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Professional Doctorate in Counselling Psychology (DPsych)

Heroin Addiction and Longing to Belong

City University

Department of Psychology

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September 2009

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City University Declaration

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Table of Contents

	Page
Acknowledgements	1
Declaration	2
Table of contents	3
Portfolio overview	10
Preface	11
The research	12
Professional practice	12
Critical literature review	13
A personal note	13
Section A: An Interpretative Phenomenological Analysis of people with former long-term heroin addiction about their experience of being parented in childhood and adolescence	
Abstract	15
Part 1: Introduction	16
1. Background to the study	16
1.1 What is the research topic?	16
1.2 Why this study?	16
1.3 The aims of this study	20
1.4 Why now?	21
1.5 Why design the study this way?	23
1.6 Hermeneutic tension	24

		Page
2.	**The theoretical framework**	25
2.1	Attachment and attachment measures	26
2.2	Parenting	28
2.3	Psychodynamic theory	29
3.	**Heroin addiction**	30
4.	**Review of the literature**	31
4.1	Quantitative approaches based on retrospective attachment measures	32
4.2	Approaches based on the prevalence of trauma or abuse as antecedents to heroin addiction	34

Part 2: Epistemology and methodology		38
1	**The design and aim of this research**	38
2	**A rationale for a qualitative epistemology**	38
3	**The rationale for using IPA**	41
4	**Procedures:**	47
	4.1 Participants	47
	4.2 Recruitment	48
	4.3 The interview procedure	50
	4.4 Pilot study	53
5	**Ethics**	54
6	**Validity**	56
7	**Transcription**	61
8	**Analytic strategy**	61

		Page
9.	**Methodological and procedural reflexivity**	64
9.1	Participants	64
9.2	The researcher's identity	65
9.3	Foreunderstandings	67
9.4	The interview process	68
9.5	The analytic process	69
9.6	The effect on participants	70
9.7	The researcher's agenda	71
Part 3: Analysis		72
1.	**Overview**	72
2.	**The three superordinate themes**	74
2.1	Theme 1: I was always the outsider	75
2.2	Theme 2: I wanted an ordinary mum and got Supermum	90
2.3	Theme 3: My search for a new, improved sense of self	108
Part 4: Discussion		
1.	**Overview**	130
1.1	Allowing the unexpected to emerge	131
2.	**Answering the study's central questions**	133
2.1	How do participants think and feel about their experience of the mother-child relationship?	133

Page

2.2 What characteristics of maternal and paternal relations in childhood present in heroin addicts? 138

2.3 Are there themes in the narratives of these individuals that could mediate addiction or other maladaptive coping strategies in adulthood? 140

3. The transformative power of drugs 142

4. Mentalisation 143

4.1 Mentalisation in context 143

4.2 A sense of self 144

5. The role of the unconscious 146

6. Methodological considerations and applications to practice 148

7. Limitations of the present study and suggestions for future research 152

8. Method and procedural reflexivity 154

9. Personal reflexivity 156

Conclusions 160

References 163

Appendices 190

Appendix I: The meaning of the term 'addict' within this thesis 191

Appendix II: Information on heroin and crack cocaine 192

Appendix III: Trauma definition 196

Appendix IV: Summary of the Adult Attachment Interview Protocol 197

		Page
Appendix V:	Definitions of attachment types and summary of Strange Situation protocol	199
Appendix VI:	Interview schedule	200
Appendix VII:	Demographics summary table	202
Appendix VIII:	Age profile rationale for study sample	203
Appendix IX:	Information and consent form	204
Appendix X:	Demographic information form	208
Appendix XI:	Debrief sheet	210
Appendix XII:	Excerpt from participant transcript	211
Appendix XIII:	Table of sub-themes extract	213
Appendix XIV:	Example of initial master table	215
Appendix XV:	Second master table	216
Appendix XVI:	Example of master table with illustrative quotes	221
Appendix XVII:	Additional transcript quotes	222
Appendix XVIII:	Participant Demographic Summaries	229
Glossary of Terms		230

Section B: Professional case study: The use of formulation and Transference when working with a man with an object-relations deficit 231

1. Introduction to the case study 233

2. The development of therapy 240

3. Review of therapy 249

		Page
References		253
Appendices		257
Appendix I:	Alan's family genogram	258
Appendix II:	Graphic representation of the formulation for Alan	259
Appendix III:	Therapeutic techniques applied in the work with Alan	260
Appendix IV:	Diagram of object-relations interactions for defence in borderline personality disorders	261

Section C: Critical literature review: Attachment quality – is it a therapeutically valuable construct when counselling adults with addiction? 262

Introduction 263

1.	**Attachment relationships and their function**	263
1.1	What is attachment?	263
1.2	The infant-caregiver relationship	264
1.3	The adolescent-peer relationship	265
1.4	Consequences of dysfunctional attachment	266
1.5	Types of attachment and their measurement	267
2.	**Addiction**	270
2.1	Addictive behaviours	270
2.2	What is addiction?	270
2.3	The significance of childhood trauma for addictive behaviours	271
2.4	The significance of attachment for addictive behaviours	272

		Page
3.	**Evidence of a link between attachment and addiction**	272
3.1	Maternal overprotection correlates with insecure attachment	272
3.2	Influence of maternal role on adolescent drug misuse	276
3.3	Dysfunctional parenting: a catalyst for addiction	278
3.4	Reflecting on poor parenting and countering intergenerational transmission in female addicts	281
4.	**Evidence of the relevance to therapy of the attachment construct**	283
4.1	Allan Schore: inspiring the attachment system in therapy	283
4.2	Attachment type predicts the therapeutic alliance	286
4.3	Group therapy: potential to repair social network deficits in insecurely attached addicts	288
5.	**Summary**	291
6.	**Conclusions and future directions**	293
6.1	Considerations for methodology	292
6.2	Causality	294
6.3	Measurement	294
6.4	Gaps in research knowledge	295
6.5	Conclusions	296
References		299

Portfolio overview

Preface

This thesis examines how heroin addicts[1] experienced being parented in childhood and adolescence. This represents an important topic for me: in the course of my therapeutic work with heroin addicts, I have developed a strong impression that many of them have parent-child relationship issues. However, when I explored the literature for practical help, I could find very little sufficiently rigorous evidence to test my notion. I had a strong sense that my observation might be significant, but it was nonetheless anecdotal, and it would have no value unless it was properly explored. Moreover I felt that, if it proved correct, it could be useful not just to me but to other practitioners in this very complex therapeutic area. Hence this is the reason for developing this study.

This preface introduces the doctoral portfolio and its component parts. It comprises three major sections. Section A is an exploratory piece of research which investigates the lived experiences of being parented in childhood in a sample of former heroin addicts. It is a small-scale study but, I would argue, it is rigorous enough to demonstrate a pattern of attachment issues in heroin addicts. In Section B, a psychodynamic case study charts the course of therapy with an addicted male (drugs and alcohol) who has an object-relations deficit stemming from childhood, which relates to a lack of maternal care. This is intended to illustrate my clinical skills, my ability to integrate theoretical knowledge and practice, and of my ability to remain alert and receptive to psychological movement in the client while remaining acutely self-aware at a personal and professional level. Section C is a critical literature review spanning the subject of attachment and addiction. It notes the issues that cloud the relationship between the two, and examines why studies often appear to leave therapists without the necessary insight that could help inform their therapeutic practice when treating heroin-addicted individuals.

There now follows an overview of each of these sections and of their objectives. This preface concludes with a summary of the personal journey I have undertaken and the learning that has resulted.

---

[1] The term 'heroin addict' is used throughout this portfolio as an abbreviation for 'a person dependent on heroin and/or crack cocaine'. Appendix I explains why this abbreviation was adopted.

Section A: The research

This section presents an original piece of research that I have conducted with the aim of exploring the lived experience of being parented in childhood and adolescence in six individuals with a long-term history of heroin/crack cocaine addiction[2]. The study draws on the experiences and perceptions that emerged from three consecutive semi-structured interviews with each individual, representing a homogeneous, mixed-gender clinical sample. The average length of heroin/crack cocaine addiction was just over eighteen years, and all individuals had been maintained on a low-dose methadone prescription for at least twelve months. The research draws on individuals' perceptions of being parented, and in particular that of the mother-child dyadic relationship, given the literature surrounding attachment principles and the importance of the mother's role. I selected interpretative phenomenological analysis, to try, by analysing participants' own words, to facilitate a bottom-up appreciation of the complexities of child-parent relations that was firmly embedded within their narratives. Specific attention is paid to how participants describe feeling about their self-image in childhood and adolescence, and to any ruptures or changes that occur in their primary relationships as they mature. Moving beyond description, the analysis attempts to identify and explain the emergent themes, while drawing upon theoretical insights and empirical literature.

Section B: Professional practice

The case study provides me with an opportunity to present an example of my clinical work, which allows the reader to see how theoretical perspectives such as attachment theory (Ainsworth and Bowlby, 1991) and psychodynamic concepts are utilised when trying to understand a man who is in the grip of addiction, and suffering from current relationship conflicts rooted in his distressing childhood. The case study tracks the collaborative work between me and the client over the course of five months, and the difficulties and challenges that emerged for both of us. Fundamental use of 'formulation' within the psychodynamic model is demonstrated, and throughout there is critical reflection on my clinical practice. The aim of this piece is to demonstrate competence in the psychodynamic therapeutic approach and to show how solid theoretical knowledge was applied in practice.

---

[2] See Appendix II for information on heroin and crack cocaine

Section C: Critical literature review

The aim of this section is to provide a critical evaluation of the literature around attachment by systematically reviewing its relevance to counselling psychology practice when working with people with addictive behaviours. Here I look to locate the present study in relation to background research and theoretical literature through which the central questions within this study are amplified. The literature reviewed examines attachment theory, attachment representations and their function; addiction and its links with childhood trauma, and the measurement and classification of insecure attachment. It also explores any evidence for a link between attachment and addiction. It concludes with theoretical insights into recent advocacy by some researchers of the use of attachment as a construct in therapy when working with insecurely attached individuals.

A personal note

This doctoral portfolio is the result of a three-year process of psychological training, both theoretical and practical, and the journey of self-discovery and personal growth that I have undergone during this time. It charts my path as a trainee psychologist, my academic growth and the development of my therapeutic competence. This path led to my becoming genuinely inspired by my trainee work with a population of drug addicts to conceive an original research study designed to help me explore further the significance of childhood parental relationships, the better to inform and guide my work with these troubled individuals. This recent role of qualitative researcher has brought considerable challenges along the way, but it has also delivered academic expansion and personal development in equal measure. The common thread throughout this doctoral portfolio is the relevance and importance of attachment representations in shaping the lives of people who later become addicted to heroin. I feel my own life, too, has been shaped – in my case by the past three years of training and learning. This experience has fundamentally influenced how I parent my own children, and the importance I attach to 'being in their lives' and emotionally connected to them.

Section A. Research

An Interpretative Phenomenological Analysis of people with former long-term heroin addiction about their experience of being parented in childhood and adolescence

Abstract

This study explores the lived experience of being parented in childhood and adolescence in individuals with a long history of heroin/crack cocaine dependence. This investigation uses attachment theory (Ainsworth & Bowlby, 1991; Bowlby, 1969, 1973, 1980) as a central pillar of the explanatory framework, while also drawing upon psychodynamic concepts to illuminate and interpret participants' narratives. The avowed aim of this research is to contribute towards a psychodynamic phenomenology of parental relationships in childhood, and in particular that of the mother-child dyad. The study also endeavours to begin to make up for the paucity of studies about the relationship between attachment and heroin addiction, while using a constructivist-interpretative epistemological position to examine how individuals' early life experiences may shape and influence them through later life. In this study, a clinical sample of six individuals stabilised on a low-dose methadone maintenance programme underwent three separate interviews, and analysis was conducted using interpretative phenomenological analysis. This focused on emergent themes, retaining a strong epistemological commitment to interpretations firmly embedded in the data. Three major themes emerged: 'I was always the outsider', and perceptions of not fitting in socially or with family; 'I wanted an ordinary mum and got Supermum', and the notion of a mother who was not mentally attuned with the growing child; and 'my search for a new, improved sense of self', where the child attempts to extinguish their negative self-image. These findings are then discussed, using theoretical literature as explanatory support, in an attempt to improve our understanding of the experience of being parented in a child who went on to become a heroin addict.

Introduction

Some of the questions that might naturally occur to any reader of this thesis may be 'why this study?' 'why now?' 'why this way?' This introduction aims to provide these answers, and so present a comprehensive rationale for the motivations, considerations and ambitions of this research. In summary, however, my therapeutic work over the past three years has raised many issues around heroin addiction that I feel are worthy of exploration. Among these issues were what appeared to be gaps in the literature and in therapeutic knowledge regarding the childhoods of heroin addicts. Finally, I became convinced that only a qualitative study would enable me to explore an already difficult topic within a notoriously intractable population.

1. Background to the study

1.1 What is the research topic?

This study is designed to explore the emotional and interpersonal experiences – the lived experience – of being parented from early childhood to adolescence, amongst individuals who have formerly engaged in long-term heroin abuse. It attempts to probe their perceptions and feelings in childhood about parental relationships and to understand them from a predominantly psychodynamic perspective. Due to the sheer breadth of the subject of addiction research, this study deliberately works on a manageably small scale. It does not attempt to look at causes of heroin addiction, nor to explain the aetiology of addiction. At every level my research ambitions are tempered by what can be reasonably investigated while remaining true to the stated aims of the study.

1.2 Why this study?

The inspiration for this study originated from my direct experience of working with addicted individuals with co-morbid mental health issues, within NHS primary care settings, over the past three years. This experience has had a distinct bearing on my choice both of research topic and of the methodology employed. It seemed to me that the heroin users shared a common desire for sedation, soothing and tranquillity. This was in sharp contrast with the users of cocaine or amphetamines, who sought omnipotence, stimulation and excitement. It

seemed more than possible that an individual's choice of drug, broadly sedative or stimulant, reflects some underlying state of mind.

In addition, it seemed more than coincidental that heroin addicts showed a marked tendency to have current problems with family relations, socialisation and even crime. It was not clear to me, however, whether opiate addiction created such problem areas, or whether they existed before the onset of drug use. It proved extremely hard to unpack any clear evidence of cause and effect. Such patients also seemed quick to blame themselves and their drug use for many of the problems they were experiencing in life. This raised a question for me: were early life difficulties in relationships or other problem areas being housed by the heroin addict under the convenient blame umbrella of addiction – not necessarily intentionally or consciously, but perhaps as a useful way of explaining to themselves their present social status and lifestyle. I wondered whether, in fact, heroin addicts blame themselves too much, rather than the experiences that had shaped them in the past and their early life. I was acutely aware from my therapeutic work that very few heroin addicts attributed any kind of blame towards their parents, mother or their childhood when trying to identify predisposing factors in the development of their addiction. This may not seem unusual *per se*, given that large swathes of the general population have normalised their own childhood and might not necessarily make proactive connections between their past and present. However, by and large my patients did not consciously choose to discuss their early lives and child-parent relations, and indeed they appeared to resist and defend against talking about such topics. This begged the question whether there was genuinely little of interest in these attachment histories, or whether heroin addicts were unable to tolerate bringing into conscious awareness difficulties surrounding their early life relationships.

I had also been struck by the incidence in my patients of apparent intrapsychic conflicts ('a hole in the soul' – some kind of emotional longing and lack of fulfilment, with patients often appearing to be incomplete and empty inside). I also observed an occasional incidence of childhood trauma (including sexual and physical abuse and PTSD) in heroin addicts. However, such detail only appeared to emerge after working therapeutically with a patient for six months or more, suggesting that this may not be an easy area of their lives for them to

discuss, or that they unconsciously chose not to venture towards it until they felt more secure in the therapeutic relationship. Research literature indicates that, within addicted populations (users of alcohol, drugs and the like), a high proportion of individuals have experienced trauma (Christo and Morris, 2004; Sullivan and Farrell, 2002; Reynolds, Mezey, Chapman, Wheeler, Drummond and Baldacchino, 2004); and yet few of my patients (opiate addicts) mentioned trauma (according to the conventional DSM-IV classification; APA, 2000). In fact, anecdotally, those of my patients who readily acknowledged trauma in their past had nearly all been exclusively alcoholics. This raised two questions for me: were there, in fact, subtle negative themes in these heroin addicts' childhoods (excluding trauma) that were worthy of investigation? and if so, had unpleasantness in childhood been unconsciously normalised, to the extent that heroin addicts might not routinely raise it as a problem area in their lives, or find it too uncomfortable an area to navigate consciously?

I was also mindful that, as resilience research testifies (Baumrind, 1991; Cairns, 2003; Lindley and Joseph, 2002), not everyone who experiences abuse (physical or sexual) or trauma goes on to develop an addiction or maladaptive coping strategy. To unpack this a little, it seems that some trauma sufferers do not become addicts; while some addicts may have suffered trauma, but it may not have been detected. There are several implications, though: for instance, if some trauma does not produce addiction, is there a difference between addicts' and non-addicts' traumas? and are there addicts who have no history of trauma? Obviously this opens up significant questions to be addressed by research, and they lie beyond the scope of this study. However, the air of uncertainty surrounding the literature on trauma suggested to me that some forms of negative experiences in childhood may be more subtle or less detectable, yet may be destructive and be present in heroin addicts. I was therefore encouraged to contemplate whether long-term heroin addicts shared similar characteristics, perceptions and experiences of childhood. And if that seemed possible, I wondered whether such a pattern could be uncovered if one deliberately excluded DSM-IV-type trauma (see appendix III for a definition of trauma) and if one did not choose to question them directly or steer them towards recalling traumatic events per se or the recording of specific life events but, instead, investigated more subtle forms of negative experience, and specifically those experiences relating to being parented.

Another compelling reason for this choice of study relates to definitions of attachment and their direct application to therapeutic practice. While I have the utmost respect for attachment measures such as the Adult Attachment Interview (AAI: George, Kaplan and Main, 1985; Main and Goldwyn, 1993; 1998), the Bartholomew model (Bartholomew and Horowitz, 1991) and the Hazan and Shaver Self Report (HSSR: 1987), there are major practical constraints on the use of such tools by therapists today, especially within the NHS drug treatment services. Training in the AAI measure, for instance, is expensive, and administration training is separate from coding and interpretation training, which adds another round of expense. Coding and interpretation, if self-executed, are regarded as time-consuming processes by seasoned professionals, and if interpretation is farmed out to a specialist coding agent, the expense factor looms large again. Therapists often lack the time or the budget to administer such a measure across a patient load with addictive behaviours. Hence I was most interested to examine whether one could gain access to this material in a way that could then be used by other therapists.

There is another difficulty, in my opinion, in the empirical measurement of attachment. Classification measures can be coarse-grained tools: they often cluster people under a small number of headings, a technique that usefully exposes widespread patterns in populations. Indeed these empirical measures have been standardised on normal populations and then applied to high-risk groups (Wallis and Steele, 2001). Thus, they are not necessarily designed to capture the subtleties of individual experience. It would appear that attachment classifications – for example 'preoccupied' – represent a set of umbrellas sheltering a host of sub-themes and dimensions. But it is this richness of textural detail, I would contend, that could lend value to any therapeutic approach. As one who is not trained in attachment measures, but who is brimming with curiosity (and, some might say, naïvety), I wondered whether, instead of using discrete categorisation measures, it might be possible to mine the lived experiences of former heroin addicts and, by means of Interpretative Phenomenological Analysis (IPA), to ascertain whether common themes permeated their accounts.

I determined to start with a blank sheet, using a bottom-up process that looked closely at individuals and avoided categorisation. I also considered it important to allow the

unexpected to emerge from the IPA process, as advocated by Smith and Osborn (2003), and to evaluate and explain any surprises by thinking as laterally as possible. This, I hoped, would bring me close to the participants' perceived experiences of parental interaction – cognitions, behaviours and all – and the way *they* made sense of them.

1.3 The aims of this study

The question of how former long-term heroin addicts experienced being parented is both phenomenological and psychodynamic. It thus has two clear aims: to explore individuals' lived experience of being parented, and to mine their interview data, from a *phenomenological* angle; to ascertain what these people perceive and remember about their childhood, and what they say about the meaning and effect of their relationships with their parents. It then aims to use *psychodynamic* theory to move beyond description into interpretation of the resultant analytic perspectives and emergent themes. These two perspectives might seem to be working in opposition, but (as Eatough and Smith (2008) advocate), I have sought, instead, to work on two interpretative levels – phenomenological analysis of the narratives themselves and a psychodynamic reading of the underlying themes. Meanwhile I kept always in mind the challenges the researcher faces during the transit from description to interpretation and theorising, and how that boundary might be blurred. My guiding principle is that all themes and interpretations are rooted in the participants' own words.

Three central questions were raised in the study:

1 How do participants describe their experience of the mother-child relationship[3]?

2 What characteristics of maternal and paternal relations in childhood present in long-term heroin addicts?

3 Are there shared themes in the narratives of these participants that could mediate addiction and/or other maladaptive coping strategies in adulthood?

[3] Following the lead from the literature of attachment theory, the maternal relationship was a key focus within this study, although the paternal relationship was also duly investigated.

To take account of individuals' personal experiences, the study aimed to consider the individual maternal and paternal relationships, the family setting and family relations, and emotional interaction. The following questions were used as a guide for the semi-structured interview process:

1 How do long-term heroin addicts perceive their experience of growing up?

2 How do they characterise their early to adolescent relationship with their mother?

3 How do they characterise their early to adolescent relationships with the father and other members of the family?

4 How do they describe feeling about themselves on reaching adolescence?

5 Do they indicate any earlier coping strategies (self-harming, food restriction and so on) before taking drugs?

6 How do they perceive and value their peers and their families during their adolescence?

1.4 Why now?

As a trainee counselling psychologist working within NHS drug and alcohol services, I was conscious of two key points that helped inform my decision to conduct this particular study. First, treatment in this environment is often geared to the symptoms of addiction and to prevention of relapse, and not to its underlying causes and mediating factors. Second, a psychodynamic and/or psychoanalytic approach or component is seldom used in NHS Drug Treatment Services. Most often, treatment consists of a methadone prescription, with only a minority of patients engaged with Psychology services. In fact, NICE (guidelines 2007) advises against the use of psychoanalysis, and instead advocates behaviour-based therapy.

My first-hand experience of therapy with heroin addicts has suggested that behaviour-based therapy, or any other approach that does not address the person's past and adequately link it to their present, may be no better than sticking a plaster over a gaping wound. It suggested to me that an absence of therapy in general within methadone maintenance programmes, and

specifically of psychodynamic therapy, may in part explain the 'revolving door' nature of primary care drug services in the UK, where, after a short period of reduced drug use or abstinence, individuals stumble back over the threshold requesting further help, often in a worse condition than when they were originally assessed. I note that most privately run addiction rehabilitation centres routinely examine early childhood and associated conflicts as a staple part of treatment throughout the duration of their residential stay (Gabbard, 2005). However, this treatment is expensive and only a minority of heroin addicts are ever referred by the NHS for rehabilitation, or are even considered to be stable enough for in-patient treatment.

Finally, as I began to consider this area of research and examined the literature, I was surprised to find so little qualitative research into populations of heroin addicts, and comparatively little quantitative analysis relating to attachment and substance abuse. Indeed, empirical support for an association between attachment and heroin addiction has been little explored. As other researchers note, most studies assess self-reported attachment styles (Finzi-Dottan, Cohen, Iwaniec, Sapir and Weizman, 2003; McNally, Palfai, Levine and Moore, 2003; Schindler, Thomasius, Sack, Gemeinhardt, Kustner and Eckert, 2005), rather than internal mental representations, as used in the AAI, for example. Even when the latter kind of instrument is applied, many studies fail to demonstrate a significant overall relationship between attachment classification and substance abuse (Allen, Hauser, and Borman-Spurrell, 1996).

While there is extensive literature on heroin addiction, the bulk of it is not formal research, and consists largely of self-help guides, biographies and the autobiographical accounts of former addicts (Patti Davis, 2001; Marlowe, 2002; O'Toole, 2005; and many others), providing little real insight into why they think they became addicts.

Such quantitative literature as there is relates primarily to correlations between substance use disorder (often unspecified) and insecure attachment. This is variously described and labelled by several commentators: 'insecure' (Schindler et al, 2005), 'unresolved attachment

representations' (Riggs and Jacobvitz, 2002) and 'avoidant' (Finzi-Dottan et al, 2003), to name a few. While they may all point to indicators of impoverished attachment styles, their results are inconsistent, and studies are not united on the attachment classification of opiate-dependent individuals. Moreover, many of these studies further confuse their findings by using populations of polydrug users, including both primary- and secondary-care patients, and containing significant variations in age and length of dependency, and often this important detail remains undisclosed (as in a study by Fonagy, Leigh, Steele, Steele, Kennedy, Mattoon, Target and Gerber 1996 referring to substance abuse (unspecified)). In addition, many of these studies were carried out during the 1990s (Rosenstein and Horowitz, 1990; Allen, Hauser & Boreman-Spurrell, 1996) and their views may be stale and not in line with the changing habits of heroin addicts and the more pervasive nature of the drug in today's society. Add the fact that researchers apply different methods of measuring attachment, and one can see how opaque the picture becomes. Finally, some researchers, such as Riggs and Jacobvitz (2002), have been unable convincingly to classify the attachment status of substance abusers.

