used to | 2 |
| Hardly at all                  | 3 |

- A I get sudden feelings of panic:
- |                   |   |
|-------------------|---|
| Very often indeed | 3 |
| Quite often       | 2 |
| Not very often    | 1 |
| Not at all        | 0 |

- D I can enjoy a good book or radio or TV program:
- |             |   |
|-------------|---|
| Often       | 0 |
| Sometimes   | 1 |
| Not often   | 2 |
| Very seldom | 3 |

Scoring (add the As = Anxiety. Add the Ds = Depression). The norms below will give you an idea of the level of Anxiety and Depression.

0-7 = Normal

8-10 = Borderline abnormal

11-21 = Abnormal

**Reference:**

Zigmond, A.S. & Snauth, R.P. (1983). The hospital anxiety and depression scale. *Acta Psychiatrica Scandinavia*, June 1983, 67 (6), pp.361-370.

## **Appendix 20: ICD-10 Classification of Alcohol Dependence Syndrome**

**(WHO, 1992)**

A cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take alcohol. There may be evidence that return to alcohol use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals.

### **Diagnostic Guidelines**

A definite diagnosis of dependence should usually be made only if three or more of the following have been experienced or exhibited at some time during the previous year:

- (a) a strong desire or sense of compulsion to take alcohol
- (b) difficulties in controlling alcohol-taking behaviour in terms of its onset, termination, or levels of use
- (c) a physiological withdrawal state when alcohol use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for alcohol; or use of the alcohol with the intention of relieving or avoiding withdrawal symptoms
- (d) evidence of tolerance, such that increased doses of alcohol are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol-dependent individuals who may take daily doses sufficient to incapacitate or kill non-tolerant users)
- (e) progressive neglect of alternative pleasures or interests because of alcohol use, increased amount of time necessary to obtain or take alcohol or to recover from its effects
- (f) persisting with alcohol use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm

Narrowing of the personal repertoire of patterns of alcohol use has also been described as a characteristic feature (e.g. a tendency to drink alcoholic drinks in the same way on weekdays and weekends, regardless of social constraints that determine appropriate drinking behaviour).

It is an essential characteristic of the dependence syndrome that either alcohol taking or a desire to take alcohol should be present; the subjective awareness of compulsion to use alcohol is most commonly seen during attempts to stop or control alcohol use.

## **Appendix 21: Eight Memos from Individual Tables of Themes**

### **Memo 1 Susan**

Susan is a single, unemployed woman in her late forties who has been misusing alcohol for approximately thirty years.

#### **Battled with self-containment**

Internal conflict can arise in an individual when negative emotion is triggered and his/her belief system maintains that help is not available when threat is perceived. The only option therefore is to suppress unwelcome feelings.

Susan's personal, inner struggle for emotional self-containment, compulsive self-reliance and consequent, angry withdrawal echoed the problems associated with avoidant attachment style previously identified in research (Lapsley *et al.*, 2000).

When asked about her early experiences of close relationships, Susan's lengthy pause suggested that closeness seemed an alien and unfamiliar concept; she repeated the question, possibly to give herself time to search for that elusive emotional intimacy: "*I've never been... I never been a bit... um, who was I close to when I was growing up?*" (172). Perhaps the ending to her unfinished response: "*I've never been...*" might have been: "*close to anyone*" but the emotional pain of the reality was too great to contemplate and possibly threatened to overwhelm her. Susan's attempts at suppressing her emotions were not always successful: "*You will have to excuse me a bit*" (123) and her discomfort at showing her vulnerability was evident as she regained control. Possibly, Susan perceived showing emotion as weakness, if responses to her expressed feelings had been negative in the past.

Avoidance of situations or experiences likely to trigger fearful or unpleasant thoughts is a common coping strategy for survival. Susan's seemingly self-imposed exile placed her on the social periphery to avoid anxious feelings: "*I don't like crowds because I get embarrassed and on edge*" (248). Susan's current relationships were, by her own admission, mostly superficial: "*Well, the people I do, well, I wouldn't say mix with but acquaintances where I live*" (52-53). I sensed her need to maintain control occurred through separateness and denial of emotional intimacy: "*As a friend, nothing else*" (73). Physical distancing was also perceived necessary for survival: "*I won't let them in*" (66). This may also have subconsciously alluded to her learned emotional defences, perceiving safety as either avoiding triggering childhood hurts, or by dismissing her emotional needs as in the past: "*In the finish I just took no notice*" (229).

### **Struggled with parental neglect**

Parental neglect imbues in a child a sense of worthlessness and unimportance. Perhaps Susan's need for emotional self-containment was a protective defence against the painful, parental rejection she felt as a child: "*Unwanted, to be honest*" (226) and she sought to comprehend the unhappy confusion she experienced as a child using adult rationalisation: "*It was a weird upbringing*" (239). However, her intellectualising could not lessen the disappointment in her parents' lack of interest: "*They never give me no encouragement*" (218-219). It seemed that both parents ignored her silent pleas to be validated and Susan coped by mentally preparing herself to alleviate the inevitable disappointment: "*I thought, they won't look through it, nor my Dad, they never did*" (207-208).

Susan visibly struggled to contain the overwhelming emotion she felt, as she

recalled what should have been a happy experience, sharing in her success, but was for her a time of sadness and disillusionment.

Susan's expectations were unfulfilled as her hopes for empathic connection through her achievements were dashed: "*I thought my mother would be proud of this*" (199). From a schema theory perspective, Susan's need for self-containment emanated from her parents' cold and rejecting behaviour towards her that led to the schema formation of emotional deprivation, the belief that her needs could not be met through intimate relationships. Although, as she acknowledged, their basic needs were met: "*She looked after us*" (174-175) Susan was denied the nurturing she craved.

Her coping strategies were to internalise the emotional pain of rejection and emotional neglect, manifested in self-harming that transferred emotional to physical pain: "*I started doing this when I was about 13, 14, cutting myself because I felt so resentful*" (231). It could be suggested that Susan's avoidant attachment evolved from early childhood experiences of parental rejection and coldness. This left her with anxiety and distress from unmet needs that became repressed and internalised due to parental unavailability (Bowlby, 1969).

### **Grieving for loss of acknowledgement, recognition**

The experience of feeling unwanted and unloved whilst growing up is a continual and painful succession of losses, similar to a bereavement process. I used the metaphor of grieving to explore Susan's experiences of coping with loss. Initially, as in the first stages of the bereavement process, feelings of anger, distress and resentment were revealed: "*How do you think that made me*

*feel?" (220-221).* Her halting voice betrayed the internal struggle as she endeavoured to control her pent-up emotions: *"Sorry, I'm stuttering a bit now". (200).* Her apologetic tone implied a seeming denial of right to such feelings born from childhood unmet needs, and, as in complicated grief where expression of feelings are denied, it subsequently made the emotional pain harder to bear.

Susan's internal bargaining to achieve a difference was in vain: *"I was trying my best at school" (232-233)* before her final, helpless, resigned acceptance of the reality of her neglectful parental relationship: *"It's one of those things" (240).* In Susan's eyes the ignored report book symbolised childhood rejection, loss of self-validation and the death of self.

### **Betrayed by trust**

Early experiences of betrayal of trust become the template for expectation in adult relationships. Susan's initial, seemingly childlike, hopeful expectation of what was possible in a relationship belied the sadness in her voice: *"In the beginning it's lovely, you know, you're getting on well and you're happy" (106).* Sadly, the perceived care and protectiveness denied her through childhood emotional neglect and for which she yearned became one of controlling and physically abusive behaviour that reinforced her sense of worthlessness and enhanced the schema of mistrust/abuse. Familiar patterns of communication through hostility were also re-enacted in her adult relationships.

Susan engaged in similarly abusive, adult relationships that triggered unmet needs and feelings of rejection and disappointment and enhanced her mistrust

of intimate relationships, which ultimately for her ended in hurt and betrayal (Young, 1994). Susan also displayed schemas in the domain of disconnection/rejection: mistrust/abuse, emotional deprivation and defectiveness/shame, which are considered the most psychologically damaging early maladaptive schemas that are also resistant to change (Young *et al.*, 2003).

Susan's partner's controlling behaviour suggested he may have possessed a similar insecurity of attachment and fear of abandonment that influenced his keeping her imprisoned to prevent her from leaving: "*I felt so hurt and betrayed because he tried to shut me away, shut me off from my family*" (127-128). The humiliation and shame Susan experienced as a child were re-enacted in the degradation: "*The things he did to me, he used to rip my clothes off me and everything*" (284) and the physical abuse she endured: "*Two broken noses, broken ribs*" (272). As an adult, Susan's schemas related to mistrust/abuse were re-activated by recurrent, similarly abusive relational experiences, eliciting powerful, negative feelings; the consequence was violent outbursts from Susan, which could be identified as an over-compensatory strategy to hurt those before they hurt her: "*come to blows*" (56).

Due to these traumatic experiences, the schemas of mistrust and betrayal prevailed, resulting in self-imposed avoidance and relative isolation: "*There isn't many people I can trust*" (92). Susan's lonely existence was faced with stoical acceptance through lack of expectation, based upon her childhood negative experiences of interpersonal relatedness (Mickelson *et al.*, 1997).

Susan alluded to only one close, male friendship over 33 years with which she felt relatively safe: “*Well, I have known him a long time, like I have just said, I can trust him*” (81). Possibly the difference was that he was not a heavy drinker and therefore did not collude with her self-destructive behaviours; he was also non-judgmental about her drinking. This friend helped her when she was physically ill from alcohol and at her most vulnerable. Perhaps he represented Susan’s longed for parental nurturing that had been denied her in childhood.

However, Susan also admitted that the relationship could be mutually volatile, verbally aggressive and sometimes violent: “*I have had many an argument with S..., many an argument. I have broken his glasses and everything. He has pulled my hair out, and, yeah, terrible. Blacked his eye and everything, I have*” (263-265). This hostile behaviour may have reflected familiar, repetitive, interactive patterns she experienced both from her parents and with each other.

### **Social comparison**

Social comparison has its roots in early childhood, where siblings are constantly regarding the parent-child interaction, with them and their brothers and sisters, in order to establish their sense of perceived relatedness and position within the family hierarchy. Susan seemed to be searching for an explanation for the indiscernible, ‘felt’ difference and inferiority she experienced as a child compared to her brothers, and her mother’s lack of feeling for her: “*I don’t know what it was; she seemed to favour the boys in the family*”. (175).

Susan’s way of intellectually rationalising the uncomfortable negative feeling was to seemingly minimise the felt differences: “*Different little things, just silly*



*little things*" (187) in order to suppress her sense of perceived discrimination. Susan's embarrassing experiences of peers' ridicule only served to reinforce her sense of difference: "*Must have a funny family, must do*" (228). Research identified a positive correlation between insecure attachment and later peer rejection (Wood *et al.*, 2004). Susan also maintained a sense of negative discrimination by comparing herself with her fellow drinkers in terms of alcohol consumed: "*I wouldn't say they drink as much as me*" (58).

### **Diffuse self-identity to fit in**

Insecurely attached individuals have a seeming lability of self, an adaptive capacity to comply with whatever is needed in a particular situation, to avoid conflict or threat. From an avoidant attachment perspective, due to her negative childhood experiences, Susan's internal working model of self was one of unlovability and low self-worth, with which she currently coped by avoiding emotional intimacy. She perceived any outward show of distress as vulnerability and potentially threatening (Howe, 2005), as shown in her apologies and annoyance for getting upset in the interview. As a child this had probably been met with disinterest or scorn. The expectation of rejection was prevalent as was the assumption that any show of distress would invoke negative reactions.

Subsequently, I sensed that Susan's laughter was merely a projected defence against her feelings of low self-esteem: "*I don't think they like me*" (252); it also suggested anticipated rejection, reinforced by childhood parental neglect: "*I thought, they won't look at it*" (207-208). Susan perceived her identity in the role of care giver, rather than having a sense of her own individuality: "*I like to think*

*that if I can help somebody I will. I will do the best I can. That's all you can do, your best, help people" (244).*

Her repeated remonstrations around trying so hard: "*I have tried my best over the years" (114-115)* revealed her underlying anxiety around not being quite good enough. This was a re-enactment of the behavioural pattern of doing her best to be recognised by her parents, and that was the role she had subconsciously undertaken in adulthood, to achieve validation. Susan's diffuse identity also necessitated the compensatory coping strategy of compliance: "*I like to get on with people" (247)* to relieve her anxieties around the schema of abandonment.

Susan's self-perception was self-denigratory, in that she seemed to blame herself for the abusive relationships in which she found herself, attributing it to her flaws rather than others' inadequacies: "*I was stupid" (278)*. Unconsciously, her coping response was to surrender as she re-enacted similar life patterns that hurt her as a child, but which she would attribute to her own rather than her mother's failings, due to her schemas related to defectiveness/shame.

Insecurely attached individuals often remain with abusive partners for this reason, the perception that somehow it is their fault, rather than the perpetrator's (Howe, 2005).

### **Confused by parental hostility**

A hostile and threatening environment is conducive to threat and anxiety in a child that persists into adulthood. Susan's experiences of her parents' relationship evoked images of persistent verbal abuse: "*They was always*

*arguing all the while*" (232). The physical distance between them suggested an emotional disconnection that was a source of consternation to her: "*She won't let him in the bed*" (238). Susan struggled to make sense of her parents' lack of interrelatedness: "*Even now, after all these years*" (239). Although she acknowledged the unusualness of the relationship, Susan accepted the 'status quo' with a seemingly fatalistic resignation, possibly because that was her lived experience as a child: "*That's the way it went. The way it went*" (222).

From her internal working model of relationships intimacy represented threat and rejection and was therefore to be avoided; aggression was for Susan a reliable defence, learned in early childhood from observing her parents' mutually hostile behaviour. Interestingly, research has emphasised the impact of the child-adult relationship rather than parental interpersonal interaction witnessed by the child, which was likely to have a detrimental effect if unrelenting, as was Susan's experience. This could become the focus of further research.

It seemed that the learned pattern of hostile communication had become an integral part of Susan's past and present relationships, and although she had not mentioned violence in the family environment, I did wonder whether this had occurred, or whether her lack of self-worth, engendered purely from her emotional deprivation, placed her in the vulnerable position of seeking relationships that reinforced those familiar childhood patterns of neglect and humiliation and schemas of misuse/abuse.

### **Alcohol as friend**

The relationship with alcohol tends to be complex and fraught with seeming contradictions as its seductively empowering effect takes hold. Initially, Susan's experience of alcohol was positive as she enjoyed its relaxing, anxiety-reducing quality: "*I used to like to get a bit tipsy*" (14). It allowed her an unfamiliar sense of belonging that engendered a good feeling: "*We used to share bottles of cider and you know, just have a laugh*" (16). The shared experience and social acceptance gave Susan connectedness that had previously eluded her: "*Where I live they all like a drink*" (53), albeit at a superficial level: "*Just have a laugh and that was it*" (17). The emphasis was very much around socialising: "*I used to go about with my friends*" (16). Alcohol's temporarily disinhibiting properties allowed Susan the illusion of self-confidence to engage in social activity: "*Have a conversation with people*" (44-45).