Looking wider, I explored literature from addiction as an adaptive effort at self-repair (Eigen, 1999; Russell, 1998; Schore, 1993), and the use of opiates as a form of self-medication (Khantzian, 1985, 1990; Newcomb, 1995), to the role of the endogenous opiate system in the attachment process (Kalin, Shelton and Lynn, 1995). Surprisingly, there appears to be a dearth of empirical evidence in the literature to indicate whether attachment theory is a valuable construct in a therapeutic context when working with addiction; albeit there are some compelling exceptions, focusing on the neurobiology of attachment, from Schore (2001, 2003), Cozolino (2006) and Flores (2003, 2006) and others such as Weegman and Cohen (2002) who advocate the use of psychodynamic therapy for addiction. It is also unclear from the literature whether parental (especially maternal) dysfunction appears to predispose or mediate addictive coping strategies, and if so, of what kind.

1.5 Why design the study in this way?

Given that this study was intended to draw on the lived experiences of the individual and explore their own perceptions of childhood, it was of central importance to me that

interviewees be allowed the flexibility to discuss the issues and experiences that they perceived were most significant to them. I took the view that IPA would provide this flexibility and the desired depth of intimacy, while a semi-structured interview approach should ensure that the topic under investigation was sufficiently explored without getting lost in the long grass. Moreover, a qualitative approach to the research topic could be used in a way that closely resembled elements of my own therapeutic approach, which is to let the person's story unfurl, and then use theory as a scaffolding for the interpretation of their words.

Do not go where the path may lead; go instead where there is no path and leave a trail

Ralph Waldo Emerson (1866)

It has been common IPA practice to leave the participant interview data as largely descriptive accounts, but I have chosen to examine it through a psychodynamic lens, and to use it as part of the explanatory framework also incorporating attachment principles, predicated on the seminal work of John Bowlby (1951; 1958; 1969; 1973; 1980) and on his later work on attachment theory with Mary Ainsworth (Ainsworth & Bowlby, 1991). My reasoning was that the use of a specific theoretical framework would make my particular perspective clear and comprehensible, and at the same time make the study's findings more explicable and therapeutically applicable, enabling me to design suitable interventions.

1.6 Hermeneutic tension

The reader may rightly question the degree of hermeneutic tension between my methodological position and my theoretical commitments to attachment theory and to the use of psychodynamic concepts when attempting to analyse participants' accounts. There might, for instance, be concerns about how successfully one can juggle the two seemingly parallel and often conflicting aspects of what Ashworth (2003, p.19) terms 'hermeneutics of suspicion' and 'hermeneutics of meaning-recollection' – in the one case *not* taking accounts at face value, and in the other postulating that one *should.* I have had to manage this difficulty throughout the course of the research. It is analogous to the tensions between my therapeutic instincts and my role as a researcher that I felt during the pilot interview process, which I discuss in the Methodology section below. Other possible criticisms are that my

theoretical commitments impose a pattern on the data, and could lead to me failing to capture other interesting analytic points, or that using psychodynamic theory might prove too reductionist to adequately represent the lived experience.

My response to such potential concerns is threefold. First, I do not consider IPA, or qualitative inquiry in general, incompatible with psychodynamic concepts, primarily because I am not taking a reductionist approach of seeking to extract unconscious truths in the participants' narratives; rather, I have deliberately adopted a gentle and flexible approach to psychodynamic input. By 'flexible' I mean that I consider concepts outside the context of psychodynamic thinking and am prepared to give voice to them. I am taking a perspective on participants' perspectives and using theoretical support to try to explain them. Thus, I am seeking to understand what participants have experienced and perceived in early life via my epistemological position, and this corresponds, I believe, with psychodynamic emphasis on childhood learning and the internal working model of relationships. Second, IPA researchers are increasingly being urged (Eatough & Smith, 2008) to move beyond descriptive accounts to use their own theoretical positions in their analysis and discussion, while remaining conscious of the challenges of moving from description to interpretation (as mentioned above) and of the fact that at all times they are dealing with perceptions, and not veridical descriptions of events. This study has made obvious its theoretical position from the outset.

Finally, while attachment theory is a central pillar in the explanatory framework for this study, it is not considered at the expense of all other theories, and I hope that, as a relative newcomer both to research and to psychodynamic practice, I can resist adopting an intractable position. My objective is that, by allowing the participants' words to 'do the talking', my findings will be clearly seen to be rooted within the body of their accounts.

2. The theoretical framework

This section outlines the theoretical constructs and perspectives that have informed this study, and that are considered when analysing the participants' data and attempting to explain the

findings. The framework comprises attachment theory and attachment representation measures, and psychodynamic theory.

2.1 Attachment and attachment measures

Attachment can be summarised as a survival instinct in the infant that is activated to encourage attention in the care-giver and to have its physical needs met (food, warmth...). When he proposed this idea, Bowlby (1958) named it 'secondary drive'. The child also seeks proximity in the primary object (often the mother). Ample demonstration of the need to stay close and seek reassurance can be found in the Strange Situation[4] procedure (for infants) proposed by Ainsworth, Blehar, Walters and Wall (1978).

While there has been extensive research over the last few decades into attachment experiences in early childhood and their effect on later functioning, it is only in the past decade that research has been conducted in the area of attachment and psychopathology, notably by Andersson and Eisemann (2003), Dozier, Stovall and Albus (1999) and Fonagy, Target, Gergely, Allen and Bateman (2003). Moreover, there has been surprisingly little research on attachment and addiction – surprising because attachment and addiction both show links between emotional regulation and coping strategies, as other researchers have found (Belsky, 2002).

This study thus began from the premise that optimal self-development occurs in a secure attachment relationship between the child and its primary care-giver (Bowlby, 1973; Ainsworth et al, 1978). Also borne in mind were two essential principles of attachment quality: emotional regulation (Stroufe, 1990; 1996) and a maternally sensitive (Main and Weston, 1981), 'goal-corrected partnership' (Bowlby, 1969/1982); and whether, as some researchers suggest, negative emotions in childhood are viewed as threatening, or expression of emotions is used as a means of communicating (Grossman, Grossman and Schwan, 1986 and Stroufe, 1996). Another important area relating to attachment quality appears to be emotional sensitivity (feeling responded to by, and emotionally connected with, a parent), an

[4] See Appendix IV for a brief description of the attachment classifications used in Strange Situation.

experience which has been posited as conducive to secure attachment (Isabella and Belsky, 1991).

This research focused on examining narrative content evoking parent-child communication and interaction styles and attempting to gauge the individual's internal working model (IWM) of the self by studying the narratives in relation to the presence of mental schemata, a natural process of abstraction that results from experiences and learning within the parent-child dyad, as defined by Stern (1985, 1994).

Measuring attachment

Research has shown that insecurity in childhood often predicts mental health issues and psychopathology in adults (Fonagy and Target, 2002; Ogawa, Stroufe, Weinfield, Carlson and Egeland, 1997; Pielage, Gerlsma and Schaap, 2000). However, there remains uncertainty about the relationship between the attachment system and the development of personality (Marsh, McFarland, Allen, McElhaney and Land, 2003; Ziv, Oppenheim and Sagi-Schwartz, 2004).

As previously flagged, labelling individuals as 'insecurely attached' (or alternative terms) sits uncomfortably with me. It suggests that all adults' retrospective accounts fit neatly into discrete categories of attachment, yet I have struggled to find empirical evidence for such categorisation amongst adults with heroin addiction, or at least categorisation that would serve a meaningful therapeutic purpose. It also seems important to note when conducting attachment measures that, due to the vagaries of memory, individuals' ratings of childhood experiences leading to subsequent classification cannot be considered a reliable guide to actual experience. A summary of the AAI protocol can be found in appendix V.

While several AAI studies indicate insecure attachment in abusers of (unspecified) substances, no single classification is consistently linked to them, as Schindler, Thomasius, Sack, Gemeinhardt & Kustner (2007) point out. Furthermore, these AAI studies were not

specifically designed to explore substance use disorders; abusers appear merely to have been captured within the researcher's population. When considering these issues, I sought to probe how the experience of what might be termed 'insecurity' in childhood (if conventionally measured) felt and sounded like in heroin addicts' narrative accounts. I was concerned that the use of classification measures to evaluate adult addicts' attachment styles may produce ambiguous data, making it difficult to determine whether poor adult relations reflect a drug-addicted lifestyle, a dysfunctional childhood or both.

I have considered some key factors that might preclude the use of an instrument such as AAI when working with heroin addiction. First, as previously outlined, the training is expensive and time-consuming. Second, since addicts apparently show resistance to discussing their childhood in therapy, they might find it intimidating if they feel they are being labelled or categorised in relation to this area of their life. Third, the criteria used to assess security relate to consistency, emotion and fluency of accounts; in addicted patients this may present confounding factors, due to heroin addicts' frequent lack of coherence, difficulties in concentrating and, in the case of prolonged substance abuse, possible impairment of cognition and memory (Moulton, Petros, Apostal, Park, Ronning, King and Penland, 2005; Wells, 1982; Heather, 1998) – particularly if measured during a phase of heavy substance abuse.

2.2 Parenting

In examining how people think about their experience of being parented, this study explores relationship dynamics as typifying a much wider constellation of factors involved in the early lives of heroin addicts and in the pathways to addiction. Close attention is paid to individuals' experience, perceptions and cognitions of maternal and paternal relations. According to research, the paternal role is influential – the absence of a father and passive fathering are both considered to increase the risk of drug abuse (McMahon and Rounsaville, 2002; Medici, 2006) – but most of the literature seems to point more forcefully to the pivotal role of the mother (Bowlby, 1951; Ainsworth, 1985; McArdle, Wiegersman, Gilvarry, Kolte, McCarthy, Fitzgerald, Brinkley, Blom, Stoeckel, Pierolini, Michels, Johnson and Quensel, 2002; De Rick and Vanheule, 2007; Etherington, 2007). That said, with this study's design I

aimed to allow participants the freedom within their narratives to direct me, the researcher, towards either the father or the mother, and also towards the participants' experience of relationships with them and other people.

If attachment and parenting provide the starting point of this research, it is psychodynamic theory that will be drawn upon to try to lead it to a conclusion.

2.3 Psychodynamic theory

Central to Freud's developmental theory was the notion that an individual's childhood relationships with their parents affect their relationships later in life, including adult love and the parent-child dyad. The centrality and importance of this process, including intergenerational transmission, which has been prominent in much psychoanalytic thinking and other research for some decades (Benedek, 1949; Berger and Kennedy, 1975; Feigenbaum, 1997; Winnicott, 1986), remains just as pertinent in relation to this thesis. The present study does not aim to explore intergenerational transmission, which is explicit within Bowlby's theory of attachment (1969/82); there is an abundance of research on this topic to show that there are strong links between parents' attachment styles and the attachment tendencies of their offspring (Obegi, Morrison and Shaver, 2004; van Ijzendoorn, 1992). Instead, it seeks to tap into addicts' perceptions of their childhood relationships to see if they shed light on their path to addictive behaviour.

Psychoanalytical theory suggests that there is some aetiology for addiction, relating it to object relations (Forrest, 1984; Miller, 2002), and for repetition and ritual compulsion (such as that shown by addicts), which is strongly attributed to the desire to return to old experiences (and states of mind, body and feelings: Freud, 1920). There is also research proposing that addiction occurs as a result of a failure in the separation-individuation process (Graham and Glickauf-Hughes, 1992), otherwise labelled as 'insecure attachment' (Ainsworth et al, 1978). Sandor Rádò (1993) allied addiction to childhood regression, and Fenichel's (1945) studies on alcoholism see this behaviour being used to dilute the superego, and regards addiction as a regression to infantile states. Winnicott (1953), on the other hand,

positions addiction as the transitional object which is fetishised but continues to uphold its original function of counteracting depressive anxiety. Furthermore, Winnicott posits that the normal process of opening up and development is stalled in addicts, and that the transitional object becomes susceptible to replacement with a drug because it allows the individual to avoid feelings of separation and subsequent depression. Glover (1932) offers the insight that substances are used progressively by addicts to help defend against primitive impulses, even sadistic fantasies, and that this unconscious strategy avoids psychosis. Thus there is considerable room for future empirical research to test this catalogue of theories, albeit that was not this study's intention.

There were two main reasons for considering a psychodynamic framework for this study. First, psychodynamic practice is based on the central tenets of the importance of childhood and security, which provide the bedrock of communication and relationship styles (Bowlby, 1958; Freud, 1916-17/1953, 1920; Winnicott, 1958) and object-relations (Klein, 1957). It thus marries with the central orientation of the present study. Second, I believed that using a psychodynamic lens would allow me to link the participants' pasts with their present behaviours and examine any common themes, as I do when working therapeutically.

3. Heroin addiction

The world of heroin and crack cocaine addiction (see the background information in appendix II) becomes for many people a place of harrowing ritual and of the all-consuming pursuit of a state of emotional improvement or even numbness. Those treating such clients in drug services across the UK know only too well that treatment can fail and the client relapse. The UK government agenda (the Harm Minimisation Model, launched in 1998) appears to be geared to keeping the lid on the growing addiction problem, allowing ministers to announce neat statistics of how many people are in treatment. Importantly, the published information does not reflect abstinence levels or recovery success. It essentially relates to those using a methadone prescription, a large proportion of whom may in reality be using illicit drugs on top of their prescription, many of whom are essentially 'addicted' to methadone.

The term 'addictive behaviour' embraces a wide range of interpretations when one explores the literature, so it seems important to spell out what is meant by the use of the term in this research. I acknowledge the medicalisation of the word 'addiction' and its often pejorative interpretation, but the debate about addictive personality, and whether the neurobiological effects of one drug are more addictive than others, is beyond the scope of my thesis. Instead, in line with the views of Howitt (1991) and Truan (1993), for example, I look upon addiction as a behaviour that may result from context and experience, and upon the word itself as a socially constructed term.

I also empathise with the research perspective posited by Michael Larkin and colleagues, that addiction is best understood through the lens of a complex systems account which views addiction as a dynamic process (Griffiths and Larkin, 2004; Larkin, Wood and Griffiths, 2006). This implies that the addict seeks possible satiation, and adheres to a learned pattern of behaviours influenced by their experience and environment. However, it also views the addict as having some recourse to decision-making, and views them as willing or even seeking to influence their physiological state. Thus, these researchers believe that a number of biological, psychological and socio-cultural factors determine the nature of the addict's addictive path. It is these socio-cultural and psychological factors that are of most interest to me and that I consider are of most relevance to this present study.

4. Review of the literature

While a full evaluation can be found in the Critical Literature Review (Section C), this introduction will briefly consider two specific perspectives on the existing research that should help to explain some of the difficulties when researching populations of addicted people and, it is hoped, shed some light on the choice of study and the qualitative paradigm adopted for this thesis. They relate to quantitative approaches based on retrospective attachment measures, and research approaches based on the prevalence of trauma or abuse as antecedents to heroin addiction.

The studies mentioned here were selected to illustrate the difficulties, challenges and confounds facing researchers when using conventional quantitative study methods, and some of the frustrations of using terms such as 'insecurely attached' in adults with addictive behaviours. In my view, the examples given here and in the full critical literature review together make a firm case for the qualitative research approach adopted by this doctoral study.

4.1 Quantitative approaches based on retrospective attachment measures

Andersson and Eisemann (2003) investigated parental rearing and substance-related disorders. Using a multi-factorial approach, they had participants (n=50) complete a battery of questionnaires to evaluate the presence of high-risk coping strategies and so-called self-protection behaviours. All participants – as in the present study – were on a methadone maintenance prescription. However, the researchers did not control for the amount (millilitres) of daily methadone that participants were taking, nor for the length of time they had been addicted or had been on a methadone programme. These factors could affect participants' ability to complete questionnaires, the accuracy of their recall and their ability to concentrate.

Participants completed the Bowlby Scale (1951), the RSQ-SWED (Relationship-Status Questionnaire; Bartholomew & Horowitz, 1991), the Reciprocal Attachment Questionnaire (Hazan and Shaver, 1994) and the Dysfunctional Attitudes Scale (Weissman and Beck, 1978). Researchers found that the participants confirmed the prevalence of insecure attachment types (A, C, D, see appendix IV: Ainsworth et al, 1978; Main and Solomon, 1990). They found that the influence of the pathological pattern 'Compulsive self-reliance' on the personality factor 'Confidence in self and others' was 40.3 times higher (odds ratio) for addicted individuals than for controls. Analysis of schema content in addicted individuals showed an association between individual vulnerability and decreased social competence, and a very high risk of development of various types of psychopathology.

However, as most Drugs Service workers will attest, social competence becomes extremely low in most long-term heroin addicts by virtue of their addiction (which equates to a full-time occupation) and the neurotoxic effects on their brains (Mandell and Amsel, 1976). Their memory is often impaired (Moulton, Petros, Apostal, Park, Ronning, King & Penland, 2005; Wells, 1982), their levels of paranoia, anxiety and emotion are high, and they refer to a 'loss of control' (Heather, 1998). Thus their daily rituals provide a sense of structure and have all the hallmarks of pathology (Schore, 2003). Hence, although it may be possible to use questionnaires to measure attachment and conclude that certain individuals have insecure attachment status, this does not tell us whether that is a symptom of their addiction and adult lifestyle, a reflective measure of their experience of being parented as a child or indeed any other factor.

Thorberg and Lyvvers (2005) conducted a variation on Andersson and Eisemann's (2003) research, using self-reporting questionnaires to measure attachment, fear of intimacy and differentiation of the self in individuals enrolled on addiction programmes (n=99) and a control sample (n=59). However, the participants were being treated for a range of substances, from heroin and cocaine to alcohol and cannabis, and the lengths of time that individuals had been addicted was very varied. It is well documented that substances such as heroin and alcohol have dramatically different effects on the brain, further depending on their length of use and consumption (Flores, 2006). A more robust sample would have investigated users of only one substance.

Researchers claimed that those on treatment programmes had higher levels of insecure attachment than the controls, a fear of intimacy and lower levels of secure attachment and differentiation of the self. However, addiction is often an individual's version of intimacy, according to some researchers (Mellody, 2004). During gruelling addiction, individuals can lose their relationships, become fearful of others and feel paranoid, and consequently have little present-day experience of secure attachments (Stanton and Todd, 1982); in these circumstances, their drug of choice represents security (Flores, 2003). Thus, with this research example, there is the same doubt about what is really being measured and about the therapeutic usefulness of the information.

4.2 Approaches based on the prevalence of trauma or abuse as antecedents to heroin addiction

Several studies that have investigated the emotional and trauma histories of individuals with addictive behaviours (such as Reynolds, Mezey, Chapman, Wheeler, Drummond & Baldacchino, 2004) point to the incidence of factors such as insecure attachment (Christo & Morris, 2004), sexual or physical abuse (Finzi-Dottan et al, 2003) and major life events – death, say, or abandonment (Sullivan & Farrell, 2004) – and produce correlations between such factors and substance dependence. Again, however, nearly all these studies are quantitative (although this is not a criticism in itself).

Moreover, supplementary analyses probing differences between heroin-dependent individuals and control groups in adult attachment styles (Lapidus, 2005), or using instruments such as PARQ, the Parental Acceptance-Rejection Questionnaire (Rohner, 1990), or the Relationship Questionnaire (Bartholomew & Horrowitz, 1991), very often fail to find significant differences between the populations. It may be that these tools fail to tap into the complexity of childhood experiences.

Quantitative research literature has established that trauma histories are relatively common among treatment-seeking addicts (Christo & Morris, 2004; Langeland, 2003; Moncrief, Drummond, Candy, Checinski and Farmer, 1996). However, there is little evidence that such histories directly influence substance dependence. As Christo and Morris (2004) point out, outcomes of event-prevalence studies are fundamentally influenced by the reporting methods used. The literature in this area suggests that pathways to addiction may be subtle and fine-grained, that more light may be shed on the reasons for substance addiction by examining narratives of the experiences of individuals and their early lives, and that this may be of greater therapeutic value to practitioners. This appears to be one of the clearest pieces of direct evidence for supporting the choice for a qualitative method.

In many studies, the age of onset of drug use is regularly reported and presented as significant in the development of addictive tendencies. The Gateway Hypothesis states that, generally

speaking, the earlier a person first experiences drugs (including nicotine), the more likely they are to develop an addiction, especially to opiates (Verheul, 2001). Gateway theory does highlight acute vulnerability in young people and adolescents, and points to this stage of life as a prime time for therapeutic intervention (Chen, Storr and Anthony, 2009). However, there is some opposition to the notion that there is a temporal and sequential order from first use of drugs through to addiction (Tarter, Vanyukov, Kirisci, Reynolds, and Clark, 2006; Kandel, 2002). And, importantly, research falls well short of decisively educating therapists about what to look out for.

One of the overarching problems that seems to dog many clinical studies is that they fail to find supporting evidence of a factor or factors that specifically mediate addiction. This may be because they cast their net too wide, in an attempt to detect the largest possible number of retrospective risk factors for addiction (as in McArdle et al, 2002; Rose, 2005; Walitzer and Dearing, 2006).

Poikolainen (2002) quantitatively investigated antecedents of substance abuse in adolescence and found, first, that no study could assess all risk factors simultaneously, and that control of confounds was invariably sub-optimal; and second, that adolescents did not always tell researchers the truth. Lying and/or misleading by adolescents in substance misuse research has been commonly encountered by a number of researchers (Fendrich and Yun Soo Kim, 2001). Thus there is a strong argument for using known addicts who are stabilised on methadone. Using a qualitative approach with this sort of sample may lead us towards greater insight into the mediating factors behind addiction, making it easier to predict antecedent factors and the severity of circumstances in which addiction is most likely to occur.

When research identifies a massive range of antecedents to heroin abuse – including, but not confined to, difficult temperament, aggressiveness, poor intelligence, genetics, poor parenting and parental substance misuse, through to depression and anxiety disorders (Kessler, Sonnega, Bromet, Hughes and Nelson, 1995), personality disorders (Verheul, 2001), conduct

problems, poor attachment and association with trouble-making peers (Poikolainen, Tuulio-Henriksson, and Aalto-Setälä, 2002), it is difficult for therapists to know where to begin in addressing these issues. Not least of all, one does not know to what extent these factors influenced addiction, and how they were experienced by the person concerned.

This problem was addressed in a quantitative study by **Christo and Morris (2004)** which investigated the prevalence of 12 categories of traumatic event among individuals in substance misuse treatment (n=90). These categories corresponded with the National Co-morbidity Study List of Lifetime Traumatic Events (NCS-LTE: Kessler et al, 1995), and range from the experience of war to sexual molestation, rape and neglect. Previous studies have shown a 90% prevalence of sexual abuse or physical assault history in groups of substance (non-specific) abusers (Dansky, Brady, Saladin, Killeen, Becker and Roitzsch, 1996), and 38% prevalence for crime-related PTSD criteria (Dansky, Saladin, Coffey and Brady, 1997), while factors such as conduct problems correlate positively with increased risk of substance misuse (Disney, Elkins, McGue and Iacono, 1999).

Christo and Morris (2004) found that 42.2% of active substance misusers reported some type of childhood abuse, compared with 16.7% for controls. Childhood sexual molestation was strongly reported in non-specific substance-abusers (28.3% of males and 26.7% of females), more than eight times greater than the 3.4% reporting rate of male controls. In addition, around 80% of substance misusers reported that they had experienced at least one life event that qualified as DSM-III-R trauma (APA, 1987), compared with 55.7% from a study (National Co-morbidity Survey; Kessler, 1995) of almost 6,000 individuals drawn from the general US population.

However, only three of the NCS-LTE's categories relate to childhood – physical abuse, sexual molestation and serious neglect. Moreover, these studies do not tap into emotions, perceptions or cognitions around the topic of childhood experiences of abuse or trauma, or around that of being parented. Nor do they probe for any kind of parenting dysfunction.

In addition, many of the questions within quantitative research are posed in such a way as, arguably, to prompt the participant to recall a specific event; the effect may be to fail to uncover prolonged negative experience that has perhaps been normalised over time by the growing child, and thus discounted as important chapters in adulthood.

* * *

With this brief and preliminary summary of research into the childhood experiences of addiction, I aim to suggest that there is a qualitative research gap, with four key themes of particular relevance.

First, there has been relatively little examination of the actual experiences of addicts overall, and more specifically heroin addicts, in which bottom-up themes have been allowed to emerge. Second, it seems that certain of the tools of classification and measurement may be pigeonholing people in relation to their secure or insecure status in a way that is not therapeutically useful to those working in the field of addiction treatment. Third, emotional and parental dysfunction, appear often to get lost in the noise of multi-factor analysis, or are not even touched upon. Lastly, while theory suggests that the maternal role is highly influential, few studies have attempted qualitatively to examine the lived experience of the mother-child interaction and of sustained emotional behaviours that may mediate addictive behaviours in later life.