It seems that feelings of fear, desire and anger had remained long suppressed in order not to antagonise further rejection in childhood and in subsequent adult relationships; possibly this perpetual state of stress and high anxious arousal was initially controlled using alcohol.

### **Alcohol as enemy**

Alcohol-induced, disinhibited behaviour sometimes unleashes uncontrollable and unexpected outbursts of anger. Bowlby (1982) implied that interpersonal anger emerged from the frustration of unmet attachment requirements. As the excessive drinking progressed, paradoxically alcohol as an aid to social inclusion had a deleterious effect upon relationships: "*You lose most of your friends*" (288). Alcohol became a coping strategy in that it allowed Susan an

emotional outlet from long suppressed negative feelings, occasionally in the form of aggressive behaviour: "*I have become violent*" (48); it also alienated her from people and created a self-fulfilling prophecy of rejection and exclusion.

Ironically, this only served to reinforce her expectation of being rejected and maintain her maladaptive schemas related to mistrust/abuse. Similarly, Susan's self-disgust at the negative impact upon her ability to work: "*I was going to work late or not at all*" (26-27) and her self-induced ill health supported her defectiveness /shame schemas: "*I have made myself ill through the drink*" (84), as did the distressing physical symptoms: "*Start shaking*" (18).

Alcohol dependence further reinforced maladaptive schemas around abandonment and increased Susan's avoidant coping response of social isolation and alienation, a familiar, albeit uncomfortable place. Research supports a higher prevalence of maladaptive schemas in alcohol users (Brotchie *et al.*, 2004). Possibly alcohol begins as a coping strategy to prevent anxiety provoking, negative thoughts and feelings regarding self and others that later becomes a further reinforcer of the emotions that are trying to be displaced.

**Client 1 (Susan): Table of Themes from IPA Semi-structured Interview**

<b>Master theme titles</b>	<b>Sub-theme</b>	<b>Transcript key words</b>	<b>Indicator line</b>
<b>Battled with self-containment</b>	Struggled to find the words Needed to maintain control of emotions Avoidance of social interaction Superficial relationships No physical intimacy Separateness as protection Denial of own needs	"I've never been" "You will have to excuse me a bit" "I get embarrassed and on edge" "Acquaintances where I live" "As a friend. Nothing else" "I won't let them in" "In the finish I just took no notice"	172 123 248 52-53 73 66 229
<b>Struggled with parental neglect</b>	Experience of parental rejection Seeking to understand Emotional deprivation Unfulfilled expectation Self-destructive behaviours	"Unwanted, to be honest" "It was a weird upbringing" "They never give me no encouragement" "My mother would be proud of this" "Cutting myself because I felt so resentful"	226 239 218-219 199 231
<b>Grieving for loss of acknowledgement, recognition</b>	Feelings of anger, resentment, sadness Struggled to contain distress Bargaining Resigned acceptance	"How do you think that made me feel" "I'm stuttering a bit now" "I was trying to do my best at school" "It's one of those things"	220-221 200 232-233 240
<b>Betrayed by trust</b>	Misperceived protection was control Felt humiliated and degraded Abusive nature of insecure attachment Fear of abandonment kept her trapped Re-enacted disappointment and rejection Mistrustful of people	"In the beginning it's lovely" "He used to rip my clothes off me" "Two broken noses, broken ribs" "He tried to shut me away" "I felt so hurt and betrayed" "There isn't many people I feel I can trust"	106 284 272 127-128 127 92
<b>Social comparison</b>	Inferiority – what's wrong with me? Guilt at felt difference Peer ridicule and exclusion Fellow drinkers	"She seemed to favour the boys" "Different little things, just silly little things" "Must have a funny family, must do" "I wouldn't say they drink as much as me"	175 187 228 58

**Client 1 (Susan): Table of Themes from IPA Semi-structured Interview (cont.)**

<b>Master theme titles</b>	<b>Sub-theme</b>	<b>Transcript key words</b>	<b>Indicator line</b>
<b>Diffuse self-identity to fit in</b>	Laughter as emotional defence to sadness Not good enough Low self-esteem Compensatory role as care giver Compensatory strategy - compliance	"I don't think they like me" "I have tried my best over the years" "I was stupid" "If I can help somebody I will" "I like to get on with people"	252 114-115 278 244 247
<b>Confused by parental hostility</b>	Cannot understand Physical separateness Relationships seen as threatening, abusive Helpless resignation	"Even now after all these years" "She won't let him in the bed" "They was always arguing all the while" "That's the way it went. The way it went"	239 238 232 222
<b>Alcohol as friend</b>	Liked the positive effect Social connectedness Shared experience At a superficial level Social activity Point of communication	"I used to like to get a bit tipsy" "We used to share bottles" "Where I live, they all like a drink" "Just have a laugh and that was it" "I used to go about with my friends" "Have conversations with people"	14 16 53 17 16 44-45
<b>Alcohol as enemy</b>	Social exclusion Disinhibited behaviour Self-disgust Loss of relationships Affected work Physical symptoms	"You lose most of your friends" "I have become violent" "I have made myself ill through the drink" "They have all betrayed me" "I was going to work late or not at all" "Start shaking"	288 48 84 115-116 26-27 18

## **Memo 2 Tim**

Tim was a middle-aged, unemployed, single man who had been a heavy drinker for over thirty years and was suffering serious, alcohol-related disability.

### **Surrounded by hostility**

A hostile family environment engenders insecurity and fear in a child searching for protection and care. When Tim was asked about childhood, close relationships, as with Susan, the pauses appeared to suggest he was struggling to recall his experiences, or possibly the question evoked memories that were painful. Tim's perception was that his mother was controlling: "*She was a very dominant woman*" (103) but it felt that he hardly dare verbalise his thoughts because he immediately followed it with justification: "*but for all the right reasons, you know*" (103-104) as if he needed to seek an intellectual explanation for her seeming lack of warmth.

Tim's father appeared a distant, unavailable figure who, for whatever reason, was unapproachable: "*I felt you couldn't talk to my Dad*" (133-134). I conjured this image in my mind of a lonely and anxious child, vulnerable and isolated, and he presented as such in the counselling room, with his timid and barely audible voice. From an attachment perspective, it could be suggested that Tim's negative experiences of himself, others and relationships stemmed from the traumatic, physical abuse and rejection he endured from his mother from an early age, together with his father's unavailability. What should have been a nurturing and protective environment was one of fear and invalidation.



Tim recounted traumatic beatings of himself and his sister in an unusually unaffected manner: *"I've been beaten with odd things like fishing rods you know: I used to have black marks on my back where I was hit with sticks. She used to hit me with pots: I was beaten with those. My sister was slapped until she wet herself". (118-121)*. From an attachment perspective, physically abused, similar to emotionally neglected children, become emotionally disconnected to survive, portrayed in Tim's seeming lack of affect.

His failure to respond to my expression of concern echoed either an inability to hear my empathy or a capacity to dissociate from such experiences so that they held no fear for him. Crittendon (1995) maintained that physically abused children learned avoidant behaviour and inhibition of negative affect to placate the hostile and emotionally unavailable parent but not how to evoke nurturing and protective responses in others, nor at recognising it in intimate relationships in adulthood. This can lead to social incompetence and impoverished emotional intellect.

The invalidating family environment that was Tim's existence as a child was summed up powerfully in one word: *"Hostile" (111)*. It was a world of anxiety-provoking, threatening unpredictability and aggression, as his parents' only connection appeared to be through violence: *"It used to get physical a lot. Um, I can remember when I was a kid I saw, they would just start scrapping whilst we were round at the table" (115)*.

On reflection, as an adult Tim still seemed to struggle to make sense of what had occurred: *"It was a very strange set-up" (117)*. It is easy to imagine that

witnessing such behaviour negatively influenced Tim's perception of how intimate relationships function, and if they existed in such a threatening manner, to be avoided. The primary care givers, upon which he relied for nurture and protection, fulfilled none of those criteria; ironically they were to be avoided rather than sought, to survive.

### **Burdened by multiple losses**

According to Bowlby (1980), childhood separation and loss have a negative impact upon emotional bonding and security of attachment. The absence of a supportive and nurturing relationship with care givers leaves a legacy of intensity of feeling when experiencing loss in adulthood. Tim's experiences of relationships were recurrent and unexpected losses, separation and perceived abandonment with the premature death of his parents when he was only 20 and his partner's death ten years ago. With this came the enforced separation from his son, over which he had little control, I am speculating because of his drinking: "*Took my youngest son off me*" (79-80). The tragic, untimely death of his eldest son two years ago compounded his feelings of loss and possibly inadequacy as a parent: "*My eldest son died of a heroin overdose*" (80-81). I felt his sense of grief and utter desolation: "*Now I've got nothing*" (81-82). Everyone had been taken from him, and it seemed that here was an empty shell of a man, a mere husk, stripped of life and hope.

Tim admitted that the losses had caused him to emotionally distance himself from intimate relationships to avoid further distress: "*I suppose with present relationships as well, it has stopped me getting close to people. Um, I fear it happening again, talking about it*" (88-89). From a schema theory perspective

Tim's formative experiences of a physically abusive childhood led him to believe that relationships were essentially threatening or emotionally hurtful, reinforced by later multiple losses and the schema of perceived abandonment maintained and re-enacted in those recurrent losses. Tim therefore tended to contain his feelings of emotional deprivation by avoiding intimate relationships.

### **Sense of self eluded him**

Tim found it difficult to consider his self-identity through others' eyes: "*I don't know about that. You should be really asking them*" (149). It was as if he was so disconnected from interpersonal relatedness that he could not imagine others' perception of him, when he had little knowledge of it himself. Tim's experiences of how others viewed him were very negative and maintained by his schema of defectiveness and shame: "*As a bit of a joke*" (37). I sensed his seeming invisibility and feeling of discardment, like litter in the street, either ignored or kicked aside: "*People just bump into you and push you to one side*" (57).

### **Became emotionally detached to survive**

The adaptive protective coping mechanisms to avoid further abuse were to become emotionally distance from intimacy. The consequence was relative isolation in Tim's formative years: "*Very few*" (98). His inability to recall childhood friends or associates suggested either an absence of or possibly lack of importance attributed to peer relationships in his need for emotional self-containment. From an attachment perspective, Tim's internal working model of others from negative childhood experiences was that they were rejecting and hostile when his attachment behaviours were shown. The only available solution was to look after himself, leading to seemingly disengaged behaviours

in intimate relationships and few friendships: "*I've only got one friend at the moment*" (61).

I had the impression from Tim's resigned tone that his expectation of relationships, based upon his negative experiences of abuse, was low: "*There's nobody else. Nobody else*" (62). Physically abused children's mental model of 'self' tends to be lacking in self-worth and undeserving of nurturing and protection, and stoically accepting that care and protection are not available. Thus, emotional detachment and self-containment prevailed, which sometimes resembled dismissiveness or lack of empathy, as anxiety was present but suppressed (Howe, 2005).

### **Felt alienated and isolated**

The relationship Tim experienced between his parents was one of emotional disconnectedness and seemingly devoid of communication: "*They never spoke to each other*" (105). He repeated this sentence as if it was confusing and difficult for him to comprehend why such a situation existed. Tim's father's emotional unavailability compounded his sense of isolation: "*I felt you couldn't talk to my Dad*" (133-134). Family members appeared to exist individually in a socially isolated and alienating environment whose mode of communication revolved around hostility or physical abuse; it was therefore essentially threatening and to be avoided, and a very solitary place to inhabit.

The solution for Tim was to escape from his hostile family environment as soon as he was able: "*I got out of there as soon as I could and left home*" (125). The relief in his voice was apparent as relationships apparently improved after his

departure: *"The older I got the more understanding she got"* (135-136). Possibly the emotional demands upon his mother were fewer, which enabled her to be less aggressive and rejecting. However, it also suggested Tim misattributed his mother's inadequacies and paucity of care and internalised the interpersonal difficulties as being his problem, due to his age.

### **Developed defensive coping strategies**

I struggled as much to find a sense of identity with Tim, I think, as he did.

Research (Kinard, 1980) supported the notion that physically abused children had issues regarding self-concept and struggled with a sense of self-identity.

This arose from the child of aggressive parents learning to cope with hurt and anxious feelings through suppression, in order not to antagonise further their hostility, resulting in compliance or avoidant behaviour, in which Tim engaged.

There was an implicit emptiness and absence of self as he endeavoured to fit in by making as few demands upon people as possible. From a schema perspective, Tim used over-compensatory strategies to blend in, in order not to antagonise expected further hostility in other relationships: *"I just try and be ordinary: I try to be as nice as I can"* (141). Tim's protective defence was also to minimise his experiences, possibly to prevent triggering painful childhood negative emotions: *"It was a very strict upbringing"* (153).

### **Experienced positive relationship**

Experiences of a positive and rewarding relationship were relatively unknown, possibly due to the perceived necessity of avoidance of intimacy as a means of self-protection. I sensed that Tim's only, long-standing friend made few

emotional demands upon him. Tim seemed to trust his non-threatening and non-judgmental attitude and ability to see beyond the alcohol problems to the person beneath, as far as Tim would allow: *“He doesn’t completely understand my problems, but he does listen and he accepts me for my faults”* (67-68).

However, I guessed that Tim’s barricade of self-containment from both real and perceived hurt was possibly a difficult one to surmount.

### **Dichotomous relationship with alcohol – a double-edged sword**

The dichotomous experience of the relationship with alcohol was that of both enabler and disabler. Initially, it gave Tim an illusory sense of self-esteem and confidence that allowed him to temporarily overcome his lack of self-worth and engage rather than avoid in social interaction that had previously been denied him through fear: *“Very positive. It gave me a lot of confidence, so without it I wasn’t happy, you know, very shy around people. It gave me the ability to come out of my shell, um, be a bit of a ‘Jack the Lad’, and do a lot of things you wouldn’t have dreamt of doing, you know”* (12-13). The metaphor of a protective shell was an appropriate one, as it conjured up the image of Tim retreating from threat.

Sadly, Tim’s misperceived self-control and his intimate relationship with alcohol deteriorated as he endeavoured unsuccessfully to fill the internal, emotional emptiness. For Tim, the disabling aspect of alcohol revealed itself in the developed dependence that threatened to control him: *“Without it I wasn’t happy”* (10-11).