In an attempt to begin to help fill this void, this study adopts a qualitative approach, using a group of participants stabilised on methadone, with a lengthy addiction history and with no material cognitive impairment. Not only is this sharply in contrast with the top-down quantitative methods described above, but there are important differences between the populations often researched and that examined in the present study, which uses an homogeneous sample (primary-care) and has controlled for specific drug misuse, the length of abstinence and the level of prescribed daily methadone.

Epistemology and Methodology

1. The design and aim of this research

This study used a qualitative method that gathered data from semi-structured interviews, using a small (n=6), homogenous, mixed-gender sample. Data analysis was conducted using Interpretative Phenomenological Analysis (IPA).

The aim of this research is to investigate the lived experience of being parented in a group of adult former heroin addicts. The object was to explore the dynamics of family life and interaction styles experienced by participants in childhood, while paying particular attention to the mother-child dyadic relationship and the participants' perceived quality of emotional relationships. In short, it uses the lived experience, as reported by the participant, to ascertain whether there are shared emotional experiences that could predispose addictive behaviours.

This study presents an opportunity to identify the presence of any core characteristics of participants' early relationships by reference to qualitatively recorded individual experiences. It also affords the opportunity to ask whether childhood work (a core principle of the psychodynamic approach – Freud, 1916/17) is a therapeutically valuable area when treating heroin addicted individuals outside or before in-patient rehabilitation.

2. A rationale for a qualitative epistemology

The underlying principles of my epistemological stance pervade my methodological approach, as McLeod (2001) recommends. Qualitative epistemology appears pertinent when examining recondite psychological phenomena and questions of labyrinthine complexity that are subjectively experienced by individuals. It offers the researcher a finer-grained analytic opportunity which quantitative methods are often unable to provide. Indeed, the philosophical roots of qualitative research are embedded in relativism, in the notion that every person is a reflective agent, and in the image of the researcher as one who is intimately involved in the process (McLeod, 2003).

Rather than aiming for a reductionist, neatly packaged account of peoples' life experience, qualitative research aims to furnish readers with a thick (Geertz, 1971) and rich account that

allows, and indeed embraces, this subjectivity without wanting to distil it. A qualitative paradigm thus *spoke* to me, in the same way that my psychodynamic therapeutic work with clients has allowed this subjectivity to emerge and be valued. Subjectivity, however, does not reside solely with the participant. The researcher's subjectivity is well recognised within qualitative research literature, with Janesick (1994), among others, urging the researcher to view him- or herself as a true research instrument, fully appreciative of both the importance and the potential influence of the research role.

For the subject under investigation here, a constructivist-interpretative epistemology – a 'therapeutic way' of understanding – allowed the adoption of a middle position between treating participants' data as a 'factual account' and regarding it as an 'interaction structure', as posited by Smith (1995, p.10). The term 'constructivism' is used here to mean the proposition that humans generate knowledge and meaning from their experiences, and in particular that they generate templates about parent-child relationships during their early life. Years ago, during my undergraduate psychology degree course, I was struck by the seminal work of Bowlby (1969; 1973) on attachment, and of Piaget (1959; 1977) on constructivist learning and how the child makes sense of its world. It was this learning and resultant psychological adaptation that I wanted to tap with the present study, and I consider it provided a paradigm to operate from. In essence, this approach can be best summarised as gaining access to the participant's learning about parent-child relationships, and then interpreting this learning.

This study could thus explore and describe the experience of individuals, while interpreting their data and relating it to theory in order to explain and understand those experiences. This epistemological perspective mirrors the way I prefer to work with clients as a trainee counselling psychologist – listening and interpreting, while using theory to guide and help shape interventions. Kvale (1996, 1999) observes that psychodynamic work is closely allied with the qualitative interview process. As Heron (1981) notes, the process of qualitative research should be seen as a model of cooperative inquiry, and not as the act of an authoritative researcher investigating a passive participant.

Some readers might regard psychodynamic theory as reductionist: that is, that it regards the researcher or analyst as having access to unconscious truths that the participant could not know about, as Midgley (2006) points out. Here, however, I suggest that using it as an element of the interpretative framework for qualitative analysis allows ideas to flow that are merely perspectives on the participants' narratives, and are presented neither as truths nor as facts. Just as the researcher's expectations must be bridled, and not allowed to penetrate the interviews and analysis, he or she should allow stories to unfold naturally. Thus, psychodynamic theory is used here as a conceptual scaffolding, as Freud (1933) originally advocated; while Midgley (2006) reminds us to be respectful of the constant interplay between data and emerging hypotheses, and that no observation can ever be considered 'neutral'. I did not set out to discover the real unconscious meaning of participants' words, but to take them at face value and to weave in theoretical explanations, using some concepts from psychodynamic theory.

This seems legitimate if one accepts the view that meaning lies beneath the surface and requires unmasking, as Ricoeur (1970) illustrates. I respect the descriptionists' position, as when Giorgi (1992: p.123) says that 'unified meaning can be teased out and described precisely as it presents itself', but have chosen to adopt an interpretative stance. This is done with an express intention of 'furthering our understanding of *why* such experiences take place and *why* there may be differences between individuals' representations', as Willig (2008: p. 68) outlines. And, this researcher would add, why accounts may also be similar.

If it was Bowlby's (1969) work that sparked my initial interest in early familial relations, it is my therapeutic work that has highlighted the apparent significance of relationships in early life for people with addictive behaviours. This study is not, however, intended to prove a theory, nor indeed to answer a direct question prompted by attachment theory. Rather, the aim was to cast the net wide, asking participants to talk about their childhood and examining the 'catch'. Only after analysis of their narratives and sense-making could one hope to rise above a mere description of their accounts and put them into a theoretical context. As Larkin, Watts and Clifton (2006) aver, limiting the analysis to a purely descriptive overview wastes the opportunity to contextualise and make sense of the themes from a psychological perspective. While I acknowledge the influence of attachment theory upon this project's

initial conception and as a central pillar in this study's analysis, it is not the sole driving force of this study. Rather, the study has sought to discover whether attachment theory or other theoretical perspectives can illuminate the themes that arise from the participants' narratives.

A constructivist-interpretative paradigm (Guba and Lincoln 1989; Patton, 1990) focuses on a subjective view of the world. The present research stands, therefore, in sharp contrast with that which I had conducted in the past, when my studies had been implicitly grounded in an objective view of the world. The present study's ambition was to explore the childhood interactions and relationships that constitute the learning and introjection process, with an emphasis on the participants' world as a socially constructed reality, and with the aim of examining multiple perspectives. This demands attentiveness to participants' perceptions and values in the context both of their childhood and of the research interview.

The prime methodological objective of this study was to connect with the intimate content, structure and presentation of the participants' narratives, through which they relate important historical attachment relationships, as Main and Kaplan (1985) illustrate. This study, therefore, is both hermeneutic – critically interpreting participants' underlying themes and unconscious – and literal, taking their narrative at face value. The hope is to yield both manifest and latent information, and gain an insider's perspective (Conrad, 1987).

Qualitative research today is a multifarious option for any researcher. While phenomenology is used as a 'catch-all' label, there are many different traditions and procedural variants. But with greater choice of options comes the increased challenge of demonstrating validity, as Yardley (2000) argues. This is addressed below, in the section entitled Validity, but first I hope to demonstrate the reasons for choosing IPA.

3. The rationale for using IPA

Jonathan Smith's main reason for developing IPA in the mid-1990s was to craft a qualitative approach that was grounded in psychology (Eatough & Smith, 2008, p.180), and to move researchers closer to what he perceived as an overlooked area in psychology: the subjective experiences and personal accounts of individuals (Chapman and Smith, 2002; Smith, 2003).

This approach has now been used extensively in counselling and in clinical, social and organisational psychology, but is perhaps best known in health psychology.

Smith (2004) does not put IPA in a precise epistemological position, and indeed it draws on many theoretical influences, including social constructionism (Burr, 2003), symbolic interactionism (Blumer, 1969), social cognition (Smith, 1996) and phenomenology (Moran, 2000). However, he does describe it as having a commitment to the exploration of the personal lived experience, seeking to elicit key themes in the participant's talk. It is a naturalistic research method, using a detailed analysis of elements of the reflected subjective experience of individuals. This distinguishes it from nomothetic approaches, which seek to extract general laws and traits. It is this essence that attracted me to this research method, and the notion that when participants tell their stories they permit access to their inner world, which falls to the researcher to understand, interpret and attempt to explain.

IPA considers, from a mildly social constructionist perspective, that historical and socio-cultural processes are fundamental to our experience and our understanding of our life-world. 'Life-world' (the term *Lebenswelt* was first coined by Husserl, 1936/1970) is perhaps best explained by von Eckartsberg (1998) as the 'locus of interaction between ourselves and our perceptual environments and the world of experienced horizons within which we meaningfully dwell together' (cited in Garza, 2007, p.314.) – a 'humanly relational world', as Todres (2006, p.55) outlines. The exciting aspect of investigating this lived experience is that it is pre-reflective – it represents our day-to-day existence, filled with intricacies and subtleties, the canvas on which we paint our daily actions and interactions. IPA does not seek to induce in participants a state of deep introspection, but encourages them to tell their life experiences as they perceive them and have made sense of them. In the eloquent words of Merleau-Ponty (1962, xi), 'man is in the world, and only in the world does he know himself'. The challenge facing the researcher is to create the conditions that facilitate the revelation of such experiences.

The guiding principle of IPA is to emphasise the meanings a person ascribes to their experiences and the way they make sense of them. Its philosophical and interpretative dimensions are phenomenology and hermeneutics (Eatough & Smith, 2008). It borrows from

the school of hermeneutic psychology (Gadammer, 1975; Heidegger, 1962), focussing strongly on interpretation of the phenomenon (Eatough & Smith, 2008). It allows researchers to engage with the intersubjective experiences that are embodied in participants' narratives, and aims to penetrate the social and contextual influences on the individual's history (Eatough & Smith, 2008). It does not seek objective truth, but the person's experienced and perceived reality.

I fully appreciate that this aim has inherent limitations. It is questionable how far one can ever gain access to this part of a person's experience. In addition, one cannot ignore the influence of the researcher and how it affects the process of 'telling the story'.

The way in which IPA is used in this study is to combine hermeneutic understanding and empathy with questioning hermeneutics. In analysing the work of Paul Ricoeur, Darren Langridge (2007) cites Ricoeur's two essential approaches for understanding meaning: demythologising (the empathic element) and demystifying (the suspicious element), and this challenges researchers to remain conscious of their pre-understandings and views of the world, and their interplay with the inherent content of participants' narratives. Without these two elements, however, one cannot find meaning beneath the surface (according to Ricoeur), which is described as imperative if one wants to begin with description and conclude with an explanation.

Understanding has been sought by carefully constructing key open-ended questions – rather than hypotheses – that aim to unlock the rich and textual account from an individual. (These questions constitute the interview schedule, see Appendix VI). This is a dynamic process, with the researcher taking a very active role – as Smith & Osborn term it: 'the researcher trying to make sense of the participant trying to make sense of their experience' (Smith & Osborn, 2003, p.51). It seemed that IPA could be a vehicle to take me closer to the coalface of the participants' experiences.

Considering alternative qualitative research approaches, I rejected grounded theory (Glaser and Strauss, 1967), because I was not looking to give birth to a theory from a reverse-engineered hypothesis (looking at a solution in order to understand the problem it was

intended to solve), or to build an inductive theory grounded in the data and relate it to individual or interpersonal processes (Charmaz, 2003), but to understand experience and contextualise it, using a framework of attachment theory and psychodynamic thinking. I also doubted that the constructionist approach of discursive psychology or discourse analysis would meet my objectives of blending interpretation and explanation, backed by psychoanalytically informed theory. Another reason for not adopting discursive psychology was that I perceive that approach as particularly relevant to the excavation of interpersonal communication, and the analysis of how people use language to negotiate or manage the parent-child relationship – an area that it was not this study's ambition to explore.

That said, discursive psychology (Parker, 1997; Potter, 1997; Wetherell, 1998) does have some common ground with IPA. As Willig (2003) points out, talk is action-orientated, and an individual's culture and language may influence and even limit their perception of reality. However, it also seemed desirable to move beyond 'historically situated linguistic interactions between people' (Eatough & Smith, 2008: p.485), assuming that there is more occurring than action orientation. The telling of life stories and experiences can produce a rich seam of interpretation and understanding, and is far more fruitful than mere reliance on a 'culturally available stock of meanings', as Eatough and Smith (2008: p.185) phrase it. That is, acts of justification that people present when they recall personal experiences may be examined for themselves, because they also deliver meaning that can connect past, present and future lived experience (Eatough & Smith, 2006). Again, this chimes with what I see in the psychodynamic therapeutic setting. As people tell their stories and remember their experiences, they can gradually make sense of them. They intuitively explore the breaks in their stories to add greater fluency to their accounts, suggesting that talk is indeed more than just action orientation. By embracing the sentiments behind Eatough and Smith's (2008) work, it is possible to tap into aspects of discursive psychology by examining the psychological themes that emerge. The appeal of IPA for this study is that it allows experience to be placed centrally, while acknowledging cultural and historical influences, including discourses (Eatough & Smith, 2006). Moreover, it does not require any closed *a priori* assumptions about what might be learned from participants.

The notion of using a single case study had some merit, but it did not seem likely to provide as clear a sense of the experience of being parented as would be gained from a small homogenous group of individuals. I also wished to detect any possible convergences or divergences between the data generated from male and female participants, and to understand the dynamics of the mother-son and mother-daughter dyadic relationships. Using IPA and a case-by-case analysis, followed by cross-case analysis, seemed likely to deliver a more robust understanding of the experience of being parented – including beliefs, values, wishes, desires, feelings and motivations, and how these surface manifestly or unconsciously. I believe IPA should be able to engage with the unconscious because of the freedom it affords participants during the interview process (if sensitively conducted) and because it allows the researcher to attend to non-linguistic cues – as in the present study – and record insights into spontaneous and often unconscious processes, such as tears, anger, body language and sudden changes in tone.

It is proper also to refer to the contentious issue of IPA and cognition. Researchers ask whether cognitions can realistically be studied from a phenomenological perspective (Langdridge, 2007; Willig, 2001), for the same reason that academics deny the existence of Cartesian mind-and-body dualism. In rebuttal, Eatough and Smith (2008) position the understanding of cognition in the spirit of the original cognitive movement of the mid-twentieth century, as a movement away from behaviourism. Thus, they place cognition as a part of the lived experience and as meaning-making in itself, rather than just a process for managing sensory input (Bruner, 1990). Another way of describing this is that the researcher can gain access to and interpret participants' 'hot cognitions' – those that are expressed via their feelings, desires and emotions, and are delivered in a state of arousal. These 'hot' cognitions can emerge in a crude and unanalysed state – the 'gems' of the qualitative method – as opposed to the 'cold' cognitions that participants have already analysed, and of which they are often deeply critical. This non-dualistic position is also reflected in my belief in the 'marriage' of the subject and object (researcher and participant), the way in which they are inextricably linked and influence one another, and how this allows us to witness the individual-in-context, as Heidegger posits (1962).

Another area to consider is the challenge presented when using IPA to investigate past experiences, such as the childhoods of mature adults. Because the present analysis can be described as the researcher's perceptions of the perceptions of others, a concern could be raised about the suitability of accounts in respect to how well participants are able to 'communicate the rich texture of their experience to the researcher', as Willig (2008: p.67) underlines. I tried to encourage more vivid perceptions by allowing participants flexibility and space for free-floating attention, and thus enough space to re-immerse themselves in the imagery surrounding their experiences, in the hope of tapping into a richer vein of description which captures the subtleties of their experiences. In addition, multiple interviews with all participants helped me to focus on anomalies, inconsistencies or contradictions, for later analysis and/or to re-open a question for embellishment or clarification. While I do not present this as any guarantee of accuracy, I feel it has contributed to procuring consistent perceptions from participants on a given theme. I made every attempt to 'understand their experiences well enough to explain them' and to remain 'aware of conditions that gave rise to these experiences in the first place' (Willig, 2008: p.68).

In conclusion, this study draws upon a constructivist-interpretative epistemology, using a naturalistic stage to employ IPA procedures. It is heavily influenced by the notions of subjectivity and of the interaction of the subject and the object, and mindful of the double hermeneutic (the process of dual interpretation between participant and researcher), and is influenced (but not dictated) by psychodynamic theory and thinking. I consider myself a psychodynamic novice, and so did not feel constrained by or married to such theory as the only train of thought one could acknowledge. However, it did seem to be a useful scaffolding when interpreting perceptions of the self, relationships and childhood experiences. This method acknowledges a relativist ontology, accepting that there are multiple realities and interpretations. Again, it is right to acknowledge the tensions that arise when considering this and analysing data through a psychodynamic lens. In the present study, psychodynamic interpretation has been used flexibly, not slavishly and there is no suggestion that my analysis represents irrefutable truth or direct access to their absolute hidden meaning. To be explicit, there is no attempt to seek causal factors in the aetiology of addiction, but only to draw out themes that could be described as a possible pattern of common mediating factors that were experienced in early life.

I hope I achieved a balance in the research design, in that it addressed specific questions relating to the phenomenon under investigation, and yet also allowed for the generation of prompts and the introduction of new and modified questions that could be more relevant and yield higher-quality data. Given my psychodynamic leaning as a trainee psychologist, and the inclusion of attachment theory in the original theoretical framework, it made sense to mine the participants' developmental backgrounds, the emotional and relational themes of their experiences of being parented, and their perceptions of psychological change as they journeyed towards addiction. I am wedded to the view that people are 'self-interpreting beings', as Taylor (1985, p.45) posits, a term that encapsulates both the thrill of this qualitative paradigm and its inherent challenge. I believe my qualitative approach afforded participants an epistemic space in which they could use their own words and sense-making, in contrast with the more directive use of heavily structured interviews or a quantitative approach. This allowed participants to guide me, and only when the data was collected did I examine it retrospectively through a psychodynamic lens.

4. Procedures

4.1 Participants

This study employed a mixed-gender sample of six participants (three female and three male), aged between 33 and 42 ($\bar{Y}$ = 38.7 years). An initial age spectrum for recruitment was set at 27 to 42 (see Appendix VII for demographic information). This spectrum was based on the ages of long-term heroin addicts who in the previous two years had attended counselling at the NHS unit where I have been training for the past three years (see Appendix VIII for a statistical validation). However, as the mean implies, the majority of participants were at the upper end of the age spectrum. The mean length of their former dependence was 18 years.

There is continuing debate about the appropriate number of participants for an IPA study. The magic number eight is regularly mentioned – often in the same breath as the claim that it makes it more likely that a study will get published – and many researchers aim to recruit such a number. However, my interpretation of Smith and Osborn's (2008) advice is that one should use the number of participants that is relevant to the research topic, weighed against

the probability of producing rich interview data. Thus, in the spirit of good practice, I tried to recruit and interview with the research area and the population very much in mind. My objective was to achieve a small number of rich and comprehensive interviews. Drawing on my clinical experience, I was satisfied that a study of six participants was appropriate, because of the richness of the data that I expected from three hour-long interviews with each participant. Indeed, I consider that I could have chosen to use four or even only two participants. However, I feel that the rigour applied to these six participants was high, and that the study thus equates with an hour each with 18 individuals – more than many other researchers conduct when using IPA. In the true spirit of qualitative research, I hope to demonstrate the quality of the data produced by the study, and that this quality is the result of having been sensitively generated by sympathetic interviewing.

4.2 Recruitment

Participants were recruited from among individuals engaged with an NHS Drug and Alcohol Services Unit for heroin and/or crack cocaine dependence (DSM-IV criteria for substance dependence; APA, 2000), and all stabilised on a daily methadone prescription (for 12 months or longer, and not exceeding a daily prescription of 60 ml of methadone). All participants had a history of long-term dependence (three years or more). This ensured that they were seasoned abusers of heroin, rather than short-term/occasional users or polydrug users, elements that I considered potential contaminants of other researchers' studies. (See appendix II for a description of heroin and crack cocaine).

In selecting the participants, a number of factors were considered essential to ensure the integrity of the data. First, being stable on a relatively low methadone prescription should ensure that participants were settled (not withdrawing or experiencing physical discomfort), and sufficiently alert from a cognitive perspective to facilitate rich interviews and optimal dialogue. By liaising with keyworkers at the NHS unit who regularly and randomly urine-screened these participants (as part of their normal NHS keywork), it was possible to avoid people who could have been deliberately using illicit drugs on top of their methadone prescription and potentially contaminating interview data. Second, subjects had not previously undertaken psychological therapy. This was to avoid any who might have been primed in some way to 'tell their stories', or who could have had a negative experience that

might carry through to the research. It was also essential that I should not know, or have worked with, any of the participants. Had participants known me as their therapist, this might have prevented them from delivering frank and open narratives; or they might have reassessed aspects of their lives in ways that they felt unable to share with a therapist to whom they had already provided an account. Also, it might well have contaminated my performance when trying to treat familiar material as if it was fresh. In addition, it might have disappointed or confused participants to encounter their therapist in the role of researcher, in which she would not make the accustomed therapeutic interventions and connections with their material.

Recruitment of NHS Drug Service users (n=6) was executed following full NHS Ethics Committee Approval, and in consultation with the senior Consultant Psychologist and key nursing staff at the NHS unit. Participants were informed that I am a Counselling Psychologist in training, and that the research constitutes part of my doctoral course at City University. Clients were drawn only from a population that was not, and had not been, engaged with Psychology Services at the NHS Unit, and, according to their medical records, had not been engaged with any type of psychological therapy in the past ten years.

Since it is often difficult to get people with substance abuse (current or former substance abusers) to commit to weekly sessions, participants in both the pilot study and the main study were paid with retail vouchers: £10 for the first interview, £15 for the second and £20 for the third (funded by the researcher). They received their vouchers after all three interviews had been attended. This aspect of the study was comprehensively discussed with the NHS ethics committee and the NHS Unit's management where the study was conducted. It was the latter's experience that paying participants at the end of the three interviews might attract people who were really committed to the research from the outset, rather than those looking to exploit a paying study, who might come for one session and then drop out. However, if someone dropped out because they did not wish to continue or felt distressed by the process, I intended to pay them for the interview(s) that they had attended. This did not prove necessary. The expense of travelling to each interview was reimbursed in cash on the day. This is consistent with several other research programmes conducted at this NHS Unit, and was approved by the NHS Ethics Committee.

I briefed the hospital team within the NHS unit about the research initiative, and asked them to forward names of potential participants. I then checked patients' details against the study's criteria. Once suitable candidates had been identified, their keyworkers asked them face to face whether they would be interested in and willing to participate in some research, and secured clear verbal indication from those who were. The sample was therefore self-selecting. I then approached individuals by telephone to confirm their participation and to provide them with relevant information.

4.3 The interview procedure

The interview structure and style

Planning of the research interviews was informed by my therapeutic work with a similar population of addicts over the past three years. For many individuals who have become very isolated and live on the margins of society, it is not easy to attend an interview with a psychologist and 'open up'. There is a very high drop-out rate within Psychology Services at the unit, and this is generally reflected in national statistics from the main drugs agencies and government. Hence, I decided to opt for three consecutive weekly interviews with each individual. This would allow them time to get used to the research process and, I hoped, feel more relaxed and able to talk. I also believed it might allow me to see how stories progressed, check for signs of embellishment or contradiction, and re-open a question to examine any additional, perhaps illuminating information. After conducting the interviews, I was pleased to stumble upon the work of Irving Seidman (2005) advocating a three-interview protocol (the first setting the tone, the second and third building, elaborating and probing to access sensitive content), and realised that I had inadvertently embraced what he describes as good practice.

Each interview was conducted at the NHS Drug and Alcohol unit, always in the same therapy room, which has spartan décor, two facing chairs and a small side table. I ensured that there were no papers or distracting objects, to promote the participant's free-floating attention, as Freud (1900) coined it, and to convey my neutrality and anonymity.

Interviews were semi-structured (see appendix VI for the interview schedule), using open-ended questions. They always took place between 10 am and 2 pm, to ensure that

participants felt alert and had taken their morning methadone prescription. This should allow them to feel comfortable and ready to engage with the research process. The questions allowed participants to enter into a dialogue, and I hope I used it flexibly, to allow for modification of questions as I listened and gauged the participant's responses. Although some questions formed a natural sequence, I was sympathetic to being guided by participants, while remaining aware that it was essential not to omit certain questions. This enabled me to embrace the unexpected when it occurred, as Smith and Osborn (2008) advocate, and as I would commonly do in my therapeutic work. I believe this placed all the participants at ease, and encouraged them to proceed at their own pace. Some participants later commented that they had felt comfortable, with the experience proving easier than they had imagined.