Alcohol maintained Tim's self-imposed isolation, by exacerbating his schemas of defectiveness and shame and reinforced his avoidance of intimacy: "*When I'm drinking in the house I tend to shut myself away. I don't like people, you know, I don't like people to see that side of me*" (31-32). Alcohol also disabled him physically as well as socially; it increased the 'learned helplessness' state, represented in Tim's internal working model of others as being essentially more powerful and threatening and therefore to be feared and avoided.

I had the sense of Tim as a passive victim, similar to the helpless child abused by his mother and betrayed by those who ridiculed and abused him: "*I am in my third property now, er, because of bullying by neighbours, you know that's, um, the reason I think I'm picked on by neighbours. Um, the main reason is because I can't fight them because of my disability, so, um, that side of it is very negative*" (52-57).

According to attachment theory, Tim's internal working model of relationships was that affection and care were limited, if not non-existent and that others' power lay in aggression. Antagonising the 'powerful other' was threatening and therefore to be avoided; this resulted in compliance and submissiveness and was demonstrated in his perceived fear and avoidance of bullying neighbours and his seeming passiveness. He was mistrustful of people, a maladaptive schema formed by parental abuse and maintained by neighbours' bullying behaviour. Sadly, the consequences for Tim were an isolated existence living in fear of threat and intimidation, and where retreat and avoidance of intimacy were, in his mind, the only available option.

**Client 2 (Tim): Table of Themes from IPA Semi-structured Interview**

Master theme titles	Sub-theme	Transcript key words	Indicator line
<b>Surrounded by hostility</b>	Controlling mother Unavailable father Disconnectedness Threatening environment Connection through hostility Physical violence Unpredictability Trying to make sense of relationships Seeking to understand	“She was a very dominant woman” “I felt you couldn’t talk to my Dad” “They never spoke to each other” “Hostile” “It used to get physical a lot” “She used to hit me with the pots” “They would just start scrapping” “I could be violent and so could my Mum” “It was a very strange set-up”	103 133-134 105 111 115 120 116 117-118 117
<b>Burdened by multiple losses</b>	Early parental loss Loss of partner Separation and loss Premature death of son Grief, emptiness Fear of abandonment Sadness	“I was just turned 20 when they died” “My partner died 10 years ago” “Took my youngest son off me” “2 years ago my eldest son died” “Now I’ve got nothing” “I fear it happening again” “It is very negative”	106 77-78 79-80 80-81 81-82 88-89 57
<b>Sense of self eluded him</b>	Cannot find the words Struggled to find positives (pause) Stereotypical caricature Perceived invisibility	“I don’t know about that” “People have commented on my manners” “Bit of a joke” “Push you to one side”	149 151 37 57



**Client 2 (Tim): Table of Themes from IPA Structured Interview (cont.)**

<b>Master theme titles</b>	<b>Sub-theme</b>	<b>Transcript key words</b>	<b>Indicator line</b>
<b>Became emotionally detached to survive</b>	Lack of emotional intimacy Emotional distancing Aloneness Resigned acceptance	“Very few” “It has stopped me getting close” “I’ve only got one friend at the moment” “There’s nobody else. Nobody else”	98 88 61 62
<b>Felt alienated and isolated</b>	Parental disconnectedness Inability to communicate Physical distancing	“They never spoke to each other” “I felt you couldn’t talk to my Dad” “I got out there as soon as I could”	105 133-134 125
<b>Developed defensive coping strategies</b>	Attempted to fit in Compliance Minimised abuse	“I just try and be ordinary” “I try to be as nice as I can” “It was a very strict upbringing”	141 141 153
<b>Experienced positive relationship</b>	Allowed a voice Non-judgmental	“He does listen” “He accepts me for my faults”	67 67-68
<b>Dichotomous relationship with alcohol – a double-edged sword</b>	Boosted self-esteem Confidence-building Dependence Sense of shame Self-imposed isolation Victimisation through illness and disability	“Bit of a ‘Jack the Lad’ “Do a lot of things” “Without it I wasn’t happy” “Don’t like people to see that side of me” “I tend to shut myself away” “I can’t fight them because of my disability”	12 12-13 10-11 31-32 30-31 54-55

### **Memo 3 Jean**

Jean was a married, employed woman in her mid-forties with two children who had been drinking excessively for approximately fifteen years.

#### **Barren land of emotional deprivation**

Prolonged emotional deprivation is suggested to be psychologically damaging to a child's sense of self and emotional wellbeing. Jean identified her negative family experiences as the underlying cause of her alcohol problems: "*I think the relationship with my family has made me drink. (Laughs). I think that is probably the root cause of it all*" (65-66). I sensed that her defensive laughter belied an inner tension and hurt that Jean kept firmly hidden. However, Jean's tone suggested controlled anger, a possible defence against the emotional pain of her mother's explicit cold, rejection: "*My Mum told me she didn't want me. She was forty when she had me and if it wasn't for me they could have bought a shop and lived by the seaside and all this, so I really felt a bit of a...*" (111-113).

I wondered whether the end of the sentence might have been 'nuisance' or 'intrusion' as if by her apparently unexpected arrival upsetting her parents' plans, that she was somehow to blame for her mother's behaviour. Possibly Jean had internalised her mother's unfulfilled expectations and disappointment. From an attachment perspective, Jean's negative experiences of emotional neglect and overt maternal rejection and seemingly physically and emotionally absent father left her with a projected sense of being unloved and unwanted that was internalised to feeling unlovable. It was evident from Jean's perspective that her very existence was quite openly a cause of resentment to her mother; her feelings and needs were therefore unable to be expressed, due

to her mother's emotional unavailability. Any vulnerability was therefore suppressed and contained. Her demeanour was very much of self-containment, although a certain passive aggression was detectable. This had also been repressed for fear of further rebuff from Jean's cold and unavailable care givers.

I sensed in Jean the implicit sadness and loss of an unwanted child in an emotionally barren environment with little warmth or connection: "*It was a very 'hands-off' upbringing, very strict and no affection at all, physical or emotional (71-72)*". It seemed, however, that she had adapted to contain her emotions very well as self-protection from further rejection, with little expectation of her emotional needs being met. Research identified compulsive self-reliance and self-containment as characteristics of insecure attachment style (Lapsley *et al.*, 2000).

### **Felt aloneness**

Emotional deprivation also instils in a child a sense of feeling different but unable to comprehend the reasons why, other than it must be their fault. Jean's childhood experiences of loneliness were embodied in one decisive and abrupt word that epitomised her isolation when she was asked about who she felt close to when she was growing up: "*Nobody*" (84). This may have stemmed from the absence of parental nurturing that prevented her from risking further rejection and increased her self-sufficiency as a protective defence (Howe, 2005). Jean's emotional detachment as a survival strategy was also evident in her dismissiveness of parental need: "*I have no relationship with them, basically*" (70).

Jean felt her mother even alienated her from her sister, a relationship that was denied her until they were much older: "*My mother did a divide and conquer and we really haven't got to know each other until quite recently*" (77-78). This was supported by research that revealed child-mother security of attachment was positively correlated with levels of sibling conflict (Volling & Belksy, 1992).

### **Excluded and humiliated**

Jean's aloneness as a child was seemingly imposed, rather than chosen, due to her mother's critical disapproval: "*I wasn't allowed to have friends. Friends were never good enough, always something wrong with them. I wasn't allowed to go to their house; they weren't allowed to come to my house. My local, the ones I lived next door to were all boys, and when I had my first period I was barred from seeing them, and I grew up with them; all my life. I wasn't allowed to see them from that day on, so...*" (84-88). I imagined this helpless and confused child wondering what was wrong with her, that she was separated from those closest to her, and absorbing the criticism as hers to own.

Surprisingly, the inflicted segregation also extended to alienation from her relatives, increasing the sense of separateness and felt difference: "*And certainly no family. There were my cousins, who did live close by, but I wasn't allowed to mix with them at all*" (94). In Jean's mind, the enforced avoidance of contact with boys, and the negative message around emotional intimacy was intrinsically linked to her burgeoning sexuality. It could be interpreted in two ways: that boys were untrustworthy and perceived as a possible threat or that Jean herself could not be trusted in the presence of boys and that untoward sexual activity might result. Either way, the loss of important relationships at a

crucial time of social development may have exacerbated Jean's negative self-identity and perceived unlovability.

Jean physically distanced herself from her parents as soon as she could, similar to Tim's prematurely leaving home as a means of escape from an intolerable and threatening situation that should have been a haven of safety: "*Just eating and sleeping there until at the age of 18 I got myself out*" (114). The metaphor of a temporary lodger springs to mind, of one who lives in a house but has no emotional connection to the inhabitants. It suggested Jean's early life consisted of a solitary existence with little sense of interpersonal relatedness towards her parents or anyone else.

### **Attained coping strategies and defences to survive**

People employ different coping mechanisms to deal with maladaptive schemas related to disconnection and rejection. Jean's over-compensatory coping style was to appear efficient and capable and self-contained; she felt her vulnerability was something to be hidden, possibly because her expressing need was something to be despised and she was afraid of further rejection: "*They might think you're a bit weak*" (27). Alcohol appeared to decide how she behaved in different social situations, and Jean described a 'chameleon' effect as she altered her identity according to the people with whom she associated and the context, and yet ruefully accepting that in each social situation, no-one really saw her true self: "*To some people I'm not a drinker; to other people I'm one of the girls. I drink and have totally different relationships with those people. And in both, I'm not really being myself*" (29-30). From a schema theory perspective,

Jean's over-compensatory coping strategy against her fear of social isolation was to blend in with other groups and to comply.

Interestingly, her relationship between the marginalised group with whom she worked on a voluntary basis was the exception: "*Yes, it's women who work in prostitution, who are trying to exist. There are drug issues and alcohol issues involved with them, but I've worked with them for years and I am very close to them*" (49-51). Possibly, their vulnerability, with which she could identify, made her feel at ease.

Jean's over-compensatory coping strategy against inner sadness was through humour: "*They think I'm funny, witty*" (144) or to engage in compulsive care giving that gave her a sense of being needed to combat the fear of childhood rejection: "*I'm very helpful. If anyone needs a hand, then they know I'm there. I'm a 'sorter outer' of other people's problems, emotional and you know, actual, getting the rent paid or whatever they have to do. I baby-sit for them any of the evenings, so they might go out. Um, I know I have quite a lot of empathy with people and I'm not judgmental at all*" (144-149).

It suggested that she had become the 'emotionally available parent' to an alienated group stigmatised through their sexual behaviour by society, feelings with which Jean could relate, with her mother's treatment of her and boys. Many of the women had probably suffered similar experiences of insecure attachment and childhood neglect and abuse. Possibly, Jean fulfilled a need to be needed that reduced her feelings of inner emptiness and unworthiness.

### **Confused by parental avoidance of intimacy**

Parental marital discord can contribute towards a child's feeling of instability and anxiety. Jean's early negative experience of her parents' relationship revealed a confusing absence of outward affection or emotional bonding: "*I don't think they loved each other at all. There was never any arguments or fighting, but there was never any affection*" (120-121). Although Jean witnessed no overt hostility, it felt implicit in the disconnectedness and emotional detachment she experienced that was difficult for her to understand: "*She did the housework and he did his work and that was that*" (125). It seemed that Jean's early experiences of adult relationships were one of avoidance of intimacy, with no sense of warmth.

### **Afraid to trust**

Fear of rejection is intrinsically linked to inability to trust in others. Jean's general mistrust of people necessitated the over-compensatory strategy of compliance to avoid being abused, with the exception of the prostitutes, possibly due to their non-judgmental acceptance of her: "*They like me for who I am, they can take me drinking or not drinking. I don't have to put on a front for them, in any way. I really am me*" (55-56). I sensed that Jean did not have put up her usual emotional defence against fear of rejection. She could reveal herself to this socially excluded group who were possibly alienated themselves due to the social stigma regarding their profession; she could also align herself in relation to the women's own issues with alcohol. Jean therefore felt comfortable with them on social and emotional levels.

### **Diffuse sense of self**

The negation of expressed needs can evoke a lack of self-importance that inhibits a healthy and positive concept of self. Jean's diffuse identity appeared to metamorphose, according to the situation: "*And in both I'm not really being myself*" (31). Her role as mother was very important to her as was the mutually reciprocal affection: "*I adore them and they adore me*" (133-134). However, from a schema theory perspective, her outpouring of love towards her children could be construed as an over-compensatory strategy to prevent triggering uncomfortable feelings around her own unlovability and a neediness to be loved equally in return.

### **Stable base mediated against insecurity, worthlessness**

Research suggests that the experience of a positive and nurturing adult relationship could offset the negative effect of childhood insecure attachment (Bretherton, 1992). Jean's stable current family base of husband and children appeared to act as a mediating factor upon her sense of security: "*My husband, my children*" (131).

Interestingly, despite her neglectful upbringing, Jean had the capacity to be self-reflective and the internal resources to detect perceived, similar patterns to her mother's behaviour in her own interpersonal relatedness that she was determined not to re-enact: "*I like the fact that I've been able to change myself, that I could see the tendencies and traits of my Mum in me*" (131-133), thus breaking the cycle of possible intergenerational transmission of cognition, affect and behaviour associated with insecure attachment style highlighted in research (Main *et al.*, 1985).



It is possible that having the benefit of the secure base of a stable, long-term relationship in adulthood gave her the security of attachment that she had missed as a child. This enabled her to emotionally invest in her own intimate family relationships. Jean had seemingly made a conscious decision to treat her children quite differently: *"I like the fact that I've brought up my three children with total affection"* (132-133). The emotional intimacy and self-validation Jean missed out on as a child was poured into her children with its own reward.

### **Ambivalent relationship with alcohol**

Jean appeared confused, regarding her attitude towards alcohol, suggesting that that for her it could be problematic, depending upon her social circle she inhabited or equally it provided a solution in the calming effect it exerted: *"Sometimes I don't think it's an issue"* (3). Jean's ambivalence regarding her relationship with alcohol oscillated between neediness and rejection and it may well have symbolised her feelings regarding her relationship with her parents. Her first experience of alcohol was whilst living at home and may have an unspoken expression of need towards her parents that would almost certainly have elicited a negative response, with the self-fulfilling prophecy of reinforcing her lack of self-worth: *"The first time I drank I got very drunk and was very ill"* (8-9). Despite the ill-effect of severe intoxication, her continuing perseverance suggested that alcohol satisfied an unmet need and reduced uncomfortable feelings of anxiety: *"It was nice and I used it as relaxation on a regular basis"* (14). It seemed to provide that elusive feeling of warmth and security for which she was searching.

### Client 3 (Jean): Table of Themes from IPA Semi-structured Interview

Master theme titles	Sub-theme	Transcript key words	Indicator line
<b>Barren land of emotional deprivation</b>	Root cause of alcohol problems	"I think the relationship with my family has made me drink"	65
	Maternal rejection	"Mum told me she didn't want me"	111
	Cold, neglectful environment	"No affection at all"	72
	Lack of nurturing	"It was a very 'hands off' upbringing"	71-72
<b>Felt aloneness</b>	Isolated existence	"Nobody"	84
	Disconnectedness	"I have no relationship with them"	70
	Alienated from sister	"My mother did a divide and conquer"	77-78
<b>Excluded and humiliated</b>	Social exclusion	"I wasn't allowed to have friends"	84
	Search for explanation	"Friends were never good enough"	84-85
	Sense of shame re: sexual development	"When I had my first period I was banned from seeing them"	87-88
	Imposed segregation	"I wasn't allowed to mix with them at all"	94
	Physical distancing	"I got myself out"	114
<b>Attained coping strategies and defences to survive</b>	Protective defence	"They might think you're a bit weak"	27
	Social 'chameleon' enabled her to fit in	"To some people I'm not a drinker, to other people, I'm one of the girls"	29-30
	Identifying with marginalised group	"I am very close to them"	51
	Compulsive care giver	"I'm very helpful"	144
	Humour as emotional defence	"They think I'm funny, witty"	144
	Problem-solver	"I'm a 'sorter outer' of people's problems"	145
	Over-compensating	"I have quite a lot of empathy with people and I'm not judgmental at all"	148-149

**Client 3 (Jean): Table of Themes from IPA Semi-structured Interview (cont.)**

<b>Master theme titles</b>	<b>Sub-theme</b>	<b>Transcript key words</b>	<b>Indicator line</b>
<b>Confused by parental avoidance of intimacy</b>	Searching for explanation Emotional desert Physical disconnectedness	"I don't think they loved each other" "There was never any affection" "She did the housework and he did his work"	120 121 125
<b>Afraid to trust</b>	Mistrust as emotional defence	"I don't have to put on a front"	55-56
<b>Diffuse sense of Self</b>	Positive maternal role Mask removed - who am I?	"I adore them and they adore me" "I'm not really being myself"	133-134 31
<b>Stable base mediated against insecurity, worthlessness</b>	Importance of family Developed self awareness Insight into re-enactment Broke the pattern	"My husband, my children" "I've been able to change myself" "I could see the tendencies" "I've brought up my three children with total affection"	131 131 133 132-133
<b>Ambivalent relationship with alcohol</b>	Confusion – solution or problem? Negative first experiences Relieved anxiety	"Sometimes I don't think it's an issue" "I got very drunk and was very ill" "It was nice"	3 8-9 14

## **Memo 4 Lydia**

Lydia is a twice divorced, unemployed woman in her early thirties who has had a problem with alcohol for approximately ten years. Lydia's issues appeared to focus upon childhood perceived separation, loss and rejection, which were subsequently re-enacted in adulthood.

### **Distress at abandonment**

Although Lydia felt that her relationship with alcohol grew from reliance after her husband left her, to fill the emotional gap of emptiness and to deal with the negative feelings that she was experiencing, I sensed that the inner loneliness was already present a long time ago: "*I was very isolated*" (26). It seemed like a complicated bereavement, as if she was grieving for a deeper loss, loss of expectation and absence of a nurturing relationship: "*The feeling of loneliness. I wasn't able to sleep. It was very difficult, very difficult*" (30-31).

The rejection and distress Lydia experienced may have triggered for her deeper emotions regarding her own perceived abandonment by her father as a child and left her feeling very child-like, vulnerable and uncared for: "*I was left on my own with a young baby*" (28-29). From a schema perspective, Lydia had the expectation of being abandoned, and her transitory and subsequent lost relationships reinforced that schema of others being unreliable and eventually leaving her.

### **Devastated by loss**

Alcohol can become a means of suppressing uncomfortable and distressing emotions around loss and rejection. Lydia's drinking was possibly a perceived

maladaptive coping mechanism to suppress painful feelings arising from past and present separation and loss: *"That was when I started to drink because of how I felt" (20)*. Ironically, it served to reinforced her feelings of inadequacy and failure and to result in her being permanently separated from the children, exacerbating her distress and sense of worthlessness: *"When they were taken away I was a mess" (80)*.

Her similar negative childhood experiences were of losing her father through separation: *"My Mum and Dad got divorced, um, um, when I was about nine" (108)* and she unwittingly repeated the process with her own children, with minimal contact as she had experienced with her father: *"Very little" (120)*. From a schema perspective, Lydia's coping style seemed to be in the 'surrender' response, re-enacting and reliving the emotional pain of separation and loss.

### **Deprived of affection**

The pain and loss of emotional intimacy was evident and intense: *"I felt alone, I felt hurt about what might have been" (25)* as she reflected upon unfulfilled expectations and possibly reminded her of her own father's seeming selfishness and emotional unavailability: *"My Dad would do, um, his own thing" (128-129)*. Sadly, her own children may well utter similar words, if their perceptions are that she put alcohol and her wants before their needs, thus repeating the pattern of perceived rejection.

Lydia's childhood lived experience was such that she felt unimportant and deprived of her father's presence and care. There was a sadness and yet a resigned helplessness about her, of no expectation, possibly because she felt

undeserving, or that she had internalised his lack of care into her worthlessness.

### **Shame and defectiveness**

Alcohol becomes a reinforcer of negative self-perception. Lydia felt very guilty regarding her destructive drinking behaviour and her perceived weakness: “*I feel quite guilty for the things that I’ve done*” (153-154) and particularly when in the presence of her children: “*They have seen me drunk a couple of times*” (83). Alcohol maintained her early maladaptive schema around defectiveness/shame, rooted in childhood rejection, behavioural patterns that she was re-enacting with the possible neglect and emotional unavailability towards her own children through her drinking. It almost felt like Lydia was also punishing herself and that alcohol was a form of self-harm: “*I do beat myself up a lot*” (161). The consequence of Lydia’s self-defeating core beliefs and repetitive behavioural patterns was to maintain her negative feelings of self-denigration: “*I’m not good enough*” (156).

### **Social Isolation**

Lydia’s misuse of alcohol induced alienation and an imposed social isolation, although it seemed like an unwelcome exile that she neither wanted nor enjoyed, yet resignedly accepted: “*People just tend to stay away*” (48). It was as if Lydia felt she deserved to be ostracised, because of her perceived worthlessness.

### **Sense of self defined by alcohol**

I sensed in Lydia a negative self-identity and she exhibited a real internal struggle to perceive anything positive about herself, preferring to place herself in this familiar self-denigrating mode: "*I do beat myself up a bit*" (161).

Lydia drew clear distinctions between the two aspects of herself, in terms of her alcohol state: "*Drinking, I am awful, really awful*" (57). It conjured an image of a contrasting 'Jekyll and Hyde' character, of the despised drinker whose personality flaws bore no resemblance whatsoever to the 'sober' one: "*I am quite kind and considerate*" (177). It felt like a distinct separateness, and that the negative aspect of her was dominant. It revealed Lydia's lived experience of her internal conflict, both with herself and with alcohol as she struggled to accept a more positive part of her identity.

Lydia's seemingly glowing description of her partner gave me the uncomfortable feeling of perceived unreality and his expression of disgust at her alcohol-related inadequacies suggested more a reinforcement of her own worthlessness: "*My partner, he is very good; he has been helping me out a lot*" (63-64). From a schema perspective, it is possible that her surrendering coping style influenced her choice of critical partner that compounded her sense of shame and defectiveness.

### **Developed survival coping strategies**

The use of laughter as a protective defence against painful emotions is often a means of minimising or denying negative affect, which was apparent in Lydia's disguised resentment: "*We never had any money*" (*laughs*) (19). Her previous two husbands' unreliability and unavailability mirrored her childhood

experiences of her father but also her expectation that people cannot be relied upon nor trusted. Quite possibly, from a schema theory perspective, laughter was an avoidant coping strategy to prevent triggering feelings of feeling misused and abused. She also used the over-compensatory response of neediness in her adult relationships, which, if unrequited, would have aroused greater anxiety and fear of abandonment: "*I'm very, very, very close to*" (66). Contradictorily, it could be suggested that Lydia's possibly excessive demands for emotional intimacy and nurturing to fill the emptiness she felt inside may well contribute to the possibility of a partner leaving.

From an attachment perspective, her internal working model of others assumed that others would also betray or leave her; this evoked the surrender coping responses related to the schema of emotional deprivation by choosing neglectful and unreliable partners who repeated similar but familiar behavioural patterns to which she could relate, uncomfortable though that may be: "*Most of those have been drinkers*" (68). Their eventual leaving would re-awaken feelings of loss and emotional pain around her own father's departure, which she ameliorated with alcohol.

Although Lydia acknowledged the closeness she experienced with her mother it was also a volatile relationship that echoed her own parental means of communicating through aggression: and suggested a learned way of deflecting potential hostility by attacking first: "*Swearing, maybe a bit of fisticuffs*" (115). Her difficulty in recalled experiences suggested that harm minimisation in the form of partial amnesia was a protective defence against past stressors that threatened to overwhelm her if released: "*I don't remember too much*" (135).



### **Worried by parental hostility**

Lydia's early experiences of interpersonal relatedness were both persistently threatening, with communication mostly through mutually aggressive altercation: "*They were always arguing*" (128). From an insecure attachment perspective, this would have invoked in Lydia anxiety around both her and her parents' safety and a sense of instability and fearfulness. I felt the tension of a vulnerable child frozen in a state of helplessness and caught in the crossfire between two warring parents and the fear of eliciting further discord through expressing her own needs that subsequently had to be repressed: "*I remember it being quite, quite strained*" (130).

Her emphasis upon the word "*strained*" suggested that she struggled to cope with her emotions within the context of her parent's hostile relationship: "*A lot of hostility*" (134). To Lydia, relationships were therefore experienced as intimidating and likely to trigger fear and anxiety, inducing a passive response, in order not to antagonise the situation further. This may have been why Lydia remained in relationships that were unrewarding and uncaring, because it was a familiar place and she deserved nothing more.

### **Contradictory relationship with alcohol – friend or foe?**

As with the other interviewees, Lydia's internal conflict centred on the 'double-edged sword' of alcohol, that gave the illusion of friend, but in a subversive way also became the enemy. Initially, it afforded her the ability to interact socially and have a sense of inclusion: "*It was quite fun, you know, I enjoyed it as a social thing*" (12). It was an emotional connectedness on a superficial level that

enabled her to relate to people. Lydia perceived alcohol as a supporter, a friend, in its confidence boosting appeal that over-rode her inhibitions and anxieties around her feelings of worthlessness: "*I feel able to express myself, open up a little bit more, more confidence and be able to speak to people, because in relationships with people I am very shy. I just tend to sit back and listen, rather than get involved. Drink did help me to overcome those fears of meeting people and talking to them*" (35-39). Alcohol empowered Lydia, by temporarily removing her sense of emptiness and worthlessness and possibly giving her the perception of feeling in control.

The negative aspect, however, was to unleash aggressive behaviour that seemed quite incongruous when I surveyed this quiet and meek, retreating figure in the corner: "*I can be known to be quite violent and verbal, vicious with my mouth*" (47-48). I found it difficult to equate two such extreme images, as had occurred with Susan. It seemed that anger and resentment that had been stored and repressed for so long was released through the mediator of alcohol, feelings that seemed to scream: "*I am here and in pain*" but no one understands because the full story is never told and the drinker is perceived as the problem.

It seemed that for Lydia, her entrapment occurred through emotional suppression constructed from negative and emotionally neglectful childhood experiences that occasionally escaped like a metaphorical demon wreaking havoc in its path until it was retrieved and safely hidden away until the next time. Sadly, when Lydia was able to express her true feelings, they were ignored or worse, denied her because the alcohol also coloured her partner's perception. It had the effect of sabotaging the relationship in terms of rejection

and avoidance of intimacy, which ironically was what she most feared: “*It just wasn’t happening. There was no communication, just disgust, really*” (93-94).

Lydia engineered her partner’s rejection and feelings of disgust that emulated her own self-loathing. From an attachment perspective, Lydia’s internal working model of relationships maintained her anticipation of rejection and abandonment experienced in childhood that were then re-enacted in her adult relationships.

#### Client 4 (Lydia): Table of Themes from IPA Semi-structured Interview

Master theme titles	Sub-theme	Transcript key words	Indicator line
<b>Distress at abandonment</b>	Left to cope Feelings of rejection Grieving for loss	"I was very isolated" "I was left on my own with a young baby" "The feeling of loneliness"	26 28-29 30
<b>Devastated by loss</b>	Distressed by felt loss Separated from children Loss of relationship with father Sadness at minimal contact	"That was when I started to drink" "When they were taken away I was a mess" "My Mum and Dad got divorced" "Very little"	20 80 108 120
<b>Deprived of affection</b>	Pain of loss Father's emotional unavailability	"I felt alone, I felt hurt" "My Dad would do, um, his own thing"	25 128-129
<b>Shame and defectiveness</b>	Shameful behaviour invoked Blamed herself for failing Self-denigration Self-punishing and critical Feeling unworthy	"They have seen me drunk a couple of times" "I feel quite guilty for the things that I've done" "I'm not good enough" "I do beat myself up a lot" "My partner, he is very good, he has been helping me out a lot"	83 153-154 156 161 63-64
<b>Social Isolation</b>	Alcohol induced alienation	"People just tend to stay away"	48
<b>Sense of self defined by alcohol</b>	As a drinker Sober	"Drinking, I am awful, really awful" "I am quite kind and considerate"	57 177

**Client 4 (Lydia): Table of Themes from IPA Semi-structured Interview (cont.)**

<b>Master theme titles</b>	<b>Sub-theme</b>	<b>Transcript key words</b>	<b>Indicator line</b>
<b>Developed survival coping strategies</b>	Hidden feelings	"We never had any money" (laughs)	19
	Neediness	"I'm very, very, very close to"	66
	Repeated neglectful patterns of relating	"Most of those have been drinkers"	68
	Communication through aggression	"Swearing, maybe a bit of fisticuffs"	115
	Amnesia as protective defence	"I don't remember too much"	135
<b>Worried by parental hostility</b>	Communication through aggression	"They were always arguing"	128
	Anxiety-provoking atmosphere	"I remember it being quite, quite strained"	130
	Relationships as threatening	"A lot of hostility"	134
<b>Contradictory relationship with alcohol – friend or foe?</b>	Social inclusion	"I enjoyed it as a social thing"	12
	Confidence booster	"I feel able to express myself"	35
	Unleashed aggressive behaviour	"I can be known to be quite violent and verbal, vicious with my mouth"	47-48
	Sabotaged relationship	"It just wasn't happening. There was no communication, just disgust, really"	93-94

## **Memo 5 Paul**

Paul is a divorced, unemployed man in his early sixties, who has not been in an intimate relationship for a long time and who has been alcohol dependent for over forty years. Paul began drinking in his teens, which quickly developed into a long-term alcohol dependence.