It was critical to the interviews that I maintain the stance of 'researcher as curious observer'. While IPA readily acknowledges the researcher's presence and influence, I encouraged participants to talk openly and I tried to read their conversational cues and follow them. Thus, I was careful to dilute my own effect on the process, and consistently tried to suspend my beliefs, thoughts and opinions, to minimise any contamination of their material, as Smith and Dunworth (2003) advise. As a therapist now working as a researcher, I found it challenging at first to avoid seeing patterns in the participants' information. But by the end of the pilot study I had settled into the researcher role and set aside the desire to make connections before the analytical phase. I sought to achieve a balance between methodological rigour, sensitivity to the population and the subject under investigation, and my own clinical tendencies. This obliged me to make myself more accessible to participants than I would have done in a clinically neutral mode, while trying hard to create an atmosphere of safety and to avoid research intrusion. Thus, I did not dictate an inescapable direction to the questioning, nor did I make interjections or challenges, as is done in some modes of therapy, but instead allowed participants space for their thoughts and feelings as they occurred to them.

The interview schedule was inspired by what I saw as gaps in the literature about the parenting experienced by addicts. Much of the relevant research literature is quantitative, often using instruments such as the Parental Bonding Instrument (Parker, Tupling and Brown, 1979) or the Adult Attachment Interview (Main & Goldwyn, 1993).

Research has often focused on drug-dependent individuals and their role as parents, or examined the nature and status of their current relationship styles (Barnard and McKeganey, 2004; Bernardi, Jones and Tennant, 1989; Hogan, 2003; Rosenbaum, 1979). The present study sought instead to probe the mother-child dyad that participants had known in childhood, while ensuring that questions about the father and the interaction between the parents were not ignored.

To put participants at ease, initial questions were of a general nature, allowing the interviewee freedom of movement and avoiding any connotation of interrogation. I took time to build rapport, particularly in the first interview, and frequently reminded the participant that I was not looking for right answers, but merely trying to get a picture of their experience and what it felt like for them.

All the questions were designed to be general, following the recommendation of many researchers (Smith & Osborn, 2008), and to encourage participants to interpret the questions in relation to their own thoughts and feelings and explain their responses, rather than impose my own interpretation.

Conducting the interviews

At the beginning of the first interview, each participant was verbally briefed on the proposed study. This gave details of its nature, the timing and the commitment asked of them, the general aim of the research, data collection, confidentiality and incentives. Theoretical perspectives were not disclosed, to guard against participant bias and the risk of priming participants in any way.

Each participant was then asked to provide written informed consent (see appendix IX). Participants were made aware that all interviews were recorded for subsequent transcription and analysis by the researcher. They then completed a demographics form (see Appendix X). Participants were also advised that a psychological support framework was available to them during and after the research. This support was offered by Psychology Services at the NHS unit, on a weekly basis or as required by the participant. During the research interviews, no participant took up the offer of psychological support. Following the interviews, three of the

six participants chose to engage in psychological therapy (see section 9: The effect on participants).

Each interview lasted about 60 minutes. Out of respect for participants' material and the time they were giving, there was some flexibility in the timing, to allow them to conclude if they felt they had reached a natural stopping point, or to continue if they had not come to a close. This varied by both participant and interview phase.

All voice recordings were made on a Sony Mini-Disc Voice Recorder. These recordings were stored on mini-discs at the researcher's home, in a locked cabinet within a locked study. The machine was switched on before the start of interviewing and continued uninterrupted until the end. The discs will be destroyed when the research assessment is completed.

At the end of their third interview, each participant was given a debriefing sheet and was verbally debriefed by the researcher. The participant was reminded about the availability of continued psychological support, and offered a follow-up appointment to discuss the option of engaging with Psychology Services. Two of the six participants booked an appointment at the debriefing stage. The debriefing sheet (see Appendix XI) provided more details of the study, along with contact details for me and my research supervisor, and a list of available support services and help lines.

4.4 The pilot study

In accordance with good practice, I conducted a pilot study using two participants (one female and one male) on the basis described above. Pilot participants were of the same profile, and from the same sources, as the participants in the main study. The main purpose was to validate or amend the proposed interview schedule, and to identify areas of the study to be refined. Attention was given to the sequence and wording of questions and the general flow of the interview. In the event, no significant changes were made to the interview schedule following the pilot study. However, it allowed me a degree of technical rehearsal, to iron out any problems with the flow of the interview and interviewing style, bearing in mind the switch from the role of therapist to that of researcher.

Following transcription and analysis of the pilot interviews, a peer review by a fellow student and consultation with my research supervisor, I found the data of sufficiently high quality to allow these interviews to be included in the main study. Thus, only four further participants were recruited for the main study.

5. Ethics

The perceived vulnerability of this participant group suggested that ethics would be of the utmost importance. It was also very unlikely that they fully understood the ethical implications or were aware of their rights, as they had neither participated in previous research nor undergone psychological therapy in the past. I therefore gave full and due consideration to the ethical implications of the research in accordance with the British Psychological Society's Code of Conduct, Ethical Principles and Guidelines (2005). In particular, I carefully considered confidentiality and any potential for psychological distress.

The proposal for this study was granted full ethical approval by both the NHS Ethics Committee and the Department of Psychology at City University, London. Approval was also obtained from the NHS unit's practice manager and the Consultant Psychologist.

Informed consent was obtained from each subject for the three interviews and for the recording of each session. This written consent was requested only when I was sure that each participant had read and understood the nature of their consent, and had had the opportunity to ask any questions. The Information and Consent form (Appendix IX) also provided contact details for me and my research supervisor; a summary of the study; and a statement of the participant's anonymity and their right to refuse questions, withdraw from the study or withdraw their information at any point. I and the participants all kept copies of the written forms. This form complies with the guidelines from the British Psychological Society regarding the Ethical Principles for Conducting Research with Human Participants.

Great care had to be taken to facilitate an open exchange and to give reassurance about confidentiality and anonymity. I took considerable time to explain the nature of the support that would be available from Psychology Services.

All consent forms, demographic forms and other information pertaining to participants were kept in a locked filing cabinet at the researcher's home. All such materials will be destroyed following the assessment of this research. Importantly, once recordings had occurred, all known identifiers pertaining to the participants were removed and a code and pseudonym applied to each.

Up to the time of writing there have been no expressions of concern, refusals or withdrawals from participants.

It may be argued that the present research could cause psychological harm, by inviting people to disclose details of their childhood and perhaps recall painful memories, and even engaging them in post-hoc rationalisation and blaming. However, various ethical reviews concluded that the risks were too small to be objectionable. Nevertheless I took the following measures. First, it was agreed with the NHS Unit that participants would be personally supported and debriefed by me at the Unit immediately following their participation, and were offered psychological support on a longer-term weekly basis should they wish it. Second, other psychologists were available for therapy at the Unit, so that participants could work with an unrelated professional, and after each interview session their keyworkers (nursing staff) checked in with them to see how they were feeling about the research. This allowed participants considerable opportunity to pull out of the study without the embarrassment they might have felt in telling the researcher direct. In addition, it was in the nature of the interview schedule (Appendix VI) that it did not seek to encourage participants to analyse their childhood and make formulations about their addictive pathway.

Participants were reassured that there was no penalty for withholding or withdrawing information, and that the study was separate from their ongoing NHS care, which would be unaffected by any decision they might make with regard to the research. They were also assured that details of the study and their participation were not entered on their NHS patient records, and that their material would not be discussed with anyone at the hospital unit.

I was also very conscious of wishing to protect their anonymity, and this resulted in a strong focus on the ethical aspect of the research. At no time did I discuss the content of their

interviews with anyone at the NHS unit. Moreover, I endeavoured, without losing clarity and meaning, to avoid the use of information that could have identified them. I used detailed, personal information only if it seemed central to the enrichment of the account (as advocated by Kvale and Brinkmann, 2008).

Participants were offered the option to give the researcher their personal details, to enable a copy of summarised results to be sent to them at the end of the research and evaluation process. This is in the spirit of Mann and Stewart's (2000) suggestion that people should have access to information on themselves.

6. Validity

While the debate continues about quality and validity within IPA (Reicher, 2000; Elliot, Fischer and Rennie, 2000), the general consensus is that validation can be achieved if the study is rigorous enough. However, this is not one of those experimental approaches that can be validated by simply following a precise menu or suite of measures. Qualitative research methods are too diverse for the establishment of common procedures and standards of validity (Meyrick, 2006; Yardley, 2000). I would add that a standardised approach might not always be sympathetic to the phenomenon under investigation, or to the researcher's epistemological perspective. Moreover, as Yardley (2008) proposes, following a set of guidelines will not in itself generate good research, and a tailored and thoughtful approach to methodology is preferable – a view that gave me comfort in my decision to opt for a deeper quality of data from multiple interviews with a smaller number of participants.

In surveying IPA research, it strikes me that a good analysis balances phenomenological description with insightful interpretation, anchors these interpretations in the participants' accounts and maintains a tight idiographic grip. Furthermore, validity is demonstrated via adequate transparency throughout the process, from sampling detail and from giving context to verbatim quotes. With quantitative methods, constructs of validity and reliability are well documented and there are detailed protocols, whereas with qualitative methods those protocols that do exist cannot always be applied in a straightforward manner. To measure validity in qualitative work, for example, researchers are predisposed to compare sets of words, not sets of scores (McLeod, 2001).

The overall question of validity was among my reasons for deciding to use IPA. It seemed probable that this method could deliver the essence of the subject under investigation, could generate internal coherence and avoid unexplained or ignored inconsistencies. In addition, I felt that it would demonstrate external consistency against a theoretical background, and that it would generate a unifying power to pull disparate elements together from participants' accounts. During the analytic phase it would draw out the patterns in a diverse collection of individual accounts, and help to present a convincing and lucid interpretation and explanation of the phenomenon of the participants' experiences. An attempt would then be made to explain these experiences by relating findings to existing theoretical perspectives. All of these values, outlined by Howard (1983; 1985) as criteria for conducting robust qualitative research, have been respected in this study.

In the attempt to demonstrate validity, nine broad categories will be examined and explained. They draw on the work of various researchers, and on the publishability guidelines for qualitative work as detailed by Elliot, Fischer and Rennie (1999). The broad headings to be covered are:

- rigour
- situating the sample
- owning one's perspective
- grounding in examples
- providing credibility checks
- coherence
- sensitivity to context
- sensitivity to participants
- continual reflection

Rigour. This relates to the researcher's attitude and the consistent discipline applied to the study's processes. This research aimed for a balanced integration of openness, concreteness and actualisation. The express intention is to appreciate and blend philosophical concepts in

the methods and findings of the study, and to strike a balance between the voices of participants and the interpretation and philosophical explanation. 'Openness' relates to my effort to use a systematic, clear method of accounting for the multifarious decisions made throughout the research, providing an analytical paper trail for emergent themes (Yardley, 2008). 'Concreteness' relates to my objective of making the study's findings useful to practitioners, while 'actualisation' refers to the possibility of the study having practical application in the future.

Situating the sample. I have described in comprehensive detail the recruitment techniques used and the efforts made to ensure that the participant group is a purposive, homogenous (Meyrick, 2006) and representative sample of the broader population of long-term heroin addicts. I have sought also, by immersing myself in the participants' narratives, to provide depth of detail and interpretation in analysing the study data. I hope the resultant description of the participants and their life circumstances has situated the sample sufficiently for the reader to judge the typicality of this study's data.

The demographic information generated was intended, first, to provide general data about the participants, but also to ascertain such details as their position amongst their siblings, which seemed important in relation to any predisposition to addiction; whether there had been previous attempts to abstain from drugs; whom they considered had raised them as a child; and whether any of these points of information appeared to influence their accounts. It was considered that this information would add colour to the participants' accounts, and acknowledge any interesting demographic indicators.

Owning one's perspectives. In the spirit of Elliot, Fischer & Rennie (1999), I have attempted truly to own my perspective by outlining both my theoretical orientations and my personal expectations – both those known in advance and those that unfolded during the research. I attempted to recognise all that I brought to the research, my values, interests and assumptions, and how they may have affected my ability to understand the phenomena being researched. In highlighting these factors, I hope to enable the reader comprehensively to

assess the study's data and to gauge whether alternative interpretations have been duly considered.

I considered triangulation and checking back with participants, but rejected it on the basis that these participants were only just forming insights into their past, or so it appeared during the interviews. To confront them so soon with the researcher's interpretation, highlighting potentially painful connections, might have made their accounts feel unrecognisable to them. Without the guarantee that participants would go on to engage in therapy, I felt intuitively that such a course would be irresponsible. It could be unsettling for participants to see their account in isolation, without the broader context of the research study reading. Furthermore, I was not convinced that this would be a productive validation exercise for the themes of the present research.

Grounding in examples. To allow the reader to get close to the analysis and interpretation, and to conceptualise the meanings and consider alternative understandings, I have used verbatim narrative extracts from the data with the aim of grounding the analysis. The object here is to illustrate the procedures adopted and show how my understanding developed (see appendices XII to XVI).

Providing credibility checks. To check for credibility in emerging themes and interpretations, I have sought student peer reviews. In addition, careful attention has been paid, as Meyrick (2006) advocates, to disconfirming case analysis, where divergent experiences contradicted the emerging themes. The overall analytic process has been carefully documented, and there is a clear paper trail for the highlighted research themes. This links each participant's transcript from their interview through to the verbatim themes, to spreadsheet clustering and to their consolidation under the three key superordinate themes. I trust this makes for a transparent piece of research.

Coherence. I hope the presentation of my understandings and interpretations allows the reader to identify the coherence and integration of the participants' accounts and the emergent themes, but without obfuscating or ignoring the important nuances of the data.

Importantly, I have also attempted to make clear the aims and the research questions within the study, by describing the design and procedures employed and by grounding them in research literature, so that the reader can appreciate the method and gauge how systematically the analysis was undertaken.

Sensitivity to context. The study had two specific aims: (a) to demonstrate that the research question had relevance and sensitivity to a body of existing research and theory, and (b) to plug a perceived gap in the literature. (See Section C for the full Critical Literature Review).

Sensitivity to participants. I took care to consider participants' socio-cultural background, and their ability and communicativeness during the research interviews. The semi-structured interview format (see Appendix VI) was designed to allow them to say what they perceived was relevant to the questions, and for the researcher to embrace the unexpected as it occurred. Throughout the analysis, I endeavoured to consider alternative interpretations and to mine the complexities of the participants' accounts.

I paid close attention, as Yardley (2008) recommends, to my own characteristics and to the research setting, and their potential to influence participants and affect the collection of data. Participants were interviewed at the hospital unit where they regularly collected their methadone prescriptions. It was hoped that the familiar setting and the relevance of my work with a similar population over the past three years would help facilitate an open and honest account of participants' experience.

Continual reflection. Finally, every effort has been made to maintain a reflexive stance throughout the research process. I have tried to make clear my proximity to the data, and how my own experiences and prior knowledge have affected findings. In addition, I have laid bare my epistemological position and tried explicitly to highlight the tensions between this position and my theoretical commitments. The literature review also provides insights into the main theoretical considerations that informed this research study.

7. Transcription

In accordance with good practice, all personal identifiers for participants were removed at the time of transcription, and pseudonyms were used for participants and any other person referred to by name. This was considered sufficient to ensure participants' anonymity. A separate key was developed, listing the real names and the corresponding pseudonyms, and was kept in a securely locked cabinet at the researcher's home. This was held separately from the research data, which was held in the researcher's locked study. All these materials will be destroyed following the academic assessment of this study.

Each of the 18 interviews (3 x 1 hour x 6 participants) was transcribed in full by the researcher. In accordance with recommendations of Smith and Dunworth (2003), attention was paid to non-verbal behaviour, emotions and laughter, and to possibly significant pauses. No editing of the narratives occurred during transcription, which captured all non-words, false starts and extraneous words.

8. Analytic strategy

As mentioned above, IPA (Smith, 1995) is a form of thematic analysis that incorporates both hermeneutical and phenomenological philosophy. Its idiographic approach drives an analytic process centred on a clearly defined and articulated engagement with the participants' transcripts, and aims to gain an 'insider's perspective' (Conrad, 1987) via its inductive approach.

Following the completion of the 18 interviews, I transcribed the recordings and read them over several times to familiarise myself with the broad content. Each participant's three transcripts were then analysed in detail as a single data set, embracing the principles of IPA (Smith, 1995; 2007) and thus engaging in an interpretative relationship with the transcript (Smith & Osborn, 2008).

The first stage was to annotate each transcript, making descriptive notes (and adding verbatim excerpts in the left-hand margins of the printed transcript) on any statements that appeared

interesting and/or relevant. This process was focused on 'hearing' what the participant was communicating, and, critically, allowing surprising and unexpected material to be acknowledged and analysed. These notes were therefore not confined to items on attachment or drug addiction. Each line of the transcript was numbered to provide clarity for the paper trail. The annotation also highlighted significant-seeming non-linguistic data such as emotions, body language or sudden changes in tone.

After each interview I wrote a summary of key moments and non-linguistic highlights that had struck me during the process, and recorded how the participant had left me feeling. While this could be named as attending to transference and countertransference, I did not label it thus, nor move beyond registering my feelings and perceptions. It later became one of the several sources of interpretative material that contributed to the analysis stage. However, throughout this build-up of interpretative material, participants' words took priority. This is further covered in the Discussion section.

Re-reading the transcripts while listening to the recordings was a rich process and yielded many insights. The primary aim at this stage was to stay very close to the text and its meaning (Langdridge, 2007; Smith & Dunworth, 2003). Note-taking formed an essential part of this process, to record initial thoughts, pick up associations and links with the narratives of other participants, and begin to make crude and tentative interpretations. Potential preliminary themes were also recorded.

During the second interpretative phase of the analysis, links were identified between the initially emerging themes for each participant. These links constituted emerging sub-themes, and were represented by words or short phrases that encapsulated the longer quotes from the text (see appendix XII for a transcript excerpt). Closely related themes were then grouped under appropriate headings. The transcripts were re-read many times at this juncture, to ensure that these initial headings, sub-themes and clusters were embedded in the original text, and that they captured the participant's communicated 'essence' and not the researcher's projection. Thus, themes were linked via an iterative process of reading, interpreting and checking back with the text. Importantly, these early sub-themes and cluster headings were

still flexible, and remained subject to change during cross-case analysis and during the writing-up of the research. And indeed certain sub-themes were successively abandoned as they proved less important or pertinent to the research topic, or failed to form the clusters that would prove them to be genuinely thematic across accounts.

Each participant's three transcripts were analysed as an individual block of data to the level of sub-theming. One could have analysed the first individual transcript through to its super-ordinate stage and used this as a template, but the aim was to conduct this analysis as a bottom-up process; imposing a blueprint on other participants' data might have diluted the quality of the analysis by taking a 'best fit' approach to the data. The result was a table of notes and sub-themes for each participant. As a validation check, verbatim extracts were checked against the corresponding themes. Following this, a fellow research student with experience in IPA conducted a similar check, and finally, my research supervisor reviewed all transcripts and themes. These validity checks aimed to determine whether readers could account for the origins of themes, and to verify that the themes did not misrepresent the participants' accounts (Elliot et al, 1999).

The next phase was considerably more interpretative. A detailed table for each participant was constructed, using spreadsheet software, listing the theme, sub-theme, the page number of the transcript and the line number of the initial highlighted quote from the participant. This permitted a quick and easy validation reference, either from the bottom up (the quote) or the top down (the theme). Themes were ordered and reordered on this table as new themes were acknowledged and initial analyses amended. (see Appendix XIII for an extract of a sub-themes table.)

The third stage involved cross-case analysis and a higher level of abstraction (Smith & Dunworth, 2003). Each theme was traced across all six accounts, and any connections found were examined. This produced a master table (theme, sub-theme, participant quote identified by page and line number), encapsulating the important common ground between the individual transcripts, as Smith and Dunworth (2003) outline (see Appendix XIV for the initial master table). Each quote was re-checked against each transcript, to verify that it was

representative of the theme. At this stage, student peer reviewing occurred again, to challenge and/or validate the themes.

A second master table was then constructed, containing verbatim quotes from the original transcripts (see Appendix XV for a second master table including cluster). This was to permit a 'filtering' process in which the data were pared down before being written up. It was essential to remain flexible about the re-working of themes, and data had to be reorganised accordingly. I had to be prepared until the final hour to alter or abandon a theme, or to discard a quote felt to be insufficiently relevant. A primary objective was to pinpoint the areas of overlap or divergence in participants' accounts. A final master table was constructed to show thematic divergence between participants; while multifarious experiences were reported, there was a high level of thematic convergence between accounts. Such divergences and outliers are tackled within the Analysis and referred to in the Discussion.

The next stage was to cluster the themes that were common to all participants, and to distil them into a smaller number. Three super-ordinate themes were found to capture and organise the majority of the transcript data. These final shared themes were translated into a narrative account (Smith, 1995; Smith, Flowers & Osborn, 1997; Smith, Jarman & Osborn, 1999; Willig, 2001).

At this point it was decided what material to include in the write-up. To make it easier to read, the quotes included were modestly edited, for example by excluding some non-words, while taking extreme care to avoid altering or colouring meanings. False starts and hesitations were retained where they were deemed indicative of the participant's process.

9. Methodological and procedural reflexivity

9.1 Participants

I was surprised at my strength of feeling about the participants' narratives, and how maternal many of their stories made me feel towards them. It was humbling to hear about the tough experiences that they had known in early life, which many had normalised and dealt with as

matter of fact. As they tried to make sense of their accounts during the course of the interviews, I was able to connect with their emotions, and felt comfortable doing so, while refraining from making connections or offering insights as would have occurred in a therapeutic context. I believe that my therapeutic work during the past three years assisted me greatly in remaining contained and comfortable around what was often difficult participant material.

9.2 The researcher's identity

During the interview process, I felt more like a traveller than a miner (Kvale & Brinkmann, 2008) – but a traveller with only a rough idea of where we might be heading, and with little desire to know exactly where that would be. That felt appropriate. Participants appeared to be undertaking a journey of their own, and they often seemed surprised at where their thoughts ended up or at the intensity of their feelings. I thus felt the importance of the role of observer, while, wherever possible, acknowledging any issues of my own that were prompted by facets of their experiences.

One of the issues that worried me when I first worked as a trainee psychologist was how I would be viewed. I wondered whether the way I looked and behaved could affect the way clients perceived me. This issue re-surfaced during the present research, where there was a marked lack of similarities between my and the participants' childhoods, current life situations, appearance and lifestyles. Superficially the contrasts seemed so marked as to be almost antithetical. Of course, none of my personal details were divulged to the participants, but this highlighted the power differential in the relationship – they were telling me their stories without any reciprocity of information. On the other hand, most of the participants were relatively close to me in age, which seemed to allow them to relate, and even occasionally to refer to common experiences.

I was also aware that my speech sounds educated and middle class, whereas the participants spoke with different accents and used more slang. Trying to adapt my speech would have sounded synthetic, patronising or plain ridiculous. Clearly this difference could be acknowledged, but not altered. In addition, I wanted to avoid being read as an expert or authority figure, encouraging compliance and agreement with me. My solution was to pay

close attention to keeping my questions or comments simple, to use uncomplicated language and to avoid jargon.

I wondered how the research might have progressed had I somehow looked like a former addict, or had spoken with, say, a different accent. It might have made participants regard me as being more like themselves, and given them a sense of 'membership'; however, to the extent that the research relationship bore fruit, I feel that it was because of the way in which I conducted the interviews, my empathic style and the freedom afforded to participants to move between their narrative strands. Had I been an avowed former addict, it could have unduly influenced their narratives, significantly affected my expectations and produced accounts that were different and perhaps lacking in transparency.

Even though it had been explained to participants that I would not be answering direct questions, nor linking their information in any sort of therapeutic or theoretical context, I was often aware of them trying to use me as a judge, a sounding board or perhaps an authority who would surely have an answer to something troubling them. I sensed their frustration at not having their own answers, but it also struck me that in many cases they did not really require an answer to these questions, and perhaps were even uttering them for the first time: 'Why would she (mother) do that?' 'Why was she so weak?'

I wondered how curious participants might feel about my life and my motivations for this research. It was not until after the debriefing that any of them chose to voice any curiosity. Some wished to know if I had children, some wanted to probe my research topic and what I hoped to learn, while others simply wanted to know whether I had been an addict. I was able to be concrete with them on all of this, since I was not about to work therapeutically with any of them, and they were at the end of their part of the research process. I felt that to withhold such information would have short-changed them when they had appeared to be so honest and frank with me – a contrast with working therapeutically, where disclosure is frowned upon.