### **Addicted to alcohol**

It is suggested that a qualitative difference exists between alcohol dependent and social drinkers, namely their inability to control drinking once it commences. Paul's experiences seemed to be just that and he maintained that he became addicted from the beginning: "*I got totally with the drink, and that was virtually the first time I drank*" (16). What was initially a social experience rapidly developed into a compulsive urge to drink: "*It was a social thing. But once I started I didn't want to stop*" (25). Paul's seeming lack of self-control and self-regulation was a trait that manifested itself in other aspects of his life, particularly relationships.

It seemed that alcohol overtook his life in that Paul was totally controlled, to the point that everything else was secondary: "*I suppose, when I have a drink I'm very selfish. I just want to.... I can't see the point of going into a pub and spending what is now virtually a lot of money and not feel anything from it, and I would say it felt like that for, oh a good 30 years. If I go out to have a drink I want to feel the effect, so from that point of view nothing that anyone could say would change it*" (34-38). His experiences suggested that the compulsion rendered him a seemingly helpless victim within its grasp, unable to make a decision to stop: "*Once I started it was out of my hands virtually*" (516). Paul

appeared to have little sense of responsibility for his actions or the consequences, externalising alcohol to be some governing force that acted upon and controlled him, rather than internal lack of control for which he needed to take charge.

### **Struggled to cope - escaped from reality and responsibility**

Insecure attachment arising from negative childhood experiences may influence the perception of helpless victimisation and inability to control what may happen. Paul's abnegation of responsibility re-occurred within the interview, in the form of blaming others for his employment loss, other than examining his own part to play: "*They used the drinking as an excuse; they said I wasn't reliable at work*" (253-254).

It seemed to be a perpetual internal struggle around choosing alcohol over Paul's future and the possibility of an intimate relationship, with the sad inevitability that he chose alcohol over all: "*One day, I went out of the office at 9 o'clock to go to the bank to get the money, went into a pub. I remember walking out of the pub at just after 3, going to a pub in A... where I used to live. I remember leaving that pub just before half five to go back to the pub and the next thing I remember I was waking up in hospital*" (283-288). It could be interpreted as selfishness on Paul's part, or possibly fear of intimacy or rejection that prevented him from returning for his pregnant girlfriend. Either way, Paul seemed to emotionally disconnect from his previous life with apparent ease and he appeared to have no further contact with either the girl or his child, as if they ceased to exist within his consciousness.

## **Mistrustful through betrayal**

Mistrust through abuse or rejection is a common theme throughout the interviews. Paul felt betrayed and disappointed that his relationship with others seemed to revolve around being mistreated: *“Most of the others that I have been with have been abusing me” (45-46)* or taken advantage of through being perceived as someone always available and willing to give: *“An easy touch” (146)*. This led to his continual vigilance for ulterior motives: *“All I’m interested in is the drinking. When I don’t drink that attitude is completely different but with a lot of them it’s a two -faced attitude, you know, it’s, they’re all friendly because they know that they’d be getting something out of it, out of me when I’m drinking. It’s not out of concern for me. All they say is “it’s good to see you without a drink, it’s good to see you behaving yourself” but that only means that there’s more for them, meaning money” (136-142)*.

It seemed difficult for Paul to see people in a positive light, in that they might genuinely be glad that he was not drinking so heavily. Perhaps he can only perceive the negative, mistrustful view that people would see his relative sobriety merely as a reason for further exploitation, usually financial. This would inevitably influence Paul’s concept of relationships, informed by the schema of mistrust and abuse, that people will ultimately use and abuse you for their own purposes.

## **Defectiveness and shame**

Alcohol dependence reinforces the early maladaptive schemas of worthlessness and self-abasement. Paul seemed to be engaging in a similar re-enactment of how his father had behaved when he was a child, placing need for



alcohol before the family's basic requirements: "*There were times when I literally left her, I could say almost penniless*" (59-60). It was as if this was the accepted norms and values and not exceptional or to be questioned, although his admission of leaving his family virtually destitute did seem to elicit a certain discomfort. It is likely that Paul's experiences of insecure attachment were repeated in his own unavailability towards his family.

Paul's apparent discomfort with himself was further revealed in his disclosure of alleged offences of a sexual nature, that of possession of indecent photographs of the under-age girls known to him, with whom in the interview he had seemingly developed a possibly inappropriate relationship: "*How can I put this without sounding awkward? This case I'm up for tomorrow, right, it's possession of indecent photographs of girls, five charges, six charges of girls, under 16*" (328-331). Paul appeared keen to justify to me at length the explanation for his being in such a situation; his desire to minimise the allegations suggested an inner conflict occurring between reality and fantasy and a need to possibly deflect his sense of shame and place him in a more positive and congenial light.

### **Abused becomes abuser**

It is possible that abused children can become perpetrators of abuse. Paul's behaviour could be interpreted as 'grooming' by a sex offender; it suggested that he intentionally or unintentionally targeted vulnerable children of neglectful and possibly abusive parents who may not be as vigilant regarding with whom their child is entrusted: "*The first one of them I met, I'd met her mother. Her mother is a dual user; she used any drugs she could get: 'speed', 'dope', crack*",

*heroin. She smokes continually 'dope' and she drinks as well. She's an alcoholic as well' (344-348).*

It is possible that Paul took advantage of neglectful parenting to gain access to the child: *"Eventually she started stopping over because her mother just wasn't bothered" (361-362).* The identity he created for himself, that of a benevolent grand paternal figure may have enabled him to gain their trust: *"He's my Granddad" (417).* This could be indicative of paedophilic, offending behaviour or it could be a lonely, mistrustful old man who finds it difficult to relate to adults and prefers the less threatening company of children.

Although the interpretation is based upon conjecture, my several years' experience of working with sex offenders in a prison environment did nothing to allay my fears over Paul's unusual behaviour with the children, and the likelihood that he had developed possibly inappropriate relationships with them, to the extent that it was a loss to him when he was moved away by probation, which may have also been for his own as well as the children's protection: *"I missed them" (450).*

Recent research has highlighted a pattern of uncaring parenting, avoidant and anxious/ambivalent attachment style and personality disorder in child abusers; (Bogaerts, Vanheule & Declercq, 2005). It is possible that Paul possessed all three risk factors.

## **Perceived rejection and worthlessness from birth**

Bowlby (1980) implicated early maternal rejection and disruption of emotional bonding as contributory factors to avoidant attachment style; Paul seemed under no illusion that he was not wanted by his mother, which she outwardly displayed and her perceived indifference to whether he survived as a baby seemed to have had a profound effect upon their relationship: *“My Mother, apparently, had her heart set on a girl, and in those days they couldn’t tell you what you were having, and she had her heart set on having a girl, and there was a saying when I was born that there was a chance I was going to die and my auntie went up to my Mother and said, “Look, there’s a chance he may not live; what are you going to call him?” And my Mother’s response was, “If it’s a ‘him’ I am not interested”. So my Auntie named me”* (486-492). The rejection appeared initially to impact at a subconscious level, before Paul became aware of his birth circumstances.

This underlying sense of felt difference from his brothers insidiously pervaded his emotional wellbeing; although Paul could not explain it, he experienced it as a negative force. Later, the mother-child relationship deteriorated further, due to Paul’s excessive drinking, which evoked painful memories for his mother, as he unwittingly reminded Mum of her alcohol-dependent father: *“It deteriorated with my mother when I started drinking, the way that I was, because her father was an alcoholic”* (507-508). It is possible that an interlinked family history of insecure attachment is implicated in Paul’s development of self and his relationship with others, that is repeated in generational patterns of absent and emotionally unavailable parenting: *“My father would go out, straight from work into the pub, and, er, my Mum would have to go and drag him out, not literally,*

*but you know what I mean, say, "Come on, I want money to go and do the shopping" (525-528).*

Paul's mother witnessed in her husband similar behaviour in her own alcohol dependent father, and Paul did the same with his family. Thus the dysfunctional cycle of neglect and avoidance of intimacy continued, displayed in Paul's inability to relate to his mother and their emotional distancing: "*I could tell my Auntie things that I couldn't tell my Mother*" (543) and his subsequent detachment from his own family.

### **Experienced loneliness, isolation and alienation**

There was a sense of isolation and alienation as Paul's avoidance of emotional intimacy seemed to continue into adulthood, echoed in his apparent difficulty in making and maintaining close relationships: "*I've only had three real friends*" (44). Paul's drinking exacerbated his loneliness, resulting in the subsequent divorce and separation from his children: "*She used the drink to stop me seeing the kids and I had no contact with my daughter for 20 years*" (131-132).

Throughout the interview, however, I was conscious that the sadness was self-involved, and that there seemed to be little, if any empathy towards his children and what that might have meant for them or any concern for these losses.

It was as if Paul was either emotionally disconnected from the devastating consequences of his lived experiences with alcohol or resignedly accepting of his fate as a seemingly passive victim at the mercy of life events. Paul's extreme isolation was encapsulated in one word: "*Nobody*" (321). I had the sense with Paul that possibly he had minimised his childhood experiences for

self-protection, and that I did not know the whole story. It had the feeling of a jigsaw with several of the pieces missing, and I was left in a state of uncertainty and confusion regarding Paul.

The loss of his perceived 'grand paternal' role with the children was the only time Paul seemed to really engage with feelings around loss: "*When I moved up here from L... I missed their company because they used to come round every night; my house was just 'open house' and they'd come in, they'd put the telly on and I had to suffer 'Eastenders' or 'Coronation Street' or such thing. But they were good company because they were never cheeky, they never took advantage. You know, I'd have a smoke, I'd have my tobacco there; they'd smoke it while they were in the house but they never took any with them*" (335-342).

Perhaps the loss of the children took away his fantasised grandparental role, that of being needed by a disenfranchised, vulnerable group to whom he became this seemingly inoffensive and benevolent figure who allowed them to do as they please and indulge in secretive and forbidden behaviours, such as smoking. However, it could be argued that in reality Paul behaved at best, irresponsibly and unwisely and at worst, abusively, and certainly in no way that a loving grandparent would behave towards children in his care. The question arises as to what part did the real parents play in this uncomfortable scenario?

### **Diffuseness of identity – playing the character**

The stigma of alcohol dependence prevails in others' perceptions, creating a stereotype that elicits felt resentment: "*People I know just see me as an 'alcy'*"

(136). Paul's self-identity is intrinsically linked to the label, both in his and others' minds and seems inescapable, resulting in a negative sense of self and dislike of himself: *"Not a lot, as a person. Um, I've met worse. If you had asked me, had I one redeeming feature I would say no"* (566-567). This seems to conflict with the presented, idealised picture of a person who endeavours always to be kind and helpful, to the point where he seems to have constructed a compulsive care giving role to fill the emptiness inside: *(Pause) "I couldn't tell you, I couldn't tell you, no. Apart from the fact that I'm always there for them"* (604-605). There appears to be a contradiction between real and perceived self, which invokes an internal struggle.

It seems that Paul's identity is created through helping others, to the extent that his needs are neglected: *"I've always been there for people even if it's meant my own worth being put outside"* (621-622). There is a sense of Paul's needs being ignored in a recurrent pattern of thinking and behaviour that stemmed from parental rejection and which is maintained by the people with whom he associates. Possibly, his need to be needed is fulfilled by the vulnerable children who are similarly neglected and who seek his company. Perhaps his social incompetence or inability to interpret other's perceptions of his behaviour places him in this position. It is an uncomfortably familiar situation I find myself in, where I have listened to alcohol dependent adults who have been similarly exploited and abused as children, through parental neglect and attuned abusers, who can detect and target an insecurely attached child.

**Client 5 (Paul): Table of Themes from IPA Semi-structured Interview**

<b>Master theme titles</b>	<b>Sub-theme</b>	<b>Transcript key words</b>	<b>Indicator line</b>
<b>Addicted to alcohol</b>	Got hooked by first experience	"I got totally with the drink, and that was virtually the first time I drank"	16
	Compulsive urge to drink	"It was a social thing. But once I started I didn't want to stop"	25
	Controlled by alcohol	"I suppose, when I have a drink I'm very selfish"	34-38
	Became self-centred Helpless victim in its grasp	"All I'm interested in is the drinking" "Once I started it was out of my hands virtually"	136-137 516
<b>Struggled to cope - escaped from reality and responsibility</b>	Abnegated responsibility	"They used the drinking as an excuse; they said I wasn't reliable at work"	253-254
	Chose alcohol over relationship	"I went out of the office at 9 o'clock to go to the bank to get the money, went into a pub"	283-288
	Drank to oblivion	"The next thing I remember I was waking up in hospital"	288
<b>Mistrustful through betrayal</b>	Felt used and disappointed	"Most of the others that I have been with have been abusing me"	45-46
	Resented being taken advantage of	"An easy touch"	146
	Mistrustful of ulterior motives	"That only means that there's more for them, meaning money"	142
<b>Defectiveness and shame</b>	Ashamed at behaviour	"There were times when I literally left her, I could say almost penniless"	59-60
	Felt uncomfortable at disclosure	"This case I'm up for tomorrow, right, it's possession of indecent photographs of girls"	329-330

**Client 5 (Paul): Table of Themes from IPA Semi-structured Interview (cont.)**

<b>Master theme titles</b>	<b>Sub-theme</b>	<b>Transcript key words</b>	<b>Indicator line</b>
<b>Abused becomes abuser</b>	Targeted vulnerable children Took advantage of neglectful parent  Gained trust through paternal figure Emotional attachment in inappropriate relationship	“Her mother is a dual user” “Eventually she started stopping over because her mother just wasn’t bothered” “He’s my Granddad” “I missed them”	344 361-362  417 450
<b>Perceived rejection and worthlessness from birth</b>	Mother rejected him  Felt unwanted, cast aside Reminded Mum of negative childhood Absent father through alcohol  Emotionally distant from mother	“My mother, apparently, had her heart set on a girl” “So my Auntie named me” “Her father was an alcoholic” “My father would go out, straight from work into the pub, and, er, my Mum would have to go and drag him out” “I could tell my Auntie things that I couldn’t tell my mother”	486  492 508 525-527  543
<b>Experienced loneliness, isolation and alienation</b>	Difficulty in making relationships Separated from children Denied emotional intimacy Loss of perceived invented ‘paternal’ role	“I’ve only had 3 real friends” “She used the drink to stop me seeing the kids” “Nobody” “When I moved up here from L... I missed their company”	44 131 321 335-336
<b>Diffuseness of identity – playing the character</b>	Felt resentment Disliked himself Compulsive care giving role Sacrificed self through helping others	“People I know just see me as an ‘alcy” “Not a lot, as a person” “I’m always there for them” “I’ve always been there for people even if it’s meant my own worth being put outside”	136 566 605 621-622



## **Memo 6 Carl**

Carl is an unemployed, single male in his late thirties who has been alcohol dependent for over twenty years. He has not had a long-term intimate relationship.

### **Traumatized by abusive childhood experiences**

Carl's childhood experiences of parental abuse, neglect and cruelty had clearly affected him deeply as an adult, and which I felt he continued to relive throughout his life. His abrupt words implied hidden anger and resentment at how he had been treated as he summed up his family environment in three small words that conveyed so much: "*What was it like? A total disaster*" (146). He vividly conjured images of extremes of a threatening and fearful existence, of living on the edge in a world of unpredictability and lack of containment, where even the basic needs of physical sustenance were uncertain and emotional nurturing was denied: "*Physical abuse, mental abuse, starved...*" (150).

It felt like a struggle to survive in an intolerable situation, in which he was helpless and vulnerable: "*It were Hell as kids*" (154). The caregivers supposed to protect and support Carl were the very instigators of aggression, fear and neglect. Faced with such an invalidating and hostile environment, one of Carl's coping strategies was to block out traumatic memories; amnesia was therefore a necessary and protective defence: "*I can't remember none of that. But according to my Auntie and my Nan and my Uncle I used to get battered*" (177). I felt a transferred sense of outrage at his relatives' acknowledging the abuse

and yet seemingly reluctant to intervene to protect this little boy, for whatever reason.

Carl felt singled out in terms of harsher punishment than his siblings because of his perceived rejection. Ironically, 'preference' was interpreted as to who got beaten least and his description painted a bleak picture of suffering. His felt difference stemmed from his not being wanted as a child, which was etched indelibly into Carl's mind: "*Well, we all got it in a way, I suppose, but it was me more than anybody, 'cos I was the one who wasn't wanted*" (192).

Carl's perception was that he was punished for his very existence but his suppressed emotions of pain and anger appeared rigidly controlled, as if he wanted to express that hurt but was afraid to show his vulnerability, through fear of further rejection. Research suggests that the physically abused child attempts to minimise reflecting and mentalising through fear of unleashing uncontrollable feelings (Howe, 2005), which possibly explained Carl's seeming dismissiveness of his traumatic experiences and ignoring my empathic responses.

### **Resented and feared parental abuse and neglect**

Carl's experience of parental interaction was likely to have been one of unavailability and unreliability, due to their persistent drinking: "*Mum and Dad were always at it*" (16). He felt neglected and unimportant as their alcohol needs seemed to take priority over everything else: "*They were both drinking*" (158). Alcohol misuse disrupts parents' ability to either acknowledge or respond appropriately to their children's attachment needs, leading to fear, distress, and confusion and disorganised attachment (Howe, 2005). Even Carl's basic

requirements were neglected, to the point where there was no food in the house: *"We always used to go without for weeks, never had anything"* (160). The lack of food also seemed to symbolise a barren wasteland of emotional starvation. From an attachment perspective, Carl perceived his care givers as fearful and threatening, and to be avoided at all costs to ensure his survival, leading to perpetual vigilance: *"You used to hide, every time you heard a knock on the door and you thought it was your mother". You wouldn't believe me if I told you. I used to hide under my Nan's skirts, out of the way I'd hide*" (172-173).

Laughter was again used as a protective defence against remembered pain and fear, as if what he was describing was so unbelievable that it was necessary to laugh. Carl seemed to find it incredible and confusing that he should hide from one who was supposed to protect and care for him. Alternatively, perhaps Carl used laughter to relieve my perceived discomfort and incredulity at what I was hearing.

Carl's humiliation was further exacerbated by his mother's outward rejection of him, witnessed by others, that added to his pain and sense of deprivation: *"She's told it to people in front of me in the pub"* (200). Carl's mother appeared to control him through fear, to the point where he was denied a relationship with his father: *"That was my mother; not allowed"* (222-223). Fear invoked in Carl a perceived sense of helplessness, of being a victim in a situation totally beyond his control, and from whom his father apparently offered no protection in his inability to confront his wife's abusive behaviour. From an attachment

perspective, the very source of supposed nurturing was one of threat of harm, placing the child in an approach/avoidance dilemma.

### **Humiliated by defectiveness and guilt**

Carl's maladaptive schemas around his self-worthlessness were reinforced by his drinking and his negative assumption of others' perceptions that may or may not have had an element of reality: "*You know what they're saying: "Pissed up again". You know exactly what they're saying"* (43-44). Carl's shame was also maintained by his felt responsibility for his father's death, though he was reluctant to discuss it, apart from with his one friend, whose similar experience allowed Carl to share their shameful secret: "*We don't tell anyone else about it*" (105-106).

I had the sense of an abused and vulnerable child who was entrapped by perceived blame and guilt. Carl deftly avoided further discussion by changing the subject, possibly because his implication in his father's death was uncharted territory and he felt too unsafe to engage with distressing memories. The laughter I felt was again a protective defence and a survival strategy against triggering emotional pain.

Carl's self-denigration was apparent in his inability to find anything remotely likeable about himself: "*Nothing*" (240). The long pause suggested Carl was really struggling to find something positive to say, but found it difficult to contemplate such an alien concept, having endured years of rejection, abuse and neglect. Carl's traumatic childhood experiences had left a legacy of

psychological damage and helpless confusion, resulting in seemingly entrenched humiliation and low self esteem (Howe, 2005).

### **Negative sense of self**

Carl's experiences of expectation of others' critical evaluation appeared to encapsulate his negative self-identity: "*As a piss-head, straight to the point, yeah, I mean, I'm known for it around B..., I'm known for it in S..., I'm known for it in W..., I'm known for it everywhere. That's all they think, the same thing. He's a piss-head*" (64-66). Often, physically abused children display 'hostile attributional bias', a tendency to perceive negative intent in others' actions, irrespective of whether it is real or not (Howe, 2005). I gained a sense of sadness from Carl, a felt invisibility, as people failed to look beyond the alcohol to the person: "*They don't see anything else*" (70). Carl was labelled an alcoholic; it was an identity and a core belief I felt that he almost embraced because it supported his schema of defectiveness.

### **Separation and Loss**

Carl's childhood experiences were accentuated by enforced separation and isolation from his father and the loss of that relationship through his mothers' controlling and abusive behaviour: "*I weren't allowed to talk to him when I was at home. That was my mother; not allowed*" (221-222). It felt almost as if Carl was grieving for the loss of unfulfilled expectation, and a regretful yearning for a life that could have been very different if his grandmother had been allowed to adopt him: "*I wouldn't be nothing like I am now, If I'd had my Nan*" (162-163).

### **Isolation through fear and self-blame**

Carl's experience of struggling to recall childhood friends suggested a lonely existence: "*Well. Er, my best friend, you know. We grew up together since we was two, but I never see him now, I never seen him for 18 years. I haven't seen none of them, none of my friends*" (136-138). There was no mention of any emotionally intimate relationships in his life; its absence implied a self-imposed exile based upon mistrust of relationships to prevent further expected betrayal or abuse.

Carl appeared to be estranged from family: "*I've not seen any of them*" (142).

As a child, his mother's enforced alienation from his father prevented that relationship from developing, and there was a sense of fear, of their shared time being discovered, as if it was forbidden rather than to be enjoyed: "*No, not even my Dad, actually. I used to go fishing with him, now and again, but we'd sneak in the pub and have a quick pint*" (220-222). Carl sought to understand the confusion by intellectually interpreting his mother's behaviour as jealousy: "*I suppose it was all jealousy on my Mothers' behalf, I don't know. Me, I think it was*" (232-233). Perhaps Carl's intellectualising kept his feelings under control.

### **Emotionally detached to cope**

Throughout the interview, Carl maintained composure and an emotional detachment that I felt protected him from pain; it was as if his head was disconnected from heart: "*If they had the same laws now in my day, my mother would have done a lot of time, she would*" (208-209). I think he was trying to connect with the gravity of his abusive childhood experiences but also keeping himself safe emotionally. Children who have been subjected to chronic physical

abuse have been shown to display inhibited affect, emotional detachment and estrangement (Kolko, 1996) and which were all evident in Carl's demeanour.

### **Inclusion through alignment**

For Carl, alcohol was initially used as tactic to feel included within the family, an avenue of connection: "*I mean the family were doing it, so I might as well join in*" (11-12). It seemed that Carl also experienced a sense of superficial relatedness with fellow drinkers through a shared understanding of alcohol dependence:

*"The only people I end up knowing are people very similar to me. That's about it, really. I mean, it's no good me trying to talk to somebody who doesn't drink, and I'm sitting there getting blind drunk, because they won't have it. They'll walk away"* (30-33).

Carl's ability to relate to his one friend was through a shared, traumatic and tragic experience: "*I understand where he's coming from and he understands me. In a way we've got a similar thing between us, so he understands one way and I understand the way he is, because he actually had a fight with his Dad and he died as well*" (80-84). Their shameful secret emotionally connected them but contradictorily isolated them from everyone else.

### **Defensive coping strategy**

Carl's defensive mechanism of using humour to mask emotional pain and distress was evident throughout the interview; possibly it enabled him to experience a degree of emotional connectedness with others, whilst keeping that sense of distance and avoidance of intimacy that kept him safe: "*They like my humour*" (253). I also felt that Carl had kept me at bay and the interview

firmly under his control, possibly to avoid triggering emotions that could overwhelm him.

In Carl, I perceived a hurting child, struggling to maintain control in a confusing world where he felt ashamed and unloved. Carl oscillated between anger and fear, and alcohol assisting him in containing the emotions that threatened to overwhelm him, should they be unleashed. He was inhibited from trusting anyone through fear of rejection and abuse that persistently haunted him and kept him isolated from life's experiences but safe from its imagined threats.



**Client 6 (Carl): Table of Themes from IPA Semi-structured Interview**

<b>Master theme titles</b>	<b>Sub-theme</b>	<b>Transcript key words</b>	<b>Indicator line</b>
<b>Traumatised by abusive childhood experiences</b>	Filled with anger Threatening environment Struggled to survive Amnesia as protective defence Felt difference	“What was it like? A total disaster” “Physical abuse, mental abuse, starved...” “It were Hell as kids” “I can’t even remember none of that” “I was the one who wasn’t wanted”	146 150 154 177 192
<b>Resented and feared parental abuse and neglect</b>	Parental unavailability and unreliability Felt neglected, unimportant Lack of basic needs Care giver perceived as threat Humiliation at maternal rejection Controlled through fear	“Mum and Dad were always at it” “They were both drinking” “We always used to go without for weeks” “I used to hide under my Nan’s skirts” “She’s told it to people in front of me in the pub” “That was my mother; not allowed”	16 158 160 172-173 200 222-223
<b>Humiliated by defectiveness and guilt</b>	Others’ negative perception.  Shared shameful secret Self-denigration	“You know what they’re saying: “Pissed up again”” “We don’t tell anyone else about it” “Nothing, really”	43-44  105-106 240
<b>Negative sense of self</b>	Others’ label him Felt invisibility, emptiness	“As a pisshead” “They don’t see anything else”	64 70

**Client 6 (Carl): Table of Themes from IPA Semi-structured Interview (cont.)**

<b>Master theme titles</b>	<b>Sub-theme</b>	<b>Transcript key words</b>	<b>Indicator line</b>
<b>Separation and loss</b>	Separated from father Yearned loss of expectation  Felt responsible for father's death	"I weren't allowed to talk to him" "I wouldn't be nothing like I am now, If I'd had my Nan" "He actually had a fight with his Dad and he died as well"	221-222 162-163  83
<b>Isolation through fear and guilt</b>	Struggled to recall childhood friends Estranged from family Alienated from father Seeking to understand the confusion	"Well. Er, my best friend..." "I've not seen any of them" "No, not even my Dad, actually" "I suppose it was all jealousy on my Mothers' behalf"	136 142 220 232-233
<b>Emotionally detached to cope</b>	Head disconnected from heart to avoid pain	"If they had the same laws now in my day, my mother would have done a lot of time"	208-209
<b>Inclusion through alignment</b>	Within family to fit in  Through alcohol  Connection through similar experience.	"I mean, the family were doing it, so I might as well join in" "The only people I end up knowing are people very similar to me" "I understand where he's coming from and he understands me"	11-12  30  80-81
<b>Defensive coping strategy</b>	Need to be liked	"They like my humour"	253

## **Memo 7 Brenda**

Brenda is an unemployed, divorced woman in her late forties, who has had an issue with alcohol for approximately eighteen years and who lives with her current partner who is also alcohol dependent. He is physically disabled, due to alcohol-related illness and Brenda is his full-time carer.

### **Mistrustful through abuse**

The ability to trust others is fundamental to building and maintaining interpersonal relatedness and its absence tends to erode the very fabric, making it difficult for relationships to survive long-term. Brenda had an issue with trusting people based upon her belief system constructed from previous childhood experiences of hurt and betrayal. The unfortunate consequences were her hypervigilance and continuing scanning for ulterior motives to people's seemingly pleasant behaviour to reinforce her schemas regarding mistrust and abuse: *"I'd like to think I can get on with people but then I always think there's, that they're being friendly for a reason, you know, that there's something behind it" (38-39).*

In insecurely attached families there is evidence of increased sibling conflict and estrangement, a pattern that has occurred throughout the interviews. Brenda's abusive childhood experiences at the hands of her older siblings left indelible marks of trauma that sent a clear message to Brenda, that trusting those who should be taking care of you results in pain, isolation and abandonment: *"A holly tree; she used to go and get the leaves off and stick them in me, that sort of thing, I think. Um, I remember once they shut me in the airing cupboard, K... shut me in so I couldn't get out. Um, they left me in the park on a swing. Um, I*

*couldn't get out' (218-220)*. Being the youngest child left Brenda vulnerable to extreme bullying, to the point of being abandoned on a swing, helpless and alone, until a stranger took pity upon her and rescued her; she was taken to a police station and handed in like a lost dog. Despite the gravity of the incident, there appeared to be no evidence of any consequences to her siblings' behaviour, suggesting that the parents were either neglectful or unconcerned and ill-equipped to protect Brenda from further harm. Parental paucity of care may have engendered in Brenda feelings of worthlessness and unlovability. The only person who could be relied upon was herself, which is an anxiety-provoking and lonely place to inhabit as a young child.

Anxiety related to separation is experienced initially with the child and its primary care giver but the child soon learns that the stable base is there to return to at times of perceived threat and anxiety is therefore able to be managed and contained; in Brenda's case this did not seem to occur, which led to uncontrollable feelings of panic and distress, that appear to have prevailed throughout her life.

### **Repeated patterns of abandonment evoked anxiety**

Brenda's beliefs around fear of abandonment and feeling helpless and lost became very real for her when she was physically separated from her family when she was very small, due to illness: "*When I was little I was put in a home'* (146). This increased in her the perception that parents could not be relied upon to protect and provide care and nurture for which she yearned; In Brenda's mind, at any moment carers could disappear and the anxiety is likely to have

been great in a small child, feeling scared but it seems her distress continues to go un-noticed.