9.3 Foreunderstandings

What has most surprised me is how few or insufficiently formed were my foreunderstandings. The interviews and the analysis helped me clarify the positions I thought I had held at the outset and at the end. While I worried in the beginning that I should know precisely what I believed or expected, I became more relaxed as the process of interviewing and listening got under way, and elements of the narratives began to register. I took comfort in reading about this subject in the work of writers such as Finlay (2002a, 2002b), who advocates allowing for the emergence of foreunderstandings as an almost organic process within the research itself. As I reflected on this, it seemed increasingly logical that I could not fully understand their experiences before I had heard about them and had appreciated how they affected me. As Finlay (2008) describes it, I had to engage with participants' accounts in a fresh and open manner. It was as my relationships with the participants deepened over the three interviews, that my assumptions and preconceptions began to appear. Reassuringly, this again is spelled out by Finlay (2003).

While I knew from research, particularly quantitative examples, and from working with this population therapeutically, that trauma and dysfunctional parenting are often present in the histories of people with drug addiction (Christo and Morris, 2004), I was not prepared for the degree to which the participants with experience of trauma or abuse had normalised such experiences, how very forgiving they were of their parents, and how isolated they appeared to be, even when they were in relationships. I often left early-phase interviews with a feeling of loneliness and emptiness, and as I dedicated time to reflecting on my feelings and the impact of the research, I felt increasingly that I was picking up on their transference, in the Freudian meaning of the word (Freud, 1917).

A particular surprise related to the strong dynamic that flowed from their narratives about the interaction between mother and father. I had assumed that narrative chunks would fit into discrete categories about mum and dad, and not concern the interplay between the two. However, this also gave me some reassurance that I was not imposing my sense of order on their narratives. I consistently felt that participants were leading me to the information about their parents they thought was most pertinent, and that it was by their own choice that they continue to mine an area that appeared sensitive, confusing and important to them.

I had thought that, in acting as a depository for their information rather than a mirror or guide, as would happen in therapy, I might feel frustrated by the inability to use therapeutic interventions. However, I was really aware of these sensations only during the early stage of the pilot study, and managed to recognise and resist the urge to intervene. I sensed that, because participants did not feel that they were being analysed 'in the moment' or assessed, they did not feel the need to be or behave in a certain way, and I did not detect any attempt to please me, as can happen with therapeutic clients.

Another surprise was the degree to which participants seemed to be resourceful and copers, and not, as the media often portrays addicts, individuals who are a lost cause and have zero self-reliance. My intuition at the end of the interviews was that they are actually being very self-reliant. I felt that I was hearing about sink-or-swim situations in their past and that they had indeed all swum – albeit, perhaps, without a sense of where the shore lay. But it also seemed that it was because their coping was so fatiguing that they had taken other, maladaptive measures to bolster their dwindling resources.

I found all these surprises exciting, because they reassured me that I was letting the participants tell their story in their own way. This gave me considerable energy to continue and strive to stay close to their narratives.

9.4 The interview process

My initial urge to intervene during interviews was achieved only by reflection: on returning home, I listed possible reasons for that urge – issues arising from the content, professional instinct, natural disposition – and another list of reasons why this was contrary to the needs of the research. I reviewed this subject in my personal therapy, and that again helped clarify what I was trying to do and why, and to shed the sense of obligation to assist participants. I began to enjoy their sense of destiny in the narratives, and how they shaped the flow, and how much variety there was in the interviews. This I saw as opportunity for analysis, and it cultivated a richness in the data that both surprised and thrilled me.

I was also acutely aware of my contribution to the phenomenon in my interactions with the participants, both verbal and non-verbal. I allowed them to witness the effect of their

material when they spoke of hurt or shame, but without significant comment, realising that this could either misdirect or stifle their narrative.

The interview schedule

While every attempt was made to draft questions that encouraged participants to consider their childhood influences in respect of the way in which they were parented, there may be no such instrument as the perfect schedule with the right number and right type of questions. I resolved to use questions that I myself might commonly use in therapy (but not specifically psychodynamic in orientation). For example, I opted for questions that were not closed but reflective. They were designed to garner pertinent information, but also to allow spontaneity in the response. Certain questions caused participants to hesitate, and I felt compelled to clarify or reword them, but overall the questions were responded to favourably. How the schedule might be modified for any future research is referred to in the discussion section that follows.

9.5 The analytic process

While I had heard tall tales from former students about the scale of the work and the stamina required for doctoral research, I still sometimes found myself wondering whether there would be sufficient hours in the day. I longed to immerse myself in the research and pore over the analysis for days and days, free of the competing tensions of also being a wife, mother, friend and trainee psychologist. I recognised the extreme pressure of fitting everything in, and my over-arching desire to do justice to the research, and so I came to a decision to suspend my practice at the hospital. This allowed me a few months of immersion, and gave me breathing space to think, plan and manoeuvre. I felt I instantly became a better person to have around at home, even before leaving the hospital. I had removed some of the pressure of time, and this felt right for me.

Even so, many times I simply felt overwhelmed by the analysis, from the density of the three hours of transcripts for each participant, through to the filtering process that weeds out the themes. I was surprised by how many times I had to revisit the tapes, the transcripts and the themes, and at my continual movement between the parts and the whole. Hours could be absorbed by this process. This strongly affected my family, too: I was regularly accused of

not listening to what they were saying to me, and I appreciated how far I had become distracted. It gave me a stark warning about self-care, and reminded me that there was a life outside my research and that taking breaks and spending time with my family would make me more rather than less productive. And indeed, once I had fought this battle with myself, I did notice that a period of resuscitation and nourishment was followed by a period of productivity, engagement in and enjoyment of my work.

9.6 The effect on participants

After debriefing participants, I was often left with a feeling that the interview process had been liberating for them, and in some cases with a sense that something interesting had begun for them. I had expected at least some participants to call upon some psychological support during the weeks of interviewing, or even find the interviews too difficult to continue with. In the event, they all completed the interviews, and, as I consistently checked with them (and their keyworker nursing staff) to see how they were coping with the process, they all stated that they did not find it too demanding.

Interestingly, within four weeks of the completion of the interview phase of the research, three of the six participants decided to engage in psychological therapy at the NHS unit, with the intention of continuing the discovery process that they felt had started with the research. I am both surprised and pleased by this outcome. All of the participants had hitherto been resistant towards any form of psychotherapy, despite having been offered it on numerous occasions over the years. It may be that they had had a preconceived idea of therapists and of how it might feel to examine issues in their lives, and that the research process provided a segué into therapy by making the idea more palatable. Or it may just have been that they felt 'ready' for therapy. These participants have continued with their therapy, and appear to have engaged well with their therapists. While I have not asked these psychologists for details of their therapy, I did enquire whether any of the participants seemed to be suffering from any kind of problems associated with the research itself. All therapists report that this is not the case, and that participants report that they feel the time is right for them to try to understand themselves better, and that the research process brought this need to light. One of these three psychology clients is now methadone-free – a tremendous achievement. The other two still

attend the Unit, and keyworkers say that no negative effects of their participation in the research have been reported or observed. The same enquiry has been made of the three participants who have not chosen to engage with therapy, and their keyworkers at the NHS unit also report no apparent negative effects of participation.

9.7 The researcher's agenda

I have made it no secret that my therapeutic work has provided the influence and inspiration to conduct this research. It has been driven by a passion to understand the addictive population better, and in response to frustrations I have felt in relation to the reluctance within NHS drug treatment services to utilise psychodynamic psychotherapy. I hope that throughout this work I have made apparent my motivations and my interests, as Gough (2003) encourages. In my reflexivity (further outlined in the Discussion section) I have attempted to provide the reader with a clear perspective on the subjective and intersubjective aspects that have influenced the research, with the aim of enhancing its trustworthiness and integrity, as Maso (2003) outlines.

Analysis

1. Overview

So rich and detailed was the yield from the data that I swiftly saw the need to focus on just the most important, illuminating and of course relevant of the emergent themes. Other strands of thematic interest are reflected upon in the discussion section below, including the rationale for their omission. Importantly, there was a very high level of convergence between the accounts; any significant divergence is discussed here.

Data has been organised into three superordinate themes, each of which break down into three sub-themes. Each theme is considered to be central to the exploration and interpretation of the research question: how do people with former long-term heroin or crack cocaine addiction describe their experience of being parented in early childhood and adolescence?

This analysis attempts to explore the perceptual content of the participants' narrative accounts of their experience of growing up and family life, while acknowledging the context and emotions pertaining to both the setting and the participants' telling of their stories and how they might be influenced by the researcher. Notwithstanding the insuperable task of doing justice to all emerging themes, it is hoped that this analysis provides sufficient detail and colour for the reader to appreciate the common threads that run through the participants' accounts and my interpretative approach. It is appropriate to point out that, while focusing on specific quotes and embracing participants' precise wording, I also treat the narratives holistically and pay attention to the way in which comments are delivered beyond particular quotes, to add colour and weight to the analysis. Appendix XVII contains additional quotes which the reader may wish to refer to.

No attempt is made within this analysis to weave in explicit or expansive detail of the key underpinnings of attachment theory. These supporting elements, which help explain this

study's findings, are to be found in the Discussion section below. By not dwelling on specific references to the major theoretical framework in this section, it is hoped to leave the reader free to explore the narratives and form independent positions, while being able to clearly identify my interpretative stance without undue distraction. The emphasis here is on the content of the interviews and the narrators' own reflections; my own processes are reflected upon in the earlier Methodology and following Discussion sections.

The format of this analysis is to introduce each theme in turn, follow it with selected illustrative quotes from participants, and conclude with a description and interpretation. This reflects the double hermeneutic of IPA methodology (as outlined by Smith and Osborn, 2008) – the dual interpretation process, in which the participants' subjective perception and interpretation of the events and experiences that they report are accompanied by the researcher's own interpretation of this narrative. A more comprehensive summary of this aspect of IPA and the way it has been used can be found in the Methodology section.

It will be noted that the questions asked of the participants do not appear before the corresponding quotes. However, because the interviews were semi-structured, questions often emerged out of the narrative and varied across individuals. Painstakingly to repeat and refer to many essentially similar questions in the space of the same theme could be noisy and confusing. The full interview schedule is available, however, in Appendix VI.

In addition, this analysis illustrates each theme with just a small selection of participants' quotations. The appendices (XVII) contain further quotations relevant to specific themes. Wherever possible, a variety of participants are quoted, to avoid bias towards any specific participant or gender. In some cases a sequence of quotes is presented from a single person within the context of a given theme, to offer a deeper insight into the participant's description.

It will be seen that many of the subordinate themes do not fit precisely into one discrete superordinate theme; often a flavour from one flows across and overlaps with others. I consider this a reinforcing aspect of the analysis, demonstrating the cohesion of the overall findings.

2. The three superordinate themes

In reviewing the many fascinating themes thrown up by this research, three were clearly pre-eminent. They are treated here as superordinate themes and subdivided into a cluster of three sub-themes each. Confining the sub-themes to three for any given superordinate theme is deliberate policy on my part. I felt that a theme should be able to be encapsulated and illustrated with no more than three sub-themes, so that the description and explanation remained tight. Adding more, although tempting, would I feared, dilute the theme's overall impact and make it considerably less fluent for the reader.

In many IPA papers, the themes are given rather abstract, indeed sterile titles. Frankly, they often appear to distance the reader from the lived experience of the participants. They turn people into subjects. In a deliberate departure from this practice, the titles used here are unapologetically drawn from the lives and the language of the participants themselves.

The three superordinate themes are these.

1. I was always the outsider
   (feelings of separation from family, of being disconnected and alone)
2. I wanted an ordinary mum and got Supermum
   (the mother was always busy, and had little quality time for the child or teenager)
3. My search for a new, improved sense of self
   (negative self-perception, the 'hole in the soul' and the reparative action to which the teenager appears to feel drawn)

The sequence in which these themes are presented is pertinent: they fall effortlessly into an order that reflects and describes the emergent pattern of data in relation to key life stages, from very young childhood to the late teenage years.

2.1 Superordinate Theme 1: I was always the outsider

This theme presents an account of participants consistently perceiving themselves as outsiders in their lifeworlds. They describe feeling a sense of separateness, not only in their family life, but also in relation to school, social circles and the broader environment. They highlight a day-to-day unease about their sense of self, and of having few or no real friends through their childhood and teenage years. In short, they appear to feel that they have limited or no social capital. This narrative breaks down into three subordinate themes.

Sub-theme 1A: Not fitting in

This section captures participants' negative feelings about their own social standing. They appear to consider that somehow they cannot or will not be accepted by either their family or a circle of friends. Importantly, their comments point to a desire, not so much for popularity as to be a part of something – a community. The majority of comments within this theme seem to relate particularly to the teenage years, suggesting that this may have been a particularly memorable or important life stage for the participant. While this could be considered relevant to most people, it may be that their teenage years are very negatively recalled and that they do not look upon this period with fondness at all.

I always felt a bit different and I had very few friends... I had to be pulled in. No, no, never one of the crowd, no...

Peter: 16, 23-27

Peter indicates a heightened level of self-consciousness, of feeling separate and on the periphery of events rather than in the middle or as a part of them. It is as if there is an

invisible barrier between him and a social circle, and I sensed awkwardness and perceived social difficulties in both his body language and his tone.

Helen further expands this notion of being an outsider as she discusses her one true school friend.

...people at a sub-conscious level, you know, go for the person like them and she did, she became a magnet to me and we got very friendly and we used to put it down to the fact that we didn't fit in. She wasn't, I mean, she was half-Jewish but the fact, she'd just come over from Hungary, learning the language, blah blah blah, she felt she didn't fit in either and that's probably why our friendship was so strong...

Helen: 19, 1-5

Feeling like an outsider, Helen perceives that her only friend at school was attracted to her because she too was an outsider and that their mutual attraction was predicated on a shared belief that they did not fit in to the school environment. Helen focuses on her friend's observed difficulties in fitting in at school, perhaps because she understands these struggles only too well and strongly identifies with these perceived 'barriers to entry'. Moreover, we can hypothesise that Helen may find it difficult to acknowledge positive attributes in her friend because she is attuned to her own negative self-perceptions, and unconsciously projects them onto others. Helen may unconsciously have selected a safe friend, one who was unlikely to reject her, in an attempt to replace the missing intimacy in her maternal relationship.

Helen also provides insight into her feeling of familial isolation.

I tended to sit in my room a lot [during puberty], and if I went out and about, I wouldn't often spend time with <u>them</u> downstairs [the family]

Helen: 2, 35-36

Helen appears to be rejecting her family in some way, or at least to be demonstrating ambivalence towards them. Her emphasis on 'them' resonated strongly with me as seeming to amplify those feelings of being separate from her family. The notion of rejection may relate to the teenage struggle for autonomy and sense of being misunderstood by one's parents, while coping with the physical and emotional changes of puberty. It may also help explain the feeling of being an outsider: research has shown that the presence of maternal warmth is an indicator of better peer relationships for the adolescent female (Black and McCartney, 1997) and bodes well for social functioning (Caldwell, Rudolph, Troop-Gordon and Kim, 2004). Thus we can hypothesise that Helen's distance from her mother may connect with difficulties in forming social friendships and feeling neither a part of her family as a teenager.

Difficulties in social functioning and the struggle to fit in with peers are further amplified by the next quote from Emily.

As a kid I didn't really understand how to act [at school]... and I was getting really upset to a point where, you know, in my report they [teachers] were writing she has a problem with other pupils in the class...

Emily: 5, 37-38; 6, 1

Emily describes not knowing how to behave around other children and seems bemused that she was singled out as 'difficult' at school. She appears aware of 'being different' but unable to understand why this was so. There appears to be some confusion about how to act, and we can hear the tension between recognising that she needed to behave differently, but not knowing how to. If we hypothesise that Emily's emotional needs were not met in her home, part of her social struggle may have related to emotional neediness towards peers, as she looked elsewhere for intimacy and reassurance. This neediness usually relates to social anxiety. Research demonstrates that it is often viewed by other teenagers as off-putting (Teachman and Allen, 2008). The early work of Piaget (1923; 1955; 1967) also shows how social rejection in childhood stifles both social and

intellectual development. As others have found, such experiences can lead the child to develop less adaptive capacities (Kupersmidt, Coie and Dodge, 2000).

Helen continues to expand upon the outsider theme as she places this feeling in a context of socio-economic status.

I went to grammar school with a lot of rich people and obviously, when you get friendly with those people, you go to their houses and they've got these wonderful houses. You know, it sort of made me feel very aware of my background – working-class background, living in a council house. There were a few comments about how small and horrible my house was. So you know, I did sort of develop this idea of how I wished I was someone else's daughter rather than who I was...

Helen: 3, 24-30

This sense of difference according to social status, associated with feelings of embarrassment or even inadequacy, is a theme in Helen's account. She describes how, as a bright grammar school girl, she was acutely aware of being from a different social class than her peers, and her embarrassment seems to have been so acute that she fantasised about being the daughter of another family. This corresponds with earlier comments about rejection of her own family.

Revealingly, Helen presents this narrative in a negative frame, and seemingly struggles to interpret it otherwise. She seems unable to appreciate and applaud her intellectual ability as a girl from a less privileged background who has made it to grammar school on her own merit. The content of the narrative itself might not be considered overtly negative, but Helen has recorded and interpreted it negatively in her mind as a sense of not belonging – a feeling that Emily amply demonstrates in this quote.

I always ache because I wanted a group of friends to see every night or any night, Saturday, Friday, when everybody goes out, call somebody and you know just, you're

going to go out together, without issue, because you're a part of this gang, not in a bad way, just getting a group of people to hang out...

Emily: 27, 4-7

This tearfully presented perception sums up a sentiment that runs through all of the accounts, the desire for acceptance and to feel 'a part of' a community of friends. It echoes the painful feelings of loneliness and isolation that permeate the narratives. That 'ache' seems to crystallise the distress of perceiving oneself as the outsider. It is as if the harder Emily sought acceptance, the further it moved away from her, leaving her feeling bruised and isolated. If, as hypothesised earlier, Emily displayed emotional neediness to others, this may reflect her unmet emotional needs in her own home from her mother and father and, such behaviour may have alienated other children. In effect, she may have been 'trying too hard' with peers to compensate for her insecurities.

This subordinate theme of not fitting in has surfaced particularly during accounts of the teenage years. Research points to the increasing importance of one's peers throughout adolescence, and of the shift away from spending time with parents (Buhrmester and Furman, 1987; Larson and Richards, 1991), placing the teenage period as an important phase of ego development (Brown and Lohr, 1987). Those who report not having fitted in may have experienced, not a gradual transition in the mother-child/parent-child relationship, but an abrupt change, or may indeed never have felt a strong sense of parental relation. Then, because they found social relations difficult to negotiate, the responses of their peers may, distressingly, have left them with a sense of social rejection. It is their own perception of negative social status or inability to fit in that appears crucial here, and this may be laying the foundations for reduced long-term social functioning, as outlined by McElhaney, Antonishak and Allen (2008). Such negative self-perceptions, such a sense of 'being the outsider', may speak to the individual's beliefs about their ability to be loved and respected, and so can stifle growth and change.

Sub-theme 1B: Being treated differently

Sub-theme A referred to a perception of being different; sub-theme B examines the perception of being made to feel different, and/or receiving different treatment from the mother/parents. Such a sense may lend weight to a feeling of not fitting in with others. I have deliberately provided a diversity of perceptions: the notion of differential treatment is consistent, but the specific experiences of individuals are not. Of course, the important aspect is not the experience *per se*, but how the participant has perceived and made sense of it, and then how I have then interpreted it.

Peter refers to his perception that his mother treated him and his brother differently – in his case, more restrictively.

She wasn't like that with my brother, with my sister it's different because it's a girl and... you know, girls are different. But um, no she didn't she didn't show me that thing with my brother which she did with me, she was much more relaxed with my brother growing up than she was with me...

Peter: 3, 23-27

Peter forcefully describes his strong impression that his brother was given more liberty than him in their household. He sounds frustrated and confused at this juncture as he explores possible underlying reasons for the difference in treatment. His use of 'relaxed' appears antithetical to his angry tone. It might be that his mother was protective of him as the younger boy, and that she unwittingly overlooked his natural request for more self-governance in his teenage years. This may have led Peter to become introspective and to search for some personal defect or weakness that his mother might have seen in him. Research has demonstrated that there is little or no correlation between adolescents' and parents' perceptions of parental influence. In particular, parents' reports of high influence on their children are linked with low adolescent autonomy in relation both to parents and to friends (McElhaney, Porter, Thompson and Allen, 2008). Peter's underlying desire does seem to relate to autonomy. His perceptions of differential

treatment also appear to relate back to previously mentioned feelings of not fitting in. One could argue that such self-analysis (consistently looking for defects or reasons) about his mother's treatment of him could be expected to form the basis of pathogenic beliefs about his weakness and negative differences.

Scott also illustrates the notion of differential treatment of siblings.

But my brother T lives at home and he's always been like my mum's favourite, even though she says she hasn't got favourites.

Scott: 4, 20-21

Scott's verbal delivery was loud and forthright, and he provided several examples of his brother, in Scott's perception, receiving special treatment from their mother. He justifies his perspective by the fact that T is still living at home with their mother and is still being regarded as her favourite. He sounds resentful at his mother's denial of favouritism, and seems to feel a need to continue to question his mother's word. One might expect that following this scenario, a child might question whether there was something defective about him that did not warrant the same degree of attention from his mother.

Scott further outlines his perception of differential treatment or of missing out on what his other siblings enjoyed.

I mean they spent a bit of time and effort with the others, they went to the zoo and to the park and played football and I never had none of that, like I said before and it bugs me, you know whereas before I never used to think it did and it's only like recently, actually, cos I never thought about it before, and I think maybe I did miss out a bit

Scott: 10, 38; 11, 1-3

Scott's grievance appears to be towards a perceived lack of effort by his parents. While Scott may feel that his basic needs (food, clothing) were met and that he was taken care

of, his resentful tone may suggest that some of his emotional needs (such as to spend valuable time interacting with his parents) might not have been accommodated. Scott may feel angry when thinking about his attachment relationship and his perceived sense of deprivation, leaving him with a confused or weak sense of self.

Peter explores the possible motivations of his parents for this differential treatment, and whether they are even consciously aware of administering it.

So I dunno if parents sense you know the sensitivities of their children and you know, they give them some more leverage than others but as a child that's something that you feel and I don't think parents – I don't think they're aware of that...

Peter: 22, 13-16

Peter sounds confused as he explores parental thinking and perceptions, linking them with the more relaxed treatment of his brother by their mother. As a teenager he may have struggled to understand his parents' attitude to him, particularly his mother's (as seen above). From this account we can consider whether communication between Peter and his mother was sufficient to allow mentalising (perspective-taking) to occur.

Jackie presents an alternative angle on differential treatment, citing her father as singling her out for negative treatment.

That [violence] was with all of us but it was worse with me as I got older. Much worse with me as I got older and I always kind of resented that because at least while I was at school, you know, I was a good one, you know, my brothers... although they're very successful now, academically as well, you know, they left school with nothing, they were badly behaved at school, you know, my eldest brother was getting in trouble with the police while he was still at school and I didn't, you know, but he, he, he [her father] just

couldn't stand being in the same room as me. He even admitted it, he even admitted it once. Finally, things were very tense. It was just horrible

Jackie: 3, 4-14

Jackie appears to view the violence she experienced from her father as more than her brothers suffered. She appears to seek reasons why he treated her differently, even drawing upon her capability as a student and her ability to stay out of trouble to explain being targeted. She appears small and vulnerable as she tearfully describes the feeling that her father could not bear her presence. This paternal treatment seems to make Jackie question why she was unloved despite being a good girl. She may have felt rage towards her father, and that she had to suppress it, and this could have compounded feelings of isolation as she attempted to cope with her fear of being with him on her own. Elsewhere in her narrative Jackie refers to her father's verbal outbursts and her lack of response – almost closing down emotionally towards him. Acting as an emotional container for his verbal outbursts, Jackie may have felt there was no strategy open to her other than suppressing her rage, no one to turn to, and she may have feared that to act differently could result in an escalation of the violence, or even in abandonment.

Helen looks outside her sibling experience and compares her maternal relationship with those of other teenage girls.

...my close friend Sally ... she was very much like me, you know, couldn't speak to her mum, but a lot of other girls were quite close to their mums – used to go shopping with them and all sorts, so there was a difference. But it never actually occurred to me as to why there might be those differences. I just used to sort of accept them...

Helen: 22, 34-36; 23, 1-2

Helen appears to have normalised the difference between her maternal relationship and her observations of others' relationships. Her use of 'close' (to mothers) contrasts strikingly with the absence of intimacy or real connection between her and her mother

that she describes, whereas her use of 'close' when referencing her friend may imply that this friendship provided a different and more intimate emotional context. She may interpret 'close' to mean having one's basic needs cared for in the past by her mother and thus being loved, but she may be unaware of her emotional needs that may not have been met in relation to her mother – such as spending time with the mother and going shopping. Perhaps she unconsciously acknowledges these needs when she compares this with her close friend, with whom she may feel better attuned.

These feelings of being treated differently relate directly to the earlier quotes about not fitting in, and they are presented in a negative context. Differential treatment does not appear to relate to feeling special or positively different, but to capture individuals' perceptions of low self-worth and examination of their internal flaws, with the child struggling to understand the motivations of others. This may lead individuals down a path of anticipating rejection and normalising feelings of being distant from others, uncertain as to how to present themselves in a positive light.