Brenda's confusion and loss and sense of felt difference were greater due to being also physically separated from her siblings at this time: "*They wasn't with me; we were separated*" (159). She recalled being visited by her father and them and the image is conjured of a small, frightened child trying to comprehend why she has been singled out in such a way and excluded from everyone else. The young child's egocentric perspective possibly looked inwards at her badness or unacceptability that explained her separation, and increased her sense of worthlessness. The cognitive and behavioural patterns were already being formed, of an anxious child besieged by self-doubt, unable to trust due to the recurrent experience of disappointment and betrayal.

A review (Glaser, 2000) that explored the effects of child abuse and neglect upon the brain's biological structure, development and function argued that chronic stress induced by prolonged child maltreatment could result in perpetual hyper-arousal by the autonomic nervous system. It is possible to suggest that present adult negative emotions of panic and worthlessness that had a tendency to overwhelm Brenda had their roots intrinsically linked with childhood experiences; similar events that triggered traumatic memories evoked and exacerbated her feelings of helplessness and anxiety: "*Panic attacks and depression*" (171).

### **Resigned to emotional deprivation**

Research suggests that mothers who are heavy drinkers tend to be emotionally unreliable and inconsistent in their care, which could explain why Brenda's siblings were left to care for her and that the seeming early abuse was not dealt with: "*Basically, my Mum was a drinker*" (133). Intergenerational transmission of learned and accepted social norms could also explain the level of neglect that appeared to be commonplace and not viewed as neglectful or unusual (Kelley *et al.*, 2005): "*Nan and Granddad used to leave Mum with the other kids while they went to the pub*" (187-188). There was a certain fatalistic resignation in Brenda that this was how life was and always had been; although it evoked sadness she had very little expectation of nurturing because it was unfamiliar to her and an unimaginable concept.

### **Consumed by self-loathing, blame and worthlessness**

Often a child's way of rationalising abuse is to interpret it internally, as if the problem lies within themselves, rather than the perpetrators. It is likely that Brenda's social embarrassment and anxiety emanated from her perceived and acute sense of worthlessness, which exacerbated her self-consciousness and triggered schemas around defectiveness and shame: "*I just felt really conscious of how I get the shakes*" (71). Brenda's internalising possibly led to her self-blaming attitude: "*I'm always on a guilt trip*" (78). Brenda's apologetic tone and manner implied that she felt guilty for merely existing.

Brenda's low self-esteem and negation of self prevented her from expressing her needs, due to the maladaptive belief that they would not be met, and that she would not be listened to, based upon the reality of her experiences: "*It's not*

*very often that I can speak up for myself* (233). Sometimes in the interview, it felt as if Brenda was trying to convince herself that she had positive characteristics, but that it was a constant battle with self belief: *"I am quite a strong character, really"* (238).

The schema regarding defectiveness and shame insidiously pervades her attempts at identifying redeeming features and the intrinsic belief of unlovableness prevents her from allowing her the thought that others might not necessarily feel the same. This self-disgust isolates her and also results in her lack of self-care: *"Because I don't like myself, I don't think anybody else would"* (256-257). There is an inability for Brenda to consider herself worthy of nurturing and her self-neglect feels quite punishing: *"Nothing; nothing at the moment. I just don't like myself because I care but I don't care about me"* (257).

### **Isolated from the world**

According to Schema theory, individuals employ various strategies to avoid triggering painful and distressing memories, which includes avoidance.

Exclusion from the world prevents further hurt, but paradoxically maintains the feelings of worthlessness and aloneness: *"I don't really see anybody; nobody comes here"* (47). Brenda is unhappy with her self-imposed isolation and yet seemingly trapped by the fear associated with socialising and the possible rejection that might follow, once people discover her perceived flaws. This severely curtails her friendships, except for one person, who it appears, understands Brenda's predicament because her mother was also alcohol dependent and she is in a familiar place with Brenda: *"I've got one friend"* (56.).

It appears that Brenda's isolation and felt difference and her difficulty in

relatedness was apparent with her siblings: *"I felt out of it" (208)*. It is possible that Brenda's sense of unworthiness and not belonging began in early childhood and extended to her adult relationships later on. This heightened her fear of rejection.

### **Confused sense of self**

The concept of self-identity is partially understood in how others perceive us. In Brenda's case, she felt it was clearly labelled by her drinking: *"Oh, here's the drunk coming" (65)*. Alcohol dependent clients appear to be very much influenced by the negative and stigmatised stereotype of the drinker and seem to own that identity through their negative self-perception: *"I've lost self-esteem" (266)*.

Brenda's perceived worthlessness was reinforced by her seeming invisibility when she was surrounded by people in the street and obviously upset, yet they walked past her, apparently oblivious to her distress and rendering her invisible: *"I just sat there on the bench, crying, and no-one took no notice" (112)*. Thus her schemas regarding others' unavailability and lack of care are reinforced and maintained.

Brenda appears to struggle to integrate a positive aspect of self, as if the negative elements negate any possibility of goodness: *"I'd like to think I'm a nice person, um, (pause) but I really can't see it myself" (267)*. Brenda is consumed by self-doubt, despite the fact that she does receive compliments: *"My friend, she says I am a really nice person" (277)*. I get the sense that Brenda's selective emotional antennae tend to disregard the positive



compliments and focus upon the negative remarks that sit more comfortably with her schemas around defectiveness. It is as if she finds it impossible to reconcile her poor self-concept with the idea that there is something good about her that people might like. It seems that Brenda's internal working model of self does not contain the facility for accepting nor processing positive attributes regarding her. Rather, it is highly attuned to negative communication and responses and the resigned, fatalistic acceptance of who she is: "*I suppose if I was more confident, I wouldn't be who I am*" (294-295).

### **Mixed experiences of interpersonal relatedness**

The one area of emotional connectedness appears to be shared experiences around alcohol and an implicit understanding of fellow drinkers that is a form of emotional bonding. Similarly, people can be united in their familiarity with their own lived experience. From Brenda's perspective, her only friend appeared to be more accepting of Brenda's condition, possibly due to her own childhood memories of her alcohol dependent mother that allowed her understanding: "*She was brought up with her Mum being an alcoholic*" (57). It was possible therefore that she could relate to Brenda at a different level, based upon her own experience.

Insecure attachment is often correlated with antagonistic intimate relationships based upon conflict and lack of resolution because the communication skills have not developed to manage such threatening feelings: "*We do have our falling out*" (88). Similarly, with Brenda's sisters, the abusive relationship rendered her seemingly passive and resigned, as if in a state of 'learned helplessness', the same stance she took with her partner and his abusive

behaviour: *“One sister used to be spiteful, um, the other sister sort of stuck by me but only to get on” (121-122).*

Adults who have suffered childhood physical abuse and neglect tend to have recurrent suicidal thoughts and depression (Howe, 2005). Brenda recalled that she was hospitalised and treated for an anxiety and depressive disorder when she was 19. However, it seemed that her depression was moderated through relatedness: *“I still have suicidal thoughts now, um, but since I’ve met T... I haven’t done anything” (180-181).*

### **Avoidant and compensatory coping strategies**

Insecurely attached individuals cope through surrendering, avoiding or over-compensating coping styles to moderate their distress. Brenda emotionally withdrew to avoid conflict: *“I thought: “Don’t stay in this situation”” (97).*

Minimising or repressing negative affect is also commonly used, to the point where the protective facility of amnesia is a defence against remembered trauma: *“But I can’t remember it” (163).* Over-compensatory coping strategies in the form of a compulsive care giving role create a need for dependency that partially satisfies the emptiness inside: *“She says: “All you do is help other people but not yourself” (288-289).*

### **Alcohol as a friend and comforter**

Alcohol also has the seemingly comforting, compensatory effect of temporarily reducing feelings of isolation and emptiness: *“It has always been with me, like, loneliness” (24-25).* Alcohol offers to Brenda that feeling of safety and being cognitively cocooned from the anxiety and panic that threatens to overwhelm

her and enables her to cope. Alcohol creates the illusion of making Brenda feel warm and safe: "*It's like a security blanket, I think*" (107-108). I get the sense that Brenda minimises the negative impact of alcohol because it is the one relationship on whom she can rely, and she is not prepared to relinquish.

### Client 7 (Brenda): Table of Themes from IPA Semi-structured Interview

Master theme titles	Sub-theme	Transcript key words	Indicator line
<b>Mistrustful through abuse</b>	Difficulty trusting people Abusive childhood experiences	"They're being friendly for a reason" "They shut me in the airing cupboard..." "They left me in the park on a swing. Um, I couldn't get out"	38-39 218-219 219-220
<b>Repeated patterns of abandonment evoked anxiety</b>	Separated from family Felt loss of siblings Feelings overwhelmed her	"When I was little I was put in a home" "They wasn't with me; we were separated" "Panic attacks and depression"	146 159 171
<b>Resigned to emotional deprivation</b>	Maternal unreliability Minimised neglect through learned social norms	"Basically, my Mum was a drinker" "Nan and Granddad used to leave Mum with the other kids while they went to the pub"	133 187-188
<b>Consumed by self-loathing, blame and worthlessness</b>	Felt embarrassed and ashamed  Self-blaming Perceived invisibility  Battled with self belief Self-disgust isolated her  Lack of self care	"I just felt really conscious of how I get the shakes" "I'm always on a guilt trip" "It's not very often that I can speak up for myself" "I am quite a strong character, really" "Because I don't like myself, I don't think anybody else would" "I care but I don't care about me"	71  78 233  238 251-252  257
<b>Isolated from the world</b>	Aloneness Few social contacts Felt excluded, different from siblings	"I don't really see anybody; nobody comes here" "I've got one friend" "I felt out of it"	47 56 208

**Client 7 (Brenda): Table of Themes from IPA Semi-structured Interview (cont.)**

<b>Master theme titles</b>	<b>Sub-theme</b>	<b>Transcript key words</b>	<b>Indicator line</b>
<b>Confused sense of self</b>	Identity through alcohol Perceived invisibility, worthlessness Negative self perception Diffuse identity  Consumed by self-doubt Resigned acceptance	“Oh, here’s the drunk coming” “Crying, and no-one took no notice” “I’ve lost self-esteem” “I’d like to think I’m a nice person, um, (pause) but I really can’t see it myself” “My friend, she says I am a really nice person” “I suppose if I was more confident, I wouldn’t be who I am”	65 112 266 267  277 294-295
<b>Mixed experiences of interpersonal relatedness</b>	Connection through shared experience  Conflictual relationship Sibling conflict  Depression mediated through relatedness	“She was brought up with her Mum being an alcoholic” “We do have our falling out” “One sister used to be spiteful, um, the other sister sort of stuck by me but only to get on” “I still have suicidal thoughts now, um, but since I’ve met T... I haven’t done anything”	57  88 121-122  180-181
<b>Avoidant and compensatory coping strategies</b>	Emotional and physical withdrawal Blocked out painful memories to cope Compulsive care giver	“I thought: “Don’t stay in this situation” “But I can’t remember it” “She says: “All you do is help other people but not yourself”	97 163 288-289
<b>Alcohol as a friend and comforter</b>	Reduced feelings of isolation Alcohol made her feel warm, safe	“It has always been with me, like, loneliness” “It’s like a security blanket, I think”	24-25 107-108

## **Memo 8 Stan**

Stan is an unemployed single man in his mid-twenties, who has had an alcohol problem since the age of twelve. Stan has not had a permanent intimate relationship.

### **Rejected and neglected child afraid of abandonment**

Individuals who receive little care or attention as children tend to develop different, sometimes maladaptive coping behaviours to deal with suppressed feelings from unmet needs, Stan was no exception and engaged in recurrent patterns of extreme self-harm by cutting: *“That’s where I’ve got the big scars from when I’ve been building up” (227-228)*. It saddened me to see Stan’s arms that told a story of unremitting pain and distress.

Childhood neglect and imposed isolation teaches self-reliance and resourcefulness and a low expectation of nurturing. However, it can also suggest to the child that somehow they are to blame. Stan perceived his boredom at being left on his own and subsequent messing up of the living room as valid reason for his parents to imprison him in his bedroom. In his eyes, it was apparently his fault. Emotional detachment is a further coping strategy. Stan seemed to recall in a very matter-of-fact way how his parents would keep him constrained to his room as a little boy, possibly because he knew no different: *“Go away, Stan, we’re tired”*. And I would be like: *“But I want to get up” ‘cos they used to lock me in the room” (296-298)*.

Stan’s experiences of his mother’s premature and sudden death left him unprepared and his reliving every moment in the present were haunting

examples of how post-traumatic stress encroaches upon adulthood. Stan's fear was apparent as I visualised a lonely, frightened little boy wondering whether his father was going to abandon him also: "*My Dad standing at the window and the sun going down*" (371-372). At this point in time Stan could only rely upon himself and it was an isolated and fearful place.

A parent with severe alcohol problems, as is suggested with the amount that Stan's mother was consuming, is likely to be unreliable and inconsistent in relation to care, which necessitates the child to become self-reliant. Before his mother's death Stan had already learned this harsh lesson but accommodated it psychologically by finding an alignment with his mother, possibly to feel close to her through his drinking: "*I reckon I take after my Mum 'cos she used to have two litres of sherry a night*" (431-432). It was sadly now their only point of emotional connection.

### **Childhood bereavement and loss**

Alcohol can become a maladaptive coping strategy for dealing with the flood of emotions after a bereavement, to numb the senses and suppress painful feelings. Stan began drinking just three years after his mother died, suggesting it was an endeavour to cope with loss; he continued to use alcohol in other highly charged emotional situations, such as a relationship ending: "*With girlfriends I've managed to cut it out completely until we've split up and then I start drinking again*" (175-176). Any re-enactment of that awful time of perceived abandonment would trigger the avoidant coping style of needing to drink to avoid the feelings he so dreaded.

Fear of abandonment can result in the over-compensatory style of excessive neediness in a relationship that often paradoxically can create a self-fulfilling prophecy: "*I was too clingy*" (188). Stan was seemingly aware of his need for emotional intimacy but was unable to emotionally regulate the ever-present anxiety-laden schema that childhood experiences taught him, that people whom you love leave and cannot be relied upon.

Premature death of a parent tends to leave a child feeling isolated through difference. Stan's Mum's death separated him from his peers: "*All my classmates knew before me that my Mum had died*" (345-346). A child will often endeavour to be well-behaved in order not to upset the remaining parent, and repress their own needs for fear of further abandonment: "*I felt sorry for my dad that day, looking out the window, going: 'That's it, I can't go on anymore'*" (361-362). I imagined the anxious little boy struggling to come to terms with the trauma of his mother's death, beleaguered with his own feelings and yet unable to reveal them in order to protect and support his father, who in turn is emotionally unavailable for his child who needs him. Stan seemingly became the parent, putting his own needs aside in order to look after his father, to prevent him from possibly leaving.