Sub-theme 1C: Childhood insecurity

This concluding element of the superordinate theme 1, 'Being an outsider', brings together evidence of the experience of general unease in everyday life, and of being very attentive to the views and perceptions of others both in and outside of the family. The title 'Childhood insecurity' is used here to express these tensions because they appear to have been present in participants' early lives. Use of this term is not to be confused with the theoretical position of infant attachment and insecurity proposed by Bowlby (1973) and Ainsworth, Blehar, Waters and Wall (1978). Rather, it reflects the personal disquiet expressed by the participants about their childhoods and, more particularly, their teenage years. Of note are the multiplicity of experiences, and the lack of an overarching reason why participants felt anxious or vulnerable in childhood.

Within the quotes that follow one can identify a relationship with both sub-theme A (not fitting in) and B (being treated differently), as well as references to looking or behaving

differently which seem to support participants' previously quoted sense of being an outsider.

Scott reports a perceived physical difference from others which appears to undermine his confidence and to generate tension in him.

Yeah, of course. You hate it, don't'cha, getting called Fatty and all that and all I could do about that was punching people who called me names ...

Scott: 11, 22-23

Scott appears to have felt self-consciousness about his physical appearance (circa 11 years old) and sounds anxious and frustrated as he speaks. He describes feeling fat as a child following illness and steroid injections, and he may have felt hurt and anger at being called names. His response was to lash out, a glimpse of how he responded to these uncomfortable feelings via use of aggression. This may constitute a strategy to cope with feelings of anger towards his parents (mentioned earlier) for not spending time with him, exacerbating feelings of being the outsider in his own family. Scott may have unconsciously projected his anger and embarrassment onto others. By contrast, in the following quote Peter seems so acutely to feel shame and a sense of being different that he appears to internalise it and withdraws from others.

I was six or seven, um, my parents realised what I realised, what everybody realised that I was still wetting my bed. Um and that was hard for me, that was very hard for me because you know it's not something normal, it's something you have to hide...

Peter: 1, 31-35

Peter anxiously relates to fear about being discovered as a bed-wetter. He seems to think this is abnormal, an awful truth that he must conceal. Peter may have felt he was different because of the enuresis, creating the need to be on guard around others in case his shame was revealed. Thus he may have stigmatised this problem, as one can detect in

his reference to "not something normal". It seems that he may have tried to conceal the enuresis even from his parents for a while, suggesting possible difficulties in family communication. One can thus hypothesise that this early bed-wetting may have played a part in his mother treating him differently from his brother, as referred to earlier, and her being more protective towards him. However, Peter does not make any such positive or well-meaning links and, again, appears to look internally and to regard himself as flawed.

Moving away from perceived physical difference, we turn to another aspect of childhood insecurity, social discomfort. Here John illustrates the difficulties he experienced in navigating social situations.

So I wasn't very um confident in many ways, you know, and I always felt like I had to prove myself or, as I said before, I'd want the answer before I asked the questions, you know what I mean, I was, like to girls, I'd want to know what her answer would be before I was to ask her out, you know what I mean, before I'd asked her, which obviously is impossible so like, I probably wouldn't ask her...

John: 33, 1-6

John seems anxious about failing and making a fool of himself. He places this teenage shyness in the context of social anxiety around girls: 'needing to know the answer before asking the question' provides us with a beautiful snapshot of his anxiety level. It seems that John may be seeking such certainty in his uncertain day-to-day life. His difficulties in coping with another's perspective may reflect uncertainty that he may have felt towards his mother as he attempted to understand and communicate with her.

John also speaks of a fear of not belonging, and his overall perception is negatively constructed. It is not unusual for adolescents to go through a period of uncertainty and discomfort in negotiating relationships, as Hennighausen, Billings, Schultz and Allen, (2004) point out, and it can almost be seen as a 'rite of passage'. However, John has internalised much of this uncertainty to the point where he seems to construct a negative

self, which may have implications for stultifying ego development and generating insecurity.

While John hesitates to act, for fear of rejection, Emily braves rejection, but it is no less painful for her when it arrives.

I had this er, way of wanting to know everything and imposing and so basically I had everybody against me so they start to call you something really upsetting...

Emily: 5, 35-37

Like John, Emily expresses the idea of not wanting to get social situations wrong but feeling that somehow she always did, which resulted in her feeling like an outsider. She seems to feel a need to remove uncertainty. Her use of 'imposing' may suggest that, because of the feeling that she had no control or emotional support at home, she tried to control friendships at school, and that this may have led others to view her as difficult to maintain social ties with. Her quote ends with her revealing a sense of injury, because she had tried hard to fit in at school and not been accepted.

The final dimension to this discussion of childhood insecurity comes from perceptions of individuals within their own home. Here they appear to acknowledge an ever-present danger and a consequent need for hyper-vigilance which may have made it difficult for them to feel relaxed and carefree as children.

John relates his anxiety to feelings of isolation and vulnerability when left alone as a young child.

She [his mother] did two places [jobs] in the morning, she'd do somewhere else when I was at school or ... and I know she always did one in the evening so I'd be indoors, you know what I mean? I mean nowadays they'd call that neglect, wouldn't they? But like, as I say, like, I'd come home and do my homework and, as I say, and also, like, our

*house, in the morning, the [*street*] door was open [this was shared accommodation – a room in a house], the front door, yeah, and that was it, unless someone shut it after midnight. Anybody could come in and sit on the stairs you know what I mean, it was just a house and all that kept you from anybody was like a door like that [points to door], you know what I mean? A bedroom door...*

John: 10, 19-26

John appears to feel that his security was tenuous when he was alone at home, and he transmits a feeling that 'anything could have happened to him'. To justify his anxiety and unease, he characterises this habitual practice as neglectful. There is a marked flavour of uncertainty and low security here. It seems reasonable to infer that these long periods of being home alone would have made the child feel fearful, and perhaps encouraged the belief that others could not be relied upon to protect him.

In Emily's experience, her fear is not of strangers, as in John's case, but of her own, sexually abusive father. It seems Emily may have felt overwhelmed by her father and his violent outbursts and sexual motives, and that she may have felt trapped in her situation as a helpless child, thus promoting childhood insecurity.

Well, the fact that he abused me for quite a long time I was scared, I didn't want to stay in the same, I didn't want to stay alone with him, you know that er, I can say it disgusted me. Bad, he made me feel ... bad. You know, I, I don't know if it was just his fault but I hated my house, my life, a part of it, he was a strong part of that...

Emily: 22, 25-28

Emily's anxiety appears to relate to her paternal sexual abuse, and in her expressions of hatred she seems to oscillate between fear, confusion and anger. She seems unable to say explicitly whether the hatefulness of her life then relates to her father, and she struggles to apportion blame without considering her own part ("I don't know if it was just his fault"). Even though her father manipulated her by exerting his power over her, with the

egocentricity of children she blamed herself for what was done to her. Now, reflecting on her childhood self, she still holds herself to blame. As her narrative switched between anger and shame, this may also imply that she is at an unconscious level angry at her mother for failing to protect her.

Peter, too, gives a strong impression of self-blame, and he seemed to have experienced anticipatory anxiety in relation to making bad things occur around his mother.

My first year in high school and mum, and one day I came home and saw her crying and I'm like mama don't, and I knew straight away that something related to me. Because if it wasn't me, she had the opposite [look], I never see her like that but I knew it was me because of the way she was crying. And I really felt, it's not the only, but I think it's one of the few times I really, really felt ...alone.

Peter: 12, 35-39

This quote from Peter was one of the most confusing to analyse, and this may have been because he seemed chaotic in the room, constantly shifting his body position and with facial expressions moving quickly between puzzlement and sadness, and his words felt disjointed. It was as though he was being captured in the middle of sense-making, and I felt a temptation to somehow 'tidy up' his verbal chaos. However, in recognition of this, and in trying to understand the kernel of his delivery, I felt that his quote illustrates the awful tension that appears across participants' accounts, of knowing but not knowing why. It is the tension between knowing it was him (his fault) and not knowing why that he seems unable to tolerate. Peter's expression of feelings of isolation at the end of the quote echoes an earlier quote from Emily (about not being part of a group). Peter's preoccupation may have related to not displeasing the mother and he may have developed a pathogenic belief that he was always to blame and responsible for his mother's emotional outbursts.

Throughout these quoted examples of childhood insecurity there seems to be an underlying tension allied to low self-worth, and it can be hypothesised that these are the hallmarks of ego fragility. Insecurity in everyday life seems commonplace for these individuals and the child may have grown to normalise considerable levels of anxiety, and have adapted to cope on their own with everyday pressure and tensions. There is a flavour in some of the quotes of contamination (a feeling of spoiling things) too, even defectiveness (of character, likeability), with individuals appearing to feel helpless in their childhood situations and simply having to cope, and looking inward to apportion blame. But the responses are different: while Scott appears to cope via channelling his emotions through aggression, others appear to internalise their feelings and withdraw, as in Peter's case.

These, then, are the three key ingredients in the first superordinate theme, three elements that seem to propel the child towards feeling that they were always the outsider (and they are present across all accounts): perceptions of not fitting in and being socially unappealing, differential treatment, and childhood insecurity, perhaps predisposing the individual to high levels of anxiety. There is a good deal of introspection evident in these narratives, culminating in a shared view that the narrators were somehow defective, and this is the rationale they appear to embrace to explain their perceived misfit status.

2.2 Superordinate Theme Two: I wanted an ordinary mum, not Supermum

This section of the analysis aims to tap into the mother-child relationship and the child's perception of communication and time spent together. It explores the accounts of individuals in respect to feeling unable to access the mother emotionally, a general family style of non-communication, and feelings of unanswered questions and unresolved conflicts for the child. Many of the accounts were peppered with references to conflicts surrounding the mother's behaviour and her treatment of the child. Thus the term Supermum is used in a pejorative sense. From the outside these mothers may have seemed efficient and able, but they appear to leave their child feeling isolated and

vulnerable. A central concern to these individuals seems to have been the fear that asking questions of the mother would upset her. Thus we see evidence of a mum-pleasing mentality. It also centres on the busy life the mother led, so that she was a *presence*, but not *present* (not interacting) with the child a lot of the time. There are three sub-themes.

Sub-theme 2A: The unspoken, and unanswered questions

The unspoken

This section relates to the theme of self-containment, with the child seemingly learning to be self-sufficient and to hold back on emotional expression within the family. A multitude of examples revealed participants' perceptions that 'talking things through' was not a commonplace activity. However, the overarching concept here is one of a glaring absence of communication, and of little if any opportunity for individuals to discuss their problems as they matured, particularly in the tumultuous teenage years. It appears that the 'tough stuff' relating to emotions was left unsaid.

Here Scott describes how communication was not a feature of his everyday family life.

...nobody used to talk to their mums and dads about your feelings and all that. It just wasn't done. Nobody I knew used to do it. None of my mates used to talk to their mums...

Scott: 9, 24-26

Scott's recollections are very forthright. He appears to justify to himself the lack of communication by generalising it as a way of life, not just in his house but in his community. During the interview he appeared to struggle to recall any occasions when he had discussed a problem with either or both parents. Notably, he seems to refer to something of a generational difference in his language – 'we didn't do that then', as if nowadays it might be more accepted practice. However, in other parts of his interview

narrative he comments that communications between him and his mother appear to remain strained and superficial today.

Emily focuses on her lack of ability to talk about her sexual abuse with her mother or other family members.

I said I don't want to see [her father], I don't want to stay with him, I don't want to see him and I remember somebody telling me, somebody saying to me, how can you say that? He's your dad! But again, I couldn't bring myself to say that's the reason why...

Emily: 2, 10-13

This is a different angle on the unspoken in families, because Emily is describing her childhood sexual abuse and feeling unable to divulge this to anyone. She appears to have made strong signals to her mother and others that she did not wish to be left alone with her father, but they were perhaps misinterpreted or ignored, leaving her struggling as the possessor of a shameful secret.

John, too, picks up on the theme of being unable to tell a dark secret (a paedophile assault on him) that appeared to trouble him deeply as a child, and which he seems to have felt that he could confide in no one.

I wasn't about to say that [to his mother], I never could have got that out [the paedophile encounter], you know what I mean, you know? So I wasn't about to say nothing. So really, you're about the second person that ever heard that, you know what I mean?

John: 13, 16-18

We can hear the young boy struggling with this paedophile encounter, feeling confusion and shame, and so unable to say anything to his mother or anyone else. Again, we can hypothesise that either John's parents' styles of parenting (low communication), or his possible beliefs about himself (I have to cope, I must not worry my mother, I make bad

things happen) might have led him to blame himself for this traumatic experience. John may have felt very afraid about what he had experienced, but more afraid of the consequences if he were to divulge it to his mother. And indeed he seems to have kept it quite secret until very recently.

We now turn to some specific examples of maternal communication being perceived as unsatisfactory (not helping to resolve conflicts) or effectively degenerating over time. As Helen speaks, she evokes a sense of drifting further away from her mother.

I felt, as I went through 12, 13, that sort of era, I seemed to just draw back from her [mother] and it seemed we no longer seemed to ... communicate very much

Helen: 19, 25-27

Emily then describes how maternal communication never seemed to have the gravitas she craved, and she seems to demonstrate a need to discuss emotional and maturational issues empathically with her mother.

Well, I wanted somebody who actually took me seriously about the fact that I was flat-chested and the issue about having sex and puberty, um, [participant is weeping]. I never felt I could talk to her, say anything, have a conversation, a serious conversation, if there wasn't joking and laughing about it or being embarrassed about it

Emily: 17, 1-4

Emily's upset was evident to me as she conveyed her frustration at having revealed a problem to her mother as a teenager and not been taken seriously. She seems to imply that the maternal way of dealing with sensitive issues was to resort to humour, which she seems to have found distressing. In her teenage years Emily appears to have had much she needed to discuss, but she seems to have felt there was no one to whom she could turn within her own family. More specifically, she seems to believe that she was unable to talk to her mother about puberty. This seems to illustrate the mother's inability to

contain the child's emotions through a cohesive alliance, where the child has the opportunity to see itself in the thoughts and words of the mother.

She expands further by illustrating how she perceives her maternal relationship as mutually uncaring and lacking in intimacy.

When she [a female acquaintance] was talking with her mum she was showing her emotion. "Look, I'm sorry mum, I did that, I didn't think about it, it could have hurt you". Things like that. I don't know why, I could never have this relationship with my mum...

Emily: 4, 29-31

Emily contrasts her own experience of familial non-communication with a cameo of another child considering her own mother's problem. Emily's apparent inability to show this kind of consideration to her mother may suggest that she felt resentful towards her mother for not communicating with her on her own problems, and so felt unprepared to tackle her mother's problems: problems which, as she revealed throughout her narrative were many, consistently expressed aloud, and never concealed from Emily as a child. This may appear to present a contradiction to the earlier theme of mum-pleasing, but in fact, Emily has referenced throughout her narrative that she does not wish to upset her mother. So one notes a potential conflict for the child between love for the mother and anger towards her. Emily may have felt overburdened and overwhelmed by her mother's problems and the tension surrounding family life, and learned not to turn to her mother for advice and guidance. Thus, inadequate or non-existent mother-teen problem-solving and sharing of emotions could have led to poor emotional regulation, resulting in specific difficulties in socialising and forming relationships as she matured. The importance of this mechanism was demonstrated in early research by Kobak and colleagues (Kobak, Cole, Ferenz-Gillies, Fleming and Gamble, 1993).

The fact that all participants referred to an absence of communication, or felt they had no permission to discuss difficult or emotional topics, might suggest that their parents (and especially mothers) were insensitive to the internal mental states of their offspring. The teenage years feature heavily in this section as a symbolic period when problems loom and there appears to be a basic need in the child to express difficulties, seek reassurance and be parented. These individuals may have denied or shut down on this need, perhaps because they perceived that they were not listened to and that they would receive no emotional support, especially from the mother. Maternal sensitivity has been for some time considered to be an integral part of a secure base, as found in infants (De Wolff and van Ijzendoorn, 1997) and it has been shown to apply just as readily in adolescence (Manning, Allen and McElhaney, 2006). It is this sensitivity that would appear to be missing from these individuals' accounts.

Unanswered questions

The second element of this sub-theme provides us with a closer look at the result of poor mother-child communication. It appears to leave the child with important unanswered questions and feelings of confusion. This sense of confusion appears to surround attempts to understand why their mother or parents behaved and parented the way they did. It also registers a strong sense of the individual wanting their mother to change and be more open, in order to demystify parts of the child's thinking and inner life. These narratives also convey a strong sense of anger towards the mother.

Here is Jackie, extremely animated and angry as she tries to make sense of her mother's lack of intervention and protection from her abusive father.

He was just a shit you know, just an absolute shit. And my mother was so fucking spineless, you know. I mean I used to think, I mean now I think what the fuck? What were you thinking? What would he have done if you had pulled him on it? He would have done fuck all, he would have done nothing. He worshipped the ground my mother walks on, he would have died if she'd left him. He would have died. Couldn't have

coped without my mother. Why didn't she think she could do something, you know? [Her voice rises strongly in anger] I have no idea... No idea...

Jackie: 7, 4-13

Jackie delivers what seems a heartfelt insight into the confusion and frustration she felt as a child and the paternal abuse she was suffering. She seems to perceive her mother as having the upper hand and the father being dependent on the mother, and this seems to mean to Jackie that her mother had the opportunity to change things. She reveals her anger towards her mother in both tone and content, and this seems to relate directly to her mother's failure to intervene, or to abandon her father, to protect her child. Jackie sounds scornful about her father's inability to cope without her mother, and so seems to find her mother's non-intervention inexplicable: she cannot seem to recognise any downside risk for her mother in choosing to intervene.

Jackie may feel she was let down by her mother in this area of her childhood experience, and may have struggled as a child to understand how her mother could stand by this man who was mistreating her. Elsewhere in her narrative she makes reference to her mother having the choice to leave her father and she seems puzzled that her mother stayed with him. Her use of the contemptuous word 'spineless' seems in opposition to Jackie's more favourable comments (as quoted later in sub-theme 2B) about a strong, coping mother who took care of things. The fact that her mother either chose not to stop the abuse or felt that she could not do so may have been very difficult for Jackie to accept and make sense of as a child.

These powerful words seem to go to the heart of Jackie's puzzlement about her mother's motives. In the absence of intimate communication between the mother and child, she may have felt unable to gauge her mother's rationale.

She knew. <u>She knew</u>. Although they were great friends and everything, she liked him very much, but she knew, she knew. Yeah. Which is an abdication of your responsibility

for God's sake! You know? God. I always see my mum as being so strong in some ways and I think how could she have been so weak? What did she think that she needed from him?

Jackie: 33, 30-36

Jackie is adamant that her mother knew of the abuse. She seems to be giving her mother no place to hide in her narrative. When she refers to her parents as being 'great friends' and to her mother 'liking' her father, she sounds confused, perhaps because it is too difficult for her to understand her father's likeability. She seems to feel that her mother turned a blind eye to her father's darker side. In her tone there is rage against her mother, as she seems to imply that she feels cheated by one whom she regarded as strong, and yet in so important a matter was weak and did nothing. Again Jackie appears to struggle to reconcile what she sees as two sharply contrasting halves of the mother's character. This seems unsurprising, in the absence of consistent and intimate communication. Jackie ends by wrestling with the notion that her mother actually needed something from her father. It implies that Jackie may have found it difficult to see things from her mother's perspective and find a reason why her mother remained close to the father.

Jackie's feeling of being let down by her mother seems to be crystallised in the expression 'abdication of your responsibility', which seems to relate to her mother's lack of intervention and, perhaps, her failure to remove her from the situation. One can also hypothesise that, as Jackie had previously experienced her mother largely on a one-on-one basis, her father having recently returned to her mother from working abroad may have posed an oedipal conflict for her. Perhaps she was envious of the love her father received from her mother, or that the love her father once showed to Jackie was now exclusively given to the mother. Thus, as Klein (1957) describes, she might view her mother as all-powerful and brimming with enviable attributes.

The next quote, from Peter, again reveals an inability to understand the mother's thinking, and he echoes the anger and frustration apparent in Jackie's earlier quotes.

She still, she still was right, she still was right with that bloody jacket. I wish I hadn't bought that damn jacket, man, because that is something that is still in my brain, in a sense it's not in my brain because I've got over it but I still don't understand. It kills me. Why? ... And, I, really one day she's going to have to look me in the eye and say Peter, I took it and I threw it, because I, you know, tell me whatever you want, but don't just say to me, that jacket was horrible – that's what I can't understand, that. Oh my God...

Peter: 19, 25-33

Peter recalls a teenage incident where having saved for a fashionable jacket, he returned home from school to find his mother had thrown it away without explanation. We can hear Peter's struggle as he searches for a rationale to explain why she committed this act. He became very angry during this part of the interview, and seems frustrated that there has been no opportunity to discuss this issue with his mother. The jacket may be a metaphor for an attempt at autonomy that Peter still feels he has not fully achieved. Underlying his narrative there is a deep sense of hurt, and his eyes are full of tears. His final words seem to sum up his level of exasperation with his mother and they seem to bring into sharp relief the powerful sense of confusion that so often occur across these narrative accounts – the 'knowing yet not knowing' and the conflict between pain and rage.

Here John explores why his mother appeared to want to make him feel bad and blame him for negative events. Negative communication could be compared in its effect with psychological abuse, leaving the child with unanswered questions.

I threw it right up in the air, course where's it come down? It lands on my brother's head and sticks in [metal shovel], you know. And er, sometimes I basically wanted to be, nasty, and she would use things like that psychologically, you know what I'm saying? Like, it could have been something like that did send him over the top into schizophrenia, you know?

John: 20, 29-33

John recalls a childhood incident in which his brother was hurt. He acknowledges that he sometimes felt resentment towards his brother, perhaps because his brother (who was frail from illness) received special treatment from their mother. His concern that such an incident might have prompted schizophrenia in his brother seems to be a central point of confusion.

Moreover, John's quote seems to capture the notion of inconsistent holding and the absence of emotional containment for him, as he appears to struggle with trying to understand his mother's special treatment of his brother and his perception that she blamed him for his brother's schizophrenia. This confusion may have translated into a conflict between loving the mother and hating her, which may have resulted in fantasies about hurting his mother (to punish her), which he projected on to his brother. John had made numerous references (elsewhere) to his mother cultivating in him a worrying belief that he could have been to blame for his brother's illness because of the negative framing of this shovel incident.

Throughout this sub-theme of unspoken and unanswered questions we can hear individuals' perceived frustration and anger directed towards the mother. The child appears unable to understand the mother's motives and to take in her perspective. A general lack of communication makes it difficult for these individuals to read her state of mind and understand her behaviour. This ultimately poses conflicts for the child, leaving many questions unanswered – questions that seem to remain unanswered even in adulthood, as individuals continue to toil to rationalise their mother's actions. I perceived the present-day thinking of these individuals as having remained somewhat tentative, even naive. One can hypothesise that fragility and underdevelopment of the ego are a feature in these accounts, and that the lack of emotional contact and of opportunity to mirror the mother's state, and so to understand and regulate their own mental state, may have left these individuals perceiving themselves as defective, or at least unworthy of their mother's consideration and deeper explanation of her motives.

Sub-theme 2B: Always busy

Expanding further on the absence of mother-child communication, this next theme captures how participants appear to feel unable to gain access to their mother – that is, to be physically close and mentally attuned to her. In many cases the mother seems to have been thought of as a *presence* but was often not *present,* or adequately engaged with the child. Even when they spent time together it appears questionable whether this was 'quality time' in the eyes of the child or merely accompanying her, and therefore not about play, togetherness and a real sense of interaction. The net effect of these features of their childhood, however, is manifest in the overarching theme of not being close enough to the mother. Supporting the notion of a lack of intimacy are hints of idealisation of the mother. References to maternal admiration relate to her pragmatic coping style and the perception that she was in charge of the household. This idealisation may have made it easier for individuals to make unconscious excuses for the emotional void they may have felt they experienced in childhood, and to enforce a strategy of leaving the unspoken well alone and their urgent questions unasked. This childhood reticence may relate to a lack of perceived trust in the mother, if we define trust as acceptance of the risks associated with the nature and type of interdependence inherent in the mother-child relationship (Sheppard and Sherman, 1998). The child may have perceived any risk of maternal rejection or disapproval as high.

Jackie seems to admire her mother's ability to cope and care for her basic needs in the absence of the father. But Jackie seems to give those basic needs priority over any emotional or time needs that she may have had as a child, and perhaps not had met.

And the way mum had kind of, not that she had even been this 'little woman' d'you know what I mean, but she'd, you know, just taken everything in hand, you know, she was working full-time, she had three kids, she had a house to run, you know, she was studying, you know, and she did it all on her own with no help [while the father was working abroad]

Jackie: 3, 20-25

Jackie is supportive of her mother's struggle to keep their lives ticking along and it seems clear that her mother played a very central role in family life. However, there appears to be justification here, too. Perhaps Jackie is attempting to explain why her mother had little spare time for her, and why there was an absence of intimate communication. One is left with the impression that, from a pragmatic perspective, Jackie may idealise her mother as the ultimate juggler and coper in life, but this may have seemed an intimidating role model for Jackie, who at times may have felt emotionally vulnerable and conflicted (due to her paternal abuse) and unable to escape. Jackie may have felt that she had to live up to her mother's high expectations and standards of coping.

This theme of the coping, hard-working mother emerges, too, in Emily's account.

It was really, really hard, and after [the age of] eight or nine when I knew there were problems [financial] and my mum was trying everything, she was working, she was raising a family, she was going around, speaking with a lawyer because we had lost everything we had...

Emily: 3, 29-32

Similarly to Jackie, Emily seems to consider that life was difficult for her mother and that she was preoccupied with serious matters. This suggests that Emily, too, may have experienced a lack of maternal attunement and felt separated from her mother as she watched her plight from the sidelines, and may have considered that any emotional or general problems she might have could not be shared with the mother for fear of overburdening her. Her tone of voice sounded exasperated when she recalled how much more her mother had to do than her father.

I don't know, she had so many things to do and my father couldn't ...just to keep the food on the table

Emily: 6, 15-16

Emily seems to believe that her day-to-day existence depended on her mother, and that there was no financial or physical support from her father. There seems to be a clear link between the ever-busy mother that Emily perceives and Emily's aforementioned comments about difficulties in communication with her. This may have left Emily feeling that not only was her mother unapproachable, but much of the time she was also unavailable, too.

The impressively busy mother, trying to make financial ends meet, also features in Scott's account.

See, mum used to go, mum always had to work. Dad, never. So, then after going to work, she used to come home and start work again because she'd have to cook dinner for everybody and do the washing and ironing and all that. And with the old man being ill, even though he was there all the time, I mean I never went out and kicked a football around with my dad or anything like that. So, I don't even know what I'm trying to say, d'you know that? She was just busy, most of the time, mum, mum, and then she used to like, go to Bingo, after she'd done all that. So a few times, we used to get left with T [his brother] and he was a right bastard to us when we were kids.

Scott: 5, 15-22

Scott's mother appears to be out of his reach, her time consumed by tasks. When Scott points out that, after doing her work and her chores, she then took herself off to Bingo, this suggests that Scott may have felt he had little opportunity to connect with his mother mentally, depriving him of the chance to feel intimate with her and to deepen his understanding of her. He may also have experienced a sense of abandonment, wanting to be close with his mother at the end of the day and instead being left with his brother T, who mistreated him. Again, one can hypothesise that, while Scott's mother may have been tending to his basic needs (food and clothes), she may have had neither time, energy or inclination for meeting his emotional and proximal needs.

Here Peter begins by sharing his perception of how he and his mother were often together, but not interacting or sharing quality time.

I remember going to, you know, with my mum when I was four or five and she went to clean an office and I went with her

Peter: 1, 28-29

Apparently he was frequently in his mother's company as a young boy, but merely accompanying her (to her work) rather than spending intimate time together.

John's account is strikingly similar.

I remember mum taking me home cos she'd do, like, two jobs and then something while I was at school, you know what I mean, yeah? So I remember getting up sort of early and she'd do cleaning, you know what I mean, like office cleaning? So, like, we'd be out, I should imagine, sort of like 5-ish, I imagine, yeah. I remember waking up, like you know, to move on to another factory, yeah and then, er... waking us up to go to school sort of thing...

John: 1, 26-28; 2, 1-3

John describes accompanying his mother to her many demanding jobs, but this does not seem to translate as 'togetherness'.

Thus these accounts appear to show a pattern of the mother being near, and yet far from the child in respect of mental attunement, communication and togetherness. A lack of interaction and quality time appears to feature, and the child appears to find in their mother's work demands a reason for their lack of intimacy when they are together. Indeed, the notion of the mother's independence and emotional distance may evoke fear in the child and lead to anger that the mother does not meet their needs. Expression of anger, however, appears to be perceived as risky for the child, as the next section will

show. The child may struggle to reconcile wanting proximity with being unable to achieve it, and the lack of contact and connectedness with the mother seems to make it difficult for the child to attune and embrace an accurate reflection of themselves. Such a lack of emotional history with the mother could have significant effects on ego development. Lack of mental attunement in childhood, if extended over many years, has been shown to be detrimental to long-term psychosocial functioning (Collins and Stroufe, 1999; Allen, McElhaney & Land, 2001; Hennighausen et al, 2004).

Sub-theme 2C: Mum-pleaser

The final sub-theme within the second superordinate theme, surrounding the mother-child interaction, explores how the child feels in relation to the parent's own emotional state. In many accounts the narrator appears to feel that their mother had to be protected from the child's problems because she had enough to contend with. However, moving through these quotes there is a growing sense that the child adopts a 'mum-pleasing' strategy in the hope of earning the mother's love and approval. I do not consider this the behaviour simply of good-natured little citizens, but as a survival strategy for the child. Apparently sensitised to the tensions within the family home, the child intelligently computes that being perceived as a nuisance is an unwise strategy. Thus the child appears to embark on a strategy of procuring love and approval by being seen to be good in the eyes of the mother. Jackie's quote illustrates this.

I think as well, it probably just felt a bit indulgent telling her after [my suicide attempt], you know, it's like well, why would I tell her that? She knows I'm hideously depressed anyway, what's the point of telling her that? Like, see? See? That's how depressed I am, you know. And I didn't want to upset her, you know. So I didn't [tell her]...

Jackie: 31, 11-15

Jackie recalls her teenage attempt at suicide when she was staying away from home, maintaining that she told no one about it, even her mother. She seems to think that

confiding in her would have been futile, as if by confiding in someone something has to be proved. She refers to being depressed and her mother's knowledge of this, yet this might suggest that her mother did not appreciate or consider important the level of her depression. Tellingly, she ends on a note of not wanting to upset the mother, which amply illustrates the mum-pleasing mentality. This may reflect her adolescent belief that to internalise her upset and her mother's behaviours was the most effective means of sustaining some maternal attention and involvement without jeopardising the relationship.

Jackie appears to have felt that her mother had sufficient burdens and that her daughter's worries on top of her own would be too much to bear. Thus, Jackie may have feared her mother's disapproval or even rejection. However, Jackie's tone suggested to me that there was also anger beneath the surface of her account. This anger may never have been directed at the mother, for fear of rejection. Jackie seems to be attuned to what she perceives is her mother's perspective, yet real attunement requires mutual communication, which appears low in this case; perhaps making it difficult for the child to mentalise (take in the mother's perspective). Maternal attunement and supportiveness in adolescence have been shown to have important implications for relationship security – the lower the attunement, the more likely the adolescent is likely to feel insecure and to experience difficulties in forming relationships with others (Allen, McElhaney, Land, Kuperminc, Moore, O'Berine-Kelly and Kilmer, 2003). This lack of attunement with the mother may be strongly linked to the first superordinate theme, relating to perceptions of the self as an outsider and difficulties in socialising.

The notion of keeping the peace by internalising conflicts and not wanting to upset the mother figure (mum-pleasing) emerges again in Helen's account. It suggests that Helen may have found it difficult to cope with her mother's disapproval or negative mood. Alternatively, she may have felt that her mother's depression (referred to elsewhere in her account) influenced her decision not to bother her mother with her own worries, which she may have perceived would result in maternal withdrawal.

I just didn't want her to be in a bad mood with me. I wanted things to be nice so I just kept things to myself...

Helen: 13, 11-12

I have been a people-pleaser in life. I have noticed that. Um, when I get angry, I can't express myself as most people ... it just comes out. I do find it hard sometimes to say no to people...

Helen: 13, 15-17

Here Helen uses the term 'people-pleaser', which suggests that she may like to keep up appearances, and cannot allow others to see her as she thinks she really is. This is a theme that Powell describes in his work "Why am I afraid to tell you who I am?" (1969). It may suggest that in Helen's inner working model of relationships she views herself as responsible for maintaining calm and harmony. Hence, she bites her tongue and holds back anger in case it is viewed as unpalatable by others. As in Jackie's earlier account, there is a reference to anger – this time explicit. Helen seems to suggest that sometimes her anger does overwhelm her and spills out. This may imply that Helen has a limited menu to select from when trying to communicate her emotions. If Helen generally felt unable to communicate and express how she was feeling to her mother, on occasion she may have displayed an aggressive outburst which made her mother regard Helen as a difficult teenager. This might perpetuate the maternal distance that Helen earlier referred to in her narrative.

To conclude this mum-pleasing theme, here is a short extract from John's interview where he appears to be explaining to me why he did not feel he could share his worries with his mother, and sheds light on why he may have felt it was important not to antagonise or upset her.

J: Never really seen her cry, er... She always feared the worst, I mean with me, she always feared the worst, you know what I mean ... you know, there's a knock on the door from the police, she used to sort of pray like...

R: And before drugs? Was that something you saw in her personality, that she was a worrier or quite anxious about things?

J: Yes, she does, you know, she's always been a worrier. Like me, that's another thing we've got in common. I tend to worry a lot, you know? But not openly, you know what I mean? It sort of goes around and around in here [points to head]...

R: When you say not openly, do you mean you wouldn't necessarily share your worries with other people, you would kind of deal with them yourself?

J: Yeah, yeah. We're both sort of like that, you know what I mean...

John: 17, 31-33, 38-40; 18, 3

Researcher: 17, 36-37; 18, 1-2

This extract is notable for the comparisons that John draws between his own and his mother's coping styles. Describing them both as worriers, John may have felt as a child that he could not relay his worries to his mother when it seemed clear to him that she had so many of her own. It would appear that his mother's anxious and worried behaviour was a feature of his childhood prior to John's teenage delinquent behaviour and drug use. Bearing in mind that John has already referred to his anxiety about being home alone for long periods, this learned behaviour of worrying but not sharing may denote a child who may have felt he needed to be resourceful and self-sufficient, and act as an emotional container for his own and his mother's worries. This is in the spirit of Bion's (1959) concept of containment.

Throughout this second superordinate theme (I wanted an ordinary mum and got Supermum) we see the child perceiving difficulties in the accessibility and availability of the mother. The mum-pleasing behaviour seems to arise as a response to children's awareness of the mother's heavy load (work and emotional), with the child attempting to fix things by behaving well, believing that this is a safe strategy that is unlikely to produce ruptures in the relationship. We can hear the child's need for communication and a desire for maternal attunement, but the mother appears unable to respond or is oblivious to the child's cues, thereby depriving the child of the epistemic space to evaluate the mother's strengths and weaknesses instead of, perhaps, idealising her to a degree. Thus there may be limited opportunity for the child to see itself reflected back through the mother's eyes, and to build an emotional and interaction layering over time. This may lead to feelings of isolation, low esteem and confusion to the extent where, as teenagers, they question who they really are. And this is the third superordinate theme.

2.3 Superordinate Theme Three: My search for a new, improved sense of self

This third superordinate theme explores the concept of self-perception. It attempts to capture how participants now perceive how they were as children, how fragile their sense of self appears to become in their teenage years, and attempts to reinvent themselves through a process of increasing self-reliance and self-soothing to combat feelings of inadequacy and vulnerability. There seems to be considerable negative self-image flux among these individuals, with negative self-perceptions abounding and only a few positive beliefs about themselves in early life, which appear to dissipate swiftly. As they enter puberty, they appear to swing towards greater insecurity and often engage in 'bad behaviour', perhaps as a coping strategy, to deal with feelings of conflict and uncertainty – the metaphorical 'hole in the soul'. This coping response may constitute an attempt to escape their negative feelings, and this is where drugs begin to play a major role. However, rather than freeing them from their negativity and allowing them to forge a new sense of self, engagement in drugs results in considerable dilution of these individuals' already fragile egos. This journey culminates in the negative self-image of an addict. In effect, their journey appears to represent a self-fulfilling prophecy ('I

believe I have low value, I take drugs to relieve this negativity and I end up being worthless in the eyes of others'). Within this superordinate theme there are three subordinate themes.

Sub-theme 3A: Good kid turned bad

This sub-theme explores the change the child seems to feel in moving towards puberty and adolescence. Participants appear to perceive themselves as good and well-behaved children, even skilled – especially when comparing themselves with their siblings. They appear to have been both able and applied at school until a shift occurs around the time of pubescence. For some, there was clear ambition in young childhood about what they wanted to achieve in later life, and a modicum of self-belief. This seems, however, to have been diluted or got lost along the way as they became teenagers.

We begin with self-perceptions in early childhood, when individuals seem to think they possessed talent and real potential to achieve.

I was a good student, my brother wasn't interested, my sister not that much, and I was a really top grade student and I wanted to be a doctor, since I was four years old...

Peter: 3, 31-33

Peter seems to think that he was a strong scholar. The theme of intelligence and comparison with lower-achieving siblings chimes with some of the other participants' accounts. Peter refers to a desire to become a doctor, which was to fall by the wayside as his drug habit took hold.

Emily appears to believe that she also possessed a talent, and had a dream of becoming a professional dancer.

I had the dream of dancing... since I was five. I always regret not dancing. I should have gone to a professional school and you know, have a job, not being famous or

anything ... everybody knew that was my thing, everybody recognised that and I even said I would go to the [dancing] school and I tried to, but that was, you know, in a different family [if my family had been different] where there weren't all these problems all the time...

Emily: 17, 30-36

She claims that she and others regarded her as a talented dancer, and she perceives that without some of the family problems she might have been able to pursue this dream. She delivers this quote with passion and animation, but her tone quickly disintegrates towards the end of her comment to resemble fatigue. This may reflect how Emily may have felt as a child – that the family problems were insuperable and that her life might not turn more positive.

Scott describes having some ambition as a young boy, and how it seemed important to have a strong identity and social recognition.

When I was younger, I always thought I'd do well, to tell you the truth, I did. I always thought I was gonna do something meaningful and proper where everybody would know my name. And then, I suppose when I got ill and I got a bit bigger [that is, fatter], I lost a lot of security, I felt quite bad about myself...

Scott: 22, 21-24

He seems to note a turning point in his confidence level following his illness and weight gain and this may have affected his sense of self, resulting in poor self-esteem. It may be that resultant feelings of inadequacy were responsible for his being drawn towards a youth criminal fraternity (explained elsewhere in his account) that he could identify with (perhaps other social 'misfits' who made him feel less like an outsider), in contrast with the school environment to which he no longer seems to have felt he belonged.

John, too, seems to regard himself as having been a capable boy at school, and indeed appears to believe his mother thought he would continue with his studies.

I mean I got an education, I know she was [my mother] upset cos the school wanted me to stay on and take O-levels but I was already working then, you know, I was bunking off school and working when I should have been at school, yeah? And um, obviously it's the same with anything, but with hindsight, I wish I'd took them, because the teachers thought I had a real chance of passing...

John: 16, 26-30

Despite acknowledging his mother's disappointment, he seems to have thought that earning his own money rather than staying on to complete his exams as a teenager was the most appealing route, perhaps because he could consider himself the same as this aforementioned social group and identify with it, rather than being seen as the boy who stayed home and studied. The long periods of staying home alone as a young boy may have made John hungry to socialise with a group that he felt did not pose a threat to him and gave him a chance to feel part of something and be seen as a someone.

Another feature of this sub-theme is the idea that the child thinks they need always to behave well and be seen as good in the eyes of others. This relates back to the previously mentioned notion of being a 'mum-pleaser' in the hope of procuring love. The good behaviour seems to diminish around the age of puberty, however, when there may have been accelerated self-image conflict, leading them to experiment with alternative behaviours and delinquency – as the following few quotes show.

Helen amply captures this notion of the 'good girl'.

I got the idea that I was on the whole well-behaved, I was supposed to be intelligent, blah, blah, it was like somehow I didn't want to blot the copy-book, they [my parents] got

this idea that that's who I am, then I can't destroy it, I've got to live up to that...

Helen: 13, 23-26

Helen seems to regard herself as having been well-behaved and intelligent as a young child. However, she moves on to describe having to live up to her parents' expectations of being the good, clever girl. She may have felt a sense of obligation or pressure to be someone she perceived her parents wanted her to be, rather than someone she felt like inside. This illustrates the earlier theme of mum-pleasing, and suggests that she might have been experiencing conflict at this stage, feeling that she must be good but wanting to try and experiment with new things and discover more of herself.

She goes on to present a clear image of herself as a model citizen until she reached a pubescent turning point.

I was so well-behaved, I was good. I never talked in class up to about the age of ten, eleven and then I remember at the age of eleven getting into trouble at school, this was the last year of junior school. Um, I can't say there was one particular incident but it seemed to be around that time of my life that I suddenly didn't feel close to my mum, so I don't quite know what changed... not quite sure, but as I say, I divide my childhood into pre-puberty and post-puberty and there was a marked difference [in how she felt about herself and her mother], you know, between the two...

Helen: 20, 7-15

Helen seems to think that at around the age of eleven there was a major change in her relationship with her mother, which appears to coincide with her getting into trouble at school. This may relate to the child's conflicted self trying to navigate puberty and unconsciously seeking the mother's support. It would appear that at the important stage of early puberty, when her relationship with her mother was important for her development, she perceives that it changed for the worst and they moved further away from one another.

Trying to be good all the time may have taken its toll, especially if the child was experiencing tension and insecurity in the home. The good behaviour seems to have become contaminated with bad behaviour, and may in part be a response from the child to feeling distant from the mother, or reaching a stage of emotional vulnerability that may have felt difficult for the child to manage, perhaps prompting an unconscious need to project these conflicts onto others. This may be Helen's way of 'acting out', in the absence of a goal-corrected partnership with the mother, in order to gauge her mother's interest and love for her – an unconscious test to see how she responds. Autonomously acting out, however, can exaggerate insecure feelings and lead to more dysregulation in behaviour, as Marsh, McFarland, Allen, McElhaney and Land (2003) posit. Thus, the child fails to feel any better.

Scott, too, thinks of himself as the good child who turned bad.

...to tell the truth, I was a good kid up until I started not going to school [after a year-long absence due to illness] and then cos I had nothing to do, I started shoplifting, you know, and all sorts of other shit and just getting up to all things that they [his parents] still never knew about until I was sort of fifteen...

Scott: 6, 29-32

Scott's absence from school may have increased his feeling like an outsider and made him feel vulnerable. As an older child taking special lessons, with his former classmates having moved ahead and left him behind, he may have felt like a misfit. Again, it may be that Scott needed more emotional support at home; but, as he has already outlined, his perception seems to be that his mother was far too busy and the tough emotional stuff was not discussed in his family. The remark that his parents had no knowledge of his early life of crime until he was much older may suggest a distance in Scott's relationship with his parents.

Jackie appears to attribute her deteriorating behaviour to her difficult conditions at home at the hands of her father, and to not feeling adequately supported by her mother. However, it is noteworthy that Jackie 'keeps up appearances' until she leaves school at sixteen – unlike the other respondents, who seemed to acknowledge a deterioration in their behaviour from around twelve years old.

Looking back, I think, fucking hell, we were really fucked up, you know. The other one [her brother], he got one CSE. I did better. My noticeable bad behaviour, that was another thing that pissed me off, my noticeable bad behaviour that came to the attention of my parents, that didn't happen until I'd really left school, you know...

Jackie: 19, 13-18

Jackie seems to feel outrage that, having been a good girl for so long and in comparison with her brothers, she was then branded as badly behaved (by her parents) after she had left school (at 16). She mentions elsewhere that this bad behaviour came to the immediate attention of her parents, because it was delinquent in nature. It may have been that school presented enough of a structure to keep Jackie focused and stable, but once she left school and perhaps perceived that she was without boundaries, she felt anxious and unable to rely on her mother's protection from her father. The deterioration in her behaviour may have arisen from feelings of greater isolation and disorientation after leaving school, and this could constitute 'acting out' of unconscious conflicts and feeling she had no permission or repertoire from which to formulate emotional expression of how she was feeling.

We now reach a stage in the analysis where individuals begin to examine their challenging behaviour and consider whether they perceive blame can be apportioned to them or to others for their movement towards a drug-addicted lifestyle. The conclusions seem to be mixed: acknowledgements of responsibility, but also recognition of influences in their early lives that may have led to the negative self-perceptions.

Peter seems to think he is to blame and that he subjected his family to his drug addiction lifestyle. This is characteristic of Peter's general disposition throughout the interviews.

I'm the one to blame. That's how I see it. I'm the one to blame because I'm the one who did it [drugs], nobody else, you know. I'm the one that brought into the family that big thing that affected my brother, my sister and everybody else. I'm the one...

Peter: 7, 9-12

He directs no blame towards anyone else. His introspection finds fault and self-attribution of blame for things going wrong in his childhood. Peter may have an inner template that acts like a default setting to internalise blame and shame – just as was seen with his experience of enuresis, which he appeared to label as abnormal and defective.

Conversely, Jackie does show some ability to recognise factors that could have influenced or shaped her sense of self. Her anger surfaces again as, without prompting, she considers her parents' roles.

Yeah, she's got to shoulder some blame, yeah her part to blame for part of it. I don't want to be oh I had a shit childhood so that's why I took drugs, I made those decisions. But you know, they're formative years, the way you think about yourself, feel about yourself, it's an important time, you know and you can really make the wrong decisions if you don't have a good time...

Jackie: 22, 18-23

While apportioning some blame to her mother for not removing her from an abusive situation, Jackie also points out that she admits that she made wrong decisions and that blame also resides with her. However, she angrily rationalises that her early life may have shaped the decisions she made and influenced her path in life. It appears Jackie perceives that her low self-esteem as a teenager could have been influenced by her unsatisfactory home life, but does not hold it entirely to blame. Her anger may be a

reflection of dissatisfaction with her mother. Her inability to disengage her own blame may relate to earlier references of mum-pleasing. She may feel that she cannot fully acknowledge the mother's negative effects, because this might make her face the unpalatable truth that her maternal relationship was not her idealised one of intimacy and emotional fulfilment. Elsewhere she has referred to her maternal relationship with her mother as being one of 'great friends', although she seems to struggle to provide examples of how this 'togetherness' manifest (see Appendix XVII for additional quote number 37). Admission of any shortcomings in her relationship would thus destroy a psychological defence. I was reminded of Jackie's earlier disclosure of anger towards her mother for failing to stop her being abused, and of the unanswered questions that left her so confused.

Sub-theme 3B: Turning towards self-reliance

The general flavour of this second sub-theme is of lost childhood opportunity, and of the child trying to cope with rising discomfort. While there is some recognition of their early life shaping their futures, these individuals seem to have reacted to a difficult home life and feelings of vulnerability during adolescence by unconsciously 'acting out' and engaging in bad behaviour. However, this may not have alleviated their uncomfortable feelings or produced the perhaps longed-for response of more parental emotional engagement with them, and may have pushed them towards a more self-reliant strategy to combat these negative feelings about themselves.

This sub-theme examines how participants respond to uncomfortable personal feelings and their perceived dissatisfaction with family life. There is a strong sense of searching for an improved sense of self in their teenage years that might enable them to feel free of their perceived constraints. This is also reflected in the preceding sub-theme, 'good kid turned bad', where quotes describe a change in behaviour. The perception of the self in the present section evokes a multitude of conflicting dimensions, and it appears that this inner conflict may be growing in strength at a time when the teenager feels isolated and

conflicted about the mother, in a way that makes the teenager feel they want to escape. This leads them down a route of cultivating extreme self-reliance.

With apparent emotion in his voice, Peter eloquently paints a picture of his teenage maternal conflicts, a period he seems to have loathed.

I had horrible teenage years, which I remember them as negative to me. Teenage years were very negative to me, but it's because, you know, Mum was, you know, she could have been a bit more sensible. Yeah...

Peter: 20, 29-32

Peter is forthright about the discomfort he felt during his teenage years and how he cannot recall them as anything other than negative. It may have been that he felt he was battling against his mother to assert any sense of autonomy. He has referred elsewhere in his narrative to the drama of his mother's emotional outbursts (see Appendix XVII, quote 42), and here again he seems to reflect that if only she could have behaved a little more reasonably (that is, communicated empathically), he might not regard this period of his life so negatively, or have felt the need to search for alternatives.

John's account introduces the idea of searching for something new and walking away from an old sense of self.

I started [aged 12 or13] like listening to other people that used to say if you put an aspirin in Pepsi, right, you'd get drunk, right? So I tried that. I'm a, I would give anything a sort of go...

John: 39, 8-11

As an experimental teenager, John appears to have been prepared to try anything on anyone's recommendation – particularly if it involved getting drunk or perhaps making him feel different and more positive. This may have constituted something of an

unconscious escape strategy, to make him feel less in touch with tensions in his day-to-day life and any uncomfortable feelings and anxiety.

John also turned to violence, perhaps both to vent his anxiety and to forge a new sense of self in which he felt more positively regarded. Violence, after all, had been something he regularly witnessed in his home (elsewhere he has referred to witnessing frequent domestic violence), and so he may have felt that it was acceptable to employ violence.