### **Socially isolated for self protection**

Avoidance of intimacy and engaging in superficial relationships is a defensive strategy for self-protection against further possible hurt: "*I've got people to 'doss' with*" (91). This sentence suggested that Stan had 'drinking bedfellows' united in a common purpose. Isolation can occur in various ways, for example feeling excluded or alienated by a family's religious beliefs: "*They'm judging me*



*by my family, like*" (131). Stan mentioned this in a negative way twice, and it appeared to be problematic for him whilst growing up, possibly because he felt ridiculed or bullied due to his family's difference. It was another example of feeling singled out and alone.

Avoidance of pain can often create a need to withdraw from the world to prevent further hurt: "*I kind of keep myself in my room*" (194). It became apparent, however, that Stan had an ulterior motive for his self-imposed isolation, namely through fear of the violence he may inflict upon others: "*I try to keep myself away from people because I put one, when I was younger, I put one of my best mates in hospital 'cos he, he was joking about, it was an accident, because he'd forgot my Mum had died, and because he said something about my Mum, so, like, 'cos I lost my temper because he said it, I grabbed him, picked him up upside down, slamming his head off the concrete*" (201-205).

It was difficult to align myself with the image of uncontained and unrestrained rage in one who appeared so gentle, warm and affable in character. It suggested to me that the emotional wound eight years after his mother's death remained raw and gaping, as were the jagged, exposed nerve endings of emotion that evoked anger when triggered by associations with his mother. It felt as if a monstrous feeling was waiting just beneath the surface, circling like a shark ready to strike at the least little vibration.

Being singled out for special treatment may have contributed to Stan's felt difference and loneliness as a child that prevailed into adulthood: "*When I went back, like, they wouldn't, it was kind of like treading on eggshells round me, if*

*you know what I mean, trying not to say nothing wrong or anything* (350-351). It was unlikely that the other children would have experienced or comprehended what Stan had been through in his short life.

### **Diffuse sense of self**

Children who have been abused or neglected tend to use an over-compensatory coping style, sometimes by creating an identity through role as a carer: *"Since my Mum died it's always been me who does like the jobs and that"* (424-425). Possibly Stan felt that by emotionally and practically supporting his father he would keep his father with him and also reduce the anxiety associated with his schema of abandonment, that his father might leave.

Possibly Stan aligned his identity with his Mum's drinking, perhaps to maintain some form of emotional link with her: *"I reckon I take after my Mum"* (431). It was something in common that they shared, a part of her that may make him reluctant to relinquish if he perceives it as an integral part of his sense of self. Difficulty with interpersonal relatedness through bereavement or neglect can contribute towards a diffuse identity: *"Well, easy to get on with, I can have a laugh, don't take myself too seriously, that kind of thing, but apart from that I don't really know. No idea"* (437-438). Stan appears to struggle both with his own self-identity and with how others perceive him. This lack of integration suggests an emptiness of self that is filled using alcohol.

### **Developed compensatory coping strategies**

In order to minimise the internal confusion that diffuse identity brings, compensatory coping strategies are developed to alleviate the feelings of

emptiness, such as that of compulsive caregiver: *"I'll say 'hello' to anyone, help them out if they need anything"* (128-129). Stan finds a way of fulfilling a need, both within himself and to fit in with others' requirements, by complying and being overly friendly and helpful: *"I try my best to get on with everyone"* (140).

A less helpful coping mechanism is that of emotional transferred to physical pain: *"I end up cutting myself"* (196). Self-harm can also assist in regulating emotional 'storms' that threaten to overwhelm; Stan's rages are seemingly controlled through self-harm and his means of protecting others as well as himself: *"I have to take it out on myself otherwise I know I'll hurt someone else again, and I don't want to do that"* (211-212). Cutting becomes a safety valve for Stan's volcano of emotions waiting to erupt.

### **Perceived relationships as hostile and threatening**

Hostile interpersonal relatedness can harm a child's view of himself and the perception of others as being threatening. It seemed that Stan's form of communication within the family was often through argument: *"I know I've had enough I just go up straight to bed, 'cos otherwise I'll know I'll end up in an argument with my Dad"* (119). The relationship with his father continued to be conflictual, which seemed to be related to his father's beliefs that Stan's mother's death was smoking-related and yet despite this knowledge Stan continued to smoke, a cause of friction between them: *"Me and my Dad are pretty close but, 'cos, em, my Dad don't drink or smoke because smoking killed my Mom, so we parted, not parted completely but it's just difficult"* (147).

Learned patterns of dysfunctional communication tend to be repeated through intergenerational transmission: "*Louder bickering and then it blasted off into a big argument, like, and my Mum went out the back for a fag and I would follow her*" (306-307). For Stan this was a common occurrence and would likely to have been an anxiety-provoking and uncomfortable situation for him, portrayed in his continually following his Mum around as his world became unstable and uncertain and possibly fraught with peril. Stan's internal model of relating was based upon discord: "*You can't be in a relationship if you don't argue*" (312-313). Relationships were therefore perceived as antagonistic and threatening and to be avoided.

### **Dichotomous relationship with alcohol**

Engendered feelings of social isolation and alienation can be seemingly ameliorated using alcohol as a uniting influence and a point of connectedness. In Stan's case, it appeared to reduce his sense of felt difference and enabled him to belong to the group that had previously unintentionally excluded him through his life experiences: "*I think it was more like to be one of the group*" (43-44). In his world of lived pain, loss and sadness, Stan longed for and wanted to be part of a different existence, that of his friends with their seemingly carefree and unburdened lives, as he sought to understand: "*I thought: why are they happy?*" (48). Drinking alcohol gave him that way in, to be a member of the group, and he complied to feel included: "*It was just trying to fit in*" (50).

Alcohol had the perception of enhancing his self confidence, thus enabling him to be more sociable, rather than on the periphery: "*I have got on with people a lot better, like, since I've been drinking because before I used to be moody but*

*not mood swings, like, I'd be, like, the really quiet one and, like, just give one word answers, but I've noticed that since I've been drinking I've been more talkative" (62-64).*

Sadly, the negative aspect of alcohol was revealed in Stan's unfulfilled expectation. Despite being one of the brightest children in his class, Stan's combined inability to cope, lack of emotional support and subsequent truancy contributed to his academic failure and spiral of decline: "*I started skipping school more and buying more beer and then, it just messed up my life" (71).*

**Client 8 (Stan): Table of Themes from IPA Semi-structured Interview**

Master theme titles	Sub-theme	Transcript key words	Indicator line
<b>Rejected and neglected child afraid of abandonment</b>	Suppressed feelings through unmet needs Parental unavailability Felt rejected, in the way Abusive neglect Fear that Dad might also leave	“That’s where I’ve got the big scars from” “They’d spend half the time playing snooker” “Go away, Stan, we’re tired” “They used to lock me in the room” “My Dad standing at the window and the sun going down” “She used to have 2 litres of sherry a night”	227 294 296-297 297-298 371-372 431-432
	Maternal unreliability through alcohol misuse		
<b>Childhood bereavement and loss</b>	Coped with emotional loss using alcohol Fear of abandonment Mum’s death separated him	“We’ve split up and then I start drinking again” “I was too clingy” “All my classmates knew before me that my Mum had died”	175-176 188 345-346
	Repressed own needs for fear of abandonment	“I felt sorry for my dad that day, looking out the window, going: “That’s it, I can’t go on anymore”“	361-362
<b>Socially isolated for self protection</b>	Superficial relationships Alienated by religious beliefs Withdrawal from the world Self-imposed isolation through violence Felt difference, alienated through Mum’s death	“I’ve got people to ‘doss’ with” “They’m judging me by my family, like” “I kind of keep myself in my room” “I try to keep myself away from people...” “When I went back, like, they wouldn’t, it was kind of like treading on eggshells round me”	91 131 194 201 350-351
<b>Diffuse sense of self</b>	Identity through role as carer	“Since my Mum died it’s always been me who does like the jobs and that”	424-425
	Aligned his identity with Mum’s drinking Who am I?	“I reckon I take after my Mum” “I don’t really know”	431 437-438

**Client 8 (Stan): Table of Themes from IPA Semi-structured Interview (cont.)**

Master theme titles	Sub-theme	Transcript key words	Indicator line
<b>Developed compensatory coping strategies</b>	Compulsive care giver Needed to comply Transferred emotional pain Anger controlled through self harm	“Help them out if they need anything” “I try my best to get on with everyone” “I end up cutting myself” “I have to take it out on myself otherwise I know I’ll hurt someone else again, and I don’t want to do that”	128-129 140 196 211-212
<b>Perceived relationships as hostile and threatening</b>	Communication through argument  Conflict with father Emotional connection through shared experience Communication through hostility  Learned model of confrontational relating	“I’ll know I’ll end up in an argument with my Dad” “Not parted completely but it’s just difficult” “His Mum’s step dad died because of jaundice” “Louder bickering and then it blasted off into a big argument...” “You can’t be in a relationship if you don’t argue”	119  147 160 306-307  312-313
<b>Dichotomous relationship with alcohol</b>	Reduce separateness Seeking to understand Complied to feel included Enhanced self confidence  Unfulfilled expectation	“I think it was more like to be one of the group” “I thought: why are they happy?” “It was just trying to fit in” “I’d be, like, the really quiet one and, like, just give one word answers, but I’ve noticed that since I’ve been drinking I’ve been more talkative” “It just messed up my life”	43-44 48 50 62-64  71

## **Appendix 22: Themes from Individual Tables**

### **1. Susan**

Battled with self-containment

Struggled with parental neglect

Grieving for loss of acknowledgement, recognition

Betrayed by trust

Social comparison

Diffuse self-identity to fit in

Confused by parental hostility

Alcohol as friend

Alcohol as enemy

### **2. Tim**

Surrounded by hostility

Burdened by multiple losses

Sense of self eluded him

Became emotionally detached to survive

Felt alienated and isolated

Developed defensive coping strategies

Experienced positive relationship

Dichotomous relationship with alcohol – a double-edged sword



### **3. Jean**

Barren land of emotional deprivation

Felt aloneness

Excluded and humiliated

Attained coping strategies and defences to survive

Confused by parental avoidance of intimacy

Afraid to trust

Diffuse sense of Self

Stable base mediated against insecurity, worthlessness

Ambivalent relationship with alcohol

### **4. Lydia**

Distress at abandonment

Devastated by loss

Deprived of affection

Shame and defectiveness

Social Isolation

Sense of self defined by alcohol

Developed survival coping strategies

Worried by parental hostility

Contradictory relationship with alcohol – friend or foe?

### **5. Paul**

Addicted to alcohol

Struggled to cope - escaped from reality and responsibility

Mistrustful through betrayal

Defectiveness and shame

Abused becomes abuser

Perceived rejection and worthlessness from birth

Experienced loneliness, isolation and alienation

Diffuseness of identity – playing the character

## **6. Carl**

Traumatized by abusive childhood experiences

Resented and feared parental abuse and neglect

Humiliated by defectiveness and guilt

Negative sense of self

Separation and loss

Isolation through fear and guilt

Emotionally detached to cope

Inclusion through alignment

Defensive coping strategy

## **7. Brenda**

Mistrustful through abuse

Repeated patterns of abandonment evoked anxiety

Resigned to emotional deprivation

Consumed by self-loathing, blame and worthlessness

Isolated from the world

Confused sense of self

Mixed experiences of interpersonal relatedness

Avoidant and compensatory coping strategies

Alcohol as a friend and comforter

## **8. Stan**

Rejected and neglected child afraid of abandonment

Childhood bereavement and loss

Socially isolated for self protection

Diffuse sense of self

Developed compensatory coping strategies

Perceived relationships as hostile and threatening

Dichotomous relationship with alcohol

## **Appendix 23: Super-ordinate Themes Integrated from Clients' Tables of Themes**

### **Development of mistrust**

#### **1. Parental abuse, neglect and rejection**

Struggled with parental neglect, barren land of emotional deprivation, deprived of affection, perceived rejection and worthlessness from birth, resented and feared parental abuse and neglect, resigned to emotional deprivation, rejected and neglected child afraid of abandonment, surrounded by hostility, betrayed by trust, afraid to trust, mistrustful through betrayal, mistrustful through abuse, abused becomes abuser, traumatised by abusive childhood experiences.

#### **2. Threatening and hostile parental interaction**

Confused by parental hostility, confused by parental avoidance of intimacy, worried by parental negative interaction, perceived relationships as hostile and threatening.

#### **3. Coping strategies to survive**

Developed defensive coping strategies, attained coping strategies and defences to survive, developed survival coping strategies, defensive coping strategy, struggled to cope - escaped from reality and responsibility, inclusion through alignment, developed compensatory coping strategies, battled with self-containment, became emotionally detached to survive, emotionally detached to cope.

## **Loss and aloneness**

### **4. Separation, bereavement and abandonment**

Grieving for loss of acknowledgement, recognition, burdened by multiple losses, devastated by loss, separation and loss, childhood bereavement and loss, distress at abandonment, repeated patterns of abandonment evoked anxiety.

### **5. Social isolation and alienation**

Felt alienated and isolated, excluded and humiliated, felt aloneness, social isolation, experienced loneliness, isolation and alienation, isolation through fear and guilt, isolated from the world, socially isolated for self protection.

## **Implications for self**

### **6. Identity confusion and uncertainty**

Diffuse self-identity to fit in, sense of self eluded him, diffuse sense of self, sense of self defined by alcohol, diffuseness of identity – playing the character, negative sense of self, consumed by self-loathing, blame and worthlessness, diffuse sense of self.

### **7. Defective self**

Social comparison, shame and defectiveness, defectiveness and shame, humiliated by defectiveness and guilt, experienced positive relationship, stable base mediated against insecurity, worthlessness.

## **8. Drinking versus non-drinking self**

Alcohol as friend - alcohol as enemy, dichotomous relationship with alcohol – a double-edged sword, ambivalent relationship with alcohol, contradictory relationship with alcohol – friend or foe, addicted to alcohol, dichotomous relationship with alcohol.

### **Implications for therapy**

## **9. Avoidance of intimacy**

Socially isolated for self protection, confused by parental avoidance of intimacy, social isolation, isolation through fear and guilt.

## **10. Emotional detachment**

Battled with self-containment, became emotionally detached to survive, emotionally detached to cope.

## **11. Mistrust of people**

Mistrustful through abuse, betrayed by trust, afraid to trust, mistrustful through betrayal.

## **12. Fear of rejection**

Repeated patterns of abandonment evoked anxiety, distress at abandonment, perceived rejection and worthlessness from birth, rejected and neglected child afraid of abandonment.