I would beat on people. I would fight [aged 15]. Because I found if you were the toughest you got respect, you know what I mean, whether it be artificial respect or whatever. I find if you was viewed as the hard man, that's what I would become but I used to exact a lot of violence on people, you know what I mean? Over-the-top violence, you know? So people would think, oh bloody hell, he's nuts, like I was mad, crazy, yeah? Because like if we're gonna fight, it gives you confidence, if people are going to mess with you, people wanted to be, whether it be artificially your friend, they wanted to be in your company, because some of your glory would rub off on them, cos they knew you and everyone knew not to mess with you... You try and bite someone's ear off, or their nose, or whatever, you know what I mean?

John: 36, 15-25

John's description of how he used violence to cope with his teenage years seems to represent a means of asserting himself among his peers. It appears that respect and being known were important to John, and he felt he should act in an extreme way to build up his notoriety. Such problem behaviours, including violence, have long been considered outward demonstrations of anger and distress – a maladaptive way of coping, as described by Blatt and Homann, (1992). This could be considered as a form of escape from the person that John felt he was (and perhaps disliked) to become the person he felt he would like to be known as in his teenage years.

His use of the word 'artificial' twice during this quote seems to imply that John was aware that this newfound respect and friendship were only superficial. This may have meant that many people knew him as a teenager, but that he still had very few or no real friends. Given John's references elsewhere to the absence of socialisation with other children (outside of school) as a boy (see Appendix XVII additional quote number 4), superficial friendships may have felt acceptable to John, as being better than no friendships. Indeed, it may be that he was comfortable staying at a superficial level with others because that was his inner working model of relationships, as he has outlined in his descriptions of his maternal relationship.

Helen portrays an image of a teenager so uncomfortable in her home setting, and perhaps not knowing how to relate to her family, that the first thing she seemed to prioritise as a teenager was leaving home.

When I was a young teenager, you know, we weren't really that close [her and her mother], I was quite a rebel by that stage, so I left home at sixteen so that was the end really. I used to see them [her parents] obviously, but not a lot...

Helen: 3, 14-16

Helen describes herself as a young rebellious teenager and she appears to have craved some independence, resulting in her leaving home at sixteen. Elsewhere in Helen's narrative she describes being keen to leave home and assert some independence (see Appendix XVII for additional quote number 43). Throughout her narrative, she has not described a harsh, rule-laden environment where she had very little freedom – in fact one could interpret it as being the opposite. Yet her words here suggest that the teenage Helen perceived herself as not having enough freedom, and that this created a tension for her, with her mother, culminating in rebellious feelings. Her use of the word 'obviously' might just mean that visiting one's parents is the conventional thing to do in her social world.

Thus, it leaves us to consider whether emotional nourishment and security are things that Helen wishes to believe were in place, and unconsciously defends against the notion that they were not. She may find it difficult to acknowledge her own emotional needs. It may also relate to her having normalised security as the meeting of her basic needs rather than robust emotional maternal support. Her rebelliousness may have been an unconscious way of trying to evoke a response from her mother – whom she has already described as not being close to, and towards whom she felt hostility that she could not show. It may be that Helen effectively gave up on the idea that she could be close to her mother, and may have believed that she needed to make a new life and find a new, self-sufficient image that she could feel more positive about.

The tensions at home that these teenagers seem to have experienced appear to have been so acute that they hated this period in their lives, and seemed to be attempting to find a way to grow and develop – sometimes channelling their frustration into rebelliousness or aggression. They appear conflicted about their sense of self, and it appears to be their perception that their family life was not supporting a phase of ego development and autonomy. Experimentation seems to be a direct response to feeling trapped and confused about their sense of self, and the considerable negativity they held about themselves. One is left with an impression of an individual looking for a way to escape, eager to move away from an old sense of self.

The second element in this sub-theme on self-reliance relates to whether participants felt they could depend on others from an early age or, despite their childhood tensions, they needed to rely on themselves and cultivate self-reliance, because others may have proved impotent and failed to read their distress calls. The next quotes relate to emotional support and problem-solving.

We can detect a strong sense of having to cope as Scott presents a clear image of self-reliance.

I never really thought about how I coped [as a teenager] or anything... You got to. And if I don't cope [now], I'd rather just give up and go back on the gear or whatever, d'you know what I mean? So you gotta cope. Everybody has to, it was not just me. I don't think it's no different for me...

Scott: 17, 6-10

Scott refers to feeling that he has had to cope all of his life, a belief that appears to continue today. He normalises this childhood strategy, perceiving it as the same for everyone else. Swinging between past and present tense in his narrative, he seems to be indicating that as a teenager he felt he could not cope without drugs (the reference to heroin - 'gear') and now, as a mature man, he perceives that he must cope without them. His expression "I'd rather just give up and go back on the gear" seems to be located outside his conscious recognition of drugs as a coping strategy, which is of particular interest. Scott may be unable to make the connection between drugs and coping with feeling alone and vulnerable, and he may be referencing his anxiety about coping in his world without drugs. However, there is no mention of his having relied on anyone else for support or to help him to cope as a teenager. Scott may have felt isolated for most of his life, and so, as a mature man, does not view this as unusual. This is reflected in his next quote.

I tried to take everything on my shoulders and don't ask for help from anyone, um, didn't talk about my feelings to anyone at all, and how I get on with everybody... And I got a quick temper...I shout a lot...

Scott: 27, 8-10; 12

Scott seems to feel that in the past he could or should not ask anyone for help, and that feelings were best left undiscussed. Elsewhere in his narrative this strategy also extends to his long-term partner. It may be that Scott developed a quick temper and aggressive dimension to his behaviour as a defence mechanism against his underlying anxiety. He may often have felt overwhelmed at having to cope with his feelings on his own.

John echoes these sentiments of having to cope alone and rely on himself.

I've always sort of sorted things myself, you know, like, I've never, um, er like mentioned anything to anybody else, you know what I mean? And it's only in the last few years that I've started opening up a bit... But other than that, I was brought up to cope you know...

John: 18, 17-20

John seems to think it is his responsibility to sort out his own problems and to keep them to himself; this is his coping strategy. Now, as a man, he reflects back on how this self-reliance has modestly changed in recent years, but even as he admits this he sounds awkward and uncomfortable. Being alone and isolated as a young child while his mother worked, as quoted above, may have accustomed John to dealing with his own problems and relying on himself rather than others. What may have served him as a useful childhood strategy may have hampered his ability to develop trust and trusting relationships later in life.

Emily captures the idea of needing someone to help navigate adolescence but there being no one to trust and reach out to.

I was just trying to look after myself [as a teenager] and I don't know what it was, now sometimes I think maybe I needed a support around, a mentor around... living in my house, you know... I think I wanted to do too much by myself...

Emily: 24, 22-25

Emily seems to feel that her teenage years were a struggle. She seems aware that she felt that she had to cope on her own, but that this was difficult and that a 'significant other' in her family life could have eased her burden of responsibility. She acknowledges her teenage desire to do her own thing, but in being allowed to, or at least not prevented from doing so, she may have felt adrift and alone in the world. Her notion of a 'mentor' may imply that what she craved was not so much independence, as her mother may have

thought, as dependence and to feel safe and secure as a teenager. 'Mentor' may also imply that Emily had despaired of receiving any help within the family and felt she had to seek it elsewhere . Emily seems to have been looking for a positive change in her young life, and felt that it depended on her to instigate it. We can share Emily's hypothesis that she may have felt this due to the absence of someone she felt she could rely on at this point in her life.

The light that this sub-theme throws on self-reliance is the child's need for contact, reassurance, stability and demonstrable love. I note a clear strategy of self-sufficiency in these individuals, and argue that this comes from a normalisation of unmet emotional needs, leading to a struggle with their sense of self. They appear to grapple with life, and their self-image does not appear to be of the 'robust coper', able to take life in their stride, but one who feels vulnerable and that they somehow have to cope with what life throws at them. With the passage of time, the child's perception of emotional distance becomes increasingly a reality, and it may be that this leaves the child questioning why they are unlovable, or not loved differently and more positively.

Sub-theme 3C: The transformative power of drugs

In this final sub-theme, the analysis attempts to build on the feelings of being the outsider, difficulties in communicating with the mother and teenage ideas of escape and sense of self-quest, and explores how participants appear to achieve relief as they embark upon early heroin use. If, in their teenage years, individuals sought some form of escape, heroin seems to deliver it. In addition, the negative feelings associated with their former sense of self no longer seem to take centre stage. However, the burden of these narratives seems to be that using drugs does not constitute classic reward behaviour or thrill-seeking, but is interpreted here as a means of medicating emotional pain.

Scott describes the sense of relaxation he seems to have experienced from using heroin, of entering a comfortable, calm world.

It was just this, getting stoned. It's like when you have a drink, I suppose. You probably like having a glass of wine at home when you finish, to chill out and relax. It's the same thing, just stronger... Not thinking about anything... when I started it [heroin, at the age of 16], it was this little world and then you got accepted into it...

Scott: 18, 17-19, 25; 19, 1

His references to not thinking appear to relate to heroin's ability to slow everything down and to push things out of and numb his mind. Importantly, he describes the feeling of acceptance into a kind of heroin club – perhaps a metaphor for much-desired maternal acceptance and warmth. This may have been the first time that Scott had felt a real part of anything and had not considered himself an outsider, as he had done for most of his life.

Jackie paints a cogent picture of contentment and being worry-free, analogous to the feeling one might experience after the administration of anaesthetic prior to surgery.

It's hard to describe [taking heroin] but it's just that overwhelming feeling of contentment and warmth and it's odd, you know, it doesn't put things to the back of your mind, they're gone, you know, and like I say, it's very pleasant, you know? It's very pleasant, it's warm, it's cosy, you know, it's not like getting hammered or doing loads of buckets or getting pissed. "Oh fuck when I sober up I'll have to deal with this". It really felt like, this is it, this is it, you know. I can't remember what I was looking for.

Jackie: 20, 5-12

Jackie's early heroin use seems to revolve around comforting sensations and erasing one's memory – albeit temporarily. She seems to think that heroin did not just dilute her anxiety but, for a time, actually took it away. It may have given her a liberty she had hitherto not experienced, by allowing her worries to be temporarily erased and her anxiety quelled, and to feel better about herself and her life. The calming sensation appears so strong for Jackie that, after using drugs, she could not recall what she had been

looking for, and it no longer seemed to matter. Heroin appears to represent a self-soothing strategy for Jackie, and perhaps also the feelings of maternal dependency that she unconsciously felt she had missed out on in earlier life.

Importantly, Jackie reveals why heroin use was a natural choice for her, because of its associated sedative qualities, producing feelings of warmth and contentment rather than the extreme highs and feelings of being energised – even turbo-charged – that is associated with stimulants.

Just feeling better, feeling happy... Yeah, yeah, it's odd, it's like you know, if you're sitting in that chair and you're gouging out [heavily under the influence of heroin and sedated] and that chair and feeling like that was all you were ever going to have, then that feeling would be <u>just great</u>, you know. It's quite unique in that way. You know, I was <u>never</u> really interested in drugs like speed or coke or, you know, cos they certainly don't, you know they make your mind race and make you think...

Jackie: 20, 14; 19-25

Jackie's objective seems to have been to feel calm and, in a sense, to switch off her cognition, so she was not attracted to stimulants with mind-racing characteristics. This may imply that Jackie felt it was commonplace for her to be anxious and continually analysing – perhaps dwelling on problems she felt were insuperable. Thus she may have tried to assume a calmer, more carefree sense of self, and heroin provided the access to the on/off switch for her anxiety.

Peter explains how the negatives associated with initial heroin use were outweighed by the positives, allowing him to feel a level of relaxation he may rarely have experienced before.

There was something in it that made me just close my eyes and it was like a relaxed state that I hadn't had for some time. And even though it was hard [at first] because, my god,

*it was, vomiting and very very unpleasant, the feeling was very unpleasant but, you know, the numbness that it gave me, that was something that, that's the thing that really, that got me, even though, at the beginning, I went through you know, getting used to it. But yes, I felt numb... completely ... I mean, was it, was it as well, like peer pressure as well [*that *I was escaping from] with friends? Being shy and wanting to follow a group of friends that I had made?*

Peter: 13, 28-34; 37-38

Peter's reference to peer pressure may relate to his comparing himself unfavourably with other people. I was puzzled by the mention of peer pressure (negative) in the same breath as friends (positive), which may suggest Peter felt conflicted in his social setting – he may have felt under pressure to comply, yet did not feel one of the herd. Friends who were using heroin may have influenced his decision to try it, and may have made him feel part of a group, but thereafter heroin appears to have connected Peter with an inner peace which held a unique appeal for him.

When Emily uses the term 'belonging' here, it may be a metaphor for the warm feelings she had always sought from her mother but never felt she received, and the intimate friends she had tried to find. This links back to the first two superordinate themes in the analysis, regarding being the outsider and not being able to communicate with and attune to the mother.

The heroin is quite strong, it makes you vomit and you know, well... but it looks like it, yeah there was yeah, a feeling of belonging, something like that... it made me feel... well apart from the physical side of feeling warm and everything alright, it was probably something grubby...

Emily: 24, 35-42

Emily's accounts of using heroin as a teenager resembles those of other participants. Her references to a feeling of belonging are reminiscent of Scott's and John's references to

feeling accepted. Alongside feelings of calm, however, Emily notes her awareness of heroin's unsavoury characteristics ("something grubby"). She appears to have felt shame about her drug use from the outset. It may be that there was an absence of glamour in Emily's initial drug use, and she may have even felt cross at having to resort to such a measure to feel better about herself. To her, heroin may have been a 'last resort' in her efforts to cope with her inner turmoil. In a way, this may represent a feeling that her self-reliance was strained and that she needed some other source of support.

John seems to have viewed heroin differently from the other users. He also notes the allure of its sedative characteristics (elsewhere in his narrative), but here he seems to see it as a way of capturing the interest and potential friendship of others to achieve a sense of belonging.

Yeah, peers and like you know, I encouraged them to take it with me because I wanted to belong to something so I started my own sort of like member group so I would turn em on [encourage them to take the drug] because like I was getting gear (heroin) at the time, right, and I would sort of turn people on to sort of have friends, sort of thing, like I'd have my own little clique, I'd made my own little niche... So I had a place I fitted in, you know?

John: 34, 25-28

Drugs seem to have provided John with a powerful social tool, helping him overcome shyness and carve out his own group, inside which he may have felt a sense of community. It appears that John may have been calculating in his drug use, as it offered him an opportunity to make the friends he might otherwise have found difficult to find, due to the shyness and fears of social failure that he has referred to above. However, because of the nature of this drug (a sedative that is not an encourager of sociability and the anonymity that heroin addicts seem to prefer), it is questionable whether John felt he had acquired any real friends during this period.

An answer to some elusive questions is to be found in Helen's evocation of her teenage experience of heroin. It may be that drugs evoke the 'other self' that Helen sought throughout her childhood.

Oh euphoric. Wonderful. This is the answer to life. If I just take this, I can be happy every day. That really is what it felt like. Oh the answer to life, it was what I found, and it was absolute euphoria, oh, a wonderful feeling. Couldn't imagine anything going wrong, anything worrying me. Just felt absolutely wonderful...

Helen: 15, 22-26

Helen imparts a strong feeling of liberation, relaxation and contentment. When she spoke of not having to worry, I noted that she seemed immediately to reconnect with those earlier feelings of being carefree and calm. Helen seems to think that she had found a way to cope with her life as a teenager and its dissatisfactions. It may be that at that time she perceived that drugs vastly improved her life.

This third superordinate theme illustrates the sense of self-journey that is presented in these narratives[5]. While in early life participants dream and fantasise about becoming a doctor or a dancer, their self-belief appears low, and it undergoes further dilution as they enter a phase where their need for maternal closeness and their desire for independence are in opposition. Supported autonomy (supported by one's parents) does not appear to be perceived as an option, and results in individuals feeling distanced from their family and increasingly vulnerable. Thus the psychological structure built up in childhood and the coping methods used to keep anxiety at bay are placed under pressure on entering puberty, and individuals seem unable to respond to the challenge of adolescence. They try fighting back against this anxiety, but the strategy appears to fail them. And then they discover how this intense pain and loneliness can be medicated away.

[5] See Appendix XVIII for a summary of participant demographics

The feelings of liberation and relaxation so feelingly described in these accounts may represent a kind of pseudo-autonomy. Individuals may have felt that heroin, with its sedative traits, allowed them access to the 'other sense of self', one that felt carefree and may also have made them feel safe. Within the range of their relationships, heroin may thus have come to be perceived as more reliable and consistent than people. Instead of hovering between fear of life, fear of perpetual social judgment and maternal disapproval, heroin seems to represent a gateway to the positive feelings, which resemble those of the young child who seeks and achieves the emotional comfort of the mother – the opposite perhaps, of what they commonly experienced from their mother. Heroin seems to have allowed these individuals to dissociate, and it seems to have generated this more liberated sense of self. Finally, they had found something with which they could be intimate.

Discussion

1. Overview

This final section of the thesis concludes with a summary of its findings, elucidation of the central themes and theoretical explanation, and a consideration of the study's application to counselling psychology. I also consider whether this study has contributed to a psychodynamic understanding of the early lives of heroin addicts. I then contemplate potential avenues for future research.

I begin with a brief overview of this study's findings, and what seem to me the most striking insights. Overall, I am left with an overwhelming impression that heroin addiction takes root in people already strained and emotionally vulnerable, suffering from loneliness and a sense of powerlessness. Although participants may try to defend themselves from the damaging residues of their early lived experience, the emotional pain and unmet needs, and although their references are often tacit, the presence of those experiences is more than vestigial.

The media often portray heroin addicts as 'life's losers', or as hedonists who have chosen the 'easy option' of doing little and of self-indulgence, a somewhat parasitic existence. But I have found these participants sensitive and articulate; some of them once possessed drive and personal ambition, and all are fiercely self-reliant. They appear to be trying to cope, no matter how maladaptively. I sense that their maladaptation has developed in response to the belief from an early age that important others could not be relied upon to help them understand and manage their emotions. Society defines addiction as reprehensible, but this label is applied to people who, in this case at least, are already low in self-esteem; society's negative perception merely reflects the one they already hold of themselves.

The debate over nature versus nurture and their relative importance in relation to opiates is still controversial in research circles, as Goldberg (2001) notes. This study, however, is specifically interested in social factors that are experienced and revealed by participants. Furthermore, I adhere to the view that humans are primarily social beings, and that their behaviour crucially reflects their social relationships, while there exists an interlacing of multifarious factors (including social and experiential elements) that come together with varying degrees of force to turn a person into an addict. In short, findings from this study encourage me to believe that, for these individuals, their 'heroin career' began in early childhood.

1.1 Allowing the unexpected to emerge

During the analytic phase, the most exciting and challenging aspect was the risk of allowing the unexpected to emerge, to rein in foreunderstandings and instead think laterally. I grew to appreciate that my research might leave me with more questions unanswered than those with which I began the project, due to the enormously diverse and complex nature of heroin addiction. I believe I have managed these tensions, that I have allowed the data to speak for itself and that I have managed to embrace rather than fear the unexpected. I hope that I do justice to the guidance of other, more seasoned researchers in this qualitative field – to stay close to the idiographic content of the narratives (Eatough & Smith, 2008; Smith, 2007; Willig, 2001) – and that I have extracted the essential meanings of the narratives (Kvale, 1996).

There has been no greater surprise in this material than that presented by the forceful emergence of *mentalisation deficits* in this group of individuals. This had not featured in my thinking at the outset of the research, nor in my initial research proposal. However, as I waded through the transcripts and listened again and again to the interview tapes, I was struck by the power of participants' words when describing how they struggled with

the thinking and the perspectives of others, both with their mothers and in social contexts. This seemed similar to that which I had observed when working with borderline personality disorder patients (also associated with mentalisation deficits, as presented by Bateman and Fonagy, 2004, and drug addiction comorbidity (Casas, 2007)), and that which I detected and referred to in my *case study of Alan* (Section B). Consideration of this phenomenon and possible links to mentalisation led me to go back to the literature and investigate mentalisation theory further (Fonagy, 1991; Fonagy, Steele, Moran, Steele and Higgitt, 1991; Fonagy and Target, 1997), and to examine whether the phenomenon I believed I had uncovered matched that which is explained by leaders in this research area. This is comprehensively discussed in the section on Mentalisation, below.

Further surprises were the strength of participants' feelings about not fitting in or belonging to part of a family unit or social structure – being *the outsider*; and the turnaround in early adolescence in a formerly well-behaved and applied child towards more adventurous behaviour, culminating in self-image conflict and a deleterious pathway towards heroin addiction. Equally surprising was the degree of flux that participants seemed to express about their *sense of self* throughout their youth. Especially during adolescence, instead of their sense of self blossoming, participants were trying to build upon foundations that seemed too weak to support psychic growth and development.

Negative experience of emotional communication then culminates in intrapyschic 'holes in the soul', a sense of incompleteness and emotional deficit. This the individual manages by becoming adept at shutting down their emotional needs and cultivating self-sufficiency, often brushing with crime, violence and episodes of delinquent experimentation, particularly during adolescence. Realising that being constantly self-reliant is wearisome, and that it exacerbates rather than dilutes their feelings of

inadequacy and worthlessness, participants appeared to turn to something that delivered feelings antithetical to those they experienced in day-to-day living. A sedative substance such as heroin removes these negative feelings completely, seemingly transforming these individuals' sense of self, placing them in a warm and comfortable zone where – albeit temporarily – they feel disinhibited, safe and relaxed.

2. Answering the study's central questions

Three central questions were raised at the outset of this study:

2.1 How do participants describe their experience of the mother-child relationship?

The most eminent and ecumenical of researchers agree that human behaviour is a product of both biological and social processes – nature and nurture. This study chose to focus on the latter, to try to shed light on the analysis that evolved from participants' experience of the mother-child relationship. The ambition was to elucidate attachment issues in heroin addicts. What seemed to emerge were weak attachment representations, and degrees of dysfunction in this relationship. There is a clear picture of the growing child often feeling unlovable, and of having felt this way for a long time. Not only did there appear to be a notable absence of communication in these addicts' families, there was a lack of perceived permission to express their emotions in childhood. This was acknowledged above in the theme 'The unspoken, and unanswered questions'.

A second important wave of attachment importance for these individuals seems to occur during adolescence, when they search again for a secure base. This finding appears to concur with Hofler and Kooyman's (1996) postulation that 'addiction can be considered an attempt at attachment transition in adolescence when there is an alternative between relationships or addiction. The attachment needs are shifted to a drug, an impersonal object, an activity' (p.516). From a psychodynamic perspective, the communication void

referred to in their narratives between participants and their parents, and specifically their mother (as can be seen in superordinate theme 2, sub-theme 2A, 'the unspoken') exposes weaknesses in the child's sense of self. An object-relations deficit emerges, and some would argue that this is diverted to 'the needle as a transitional object' (Miller, 2002) in the case of heroin intravenous use, and that it plugs the emotional hole. As a patient once said to me, "the drugs don't let you down".

Without exception, participants began by speaking positively about their mother, many citing examples of her tending to their basic needs and reporting that their mother loved them – the notion of the 'good mother'. However, given space to reflect and voyage into their past, they began to paint this relationship from a broader palette. Feelings of anger, resentment and frustration towards the mother emerged, and disappointment in the maternal relationship surfaced – the notion of the 'bad mother'. Thus, reality and fantasy came head to head. The individual appears to struggle to reconcile this internal conflict, defending themselves against the idea that their experience of being mothered was less than ideal. This corresponds with the concept of splitting, and with Klein's theory about the good and bad breast creating conflict for the child (Klein, 1952). What seemed an important revelation was an apparent lack of emotional attunement, difficulties in maternal communication and a feeling of having been deprived of quality, intimate time shared with the mother. However, these references often seemed difficult for the individual to acknowledge consciously, and for every negative comment, a positive one appeared to be offered alongside to avoid sounding reproachful. I regard such conflicts, and the struggle for individuals to find expression as an account of participants' mentalising difficulties, and of an inability to appreciate the mother's mental state and thereby recognise themselves as reflected through her eyes (as noted by Winnicott, 1969). This mentalising difficulty surfaced prominently and somewhat consistently throughout the participants' narratives. (See the Mentalising section for a further discussion of this topic).

Readers might be concerned that I had indulged participants in post-hoc rationalising and maternal blaming. However, participants were not directed towards the attribution of blame – the theme was a natural element within their discourses. Indeed, participants were highly reluctant to blame their mother, and very quick to recognise their own misdemeanours and shortcomings; if anything, many appeared to idealise the mother, and make excuses for any deficits in their relationship. These findings are echoed in the words of Hinshelwood (1989) when he describes idealisation: 'When an object is conceived as primordially good then it is said to be idealised; good aspects of the object have been separated off, by splitting, followed by the annihilation (denial) of the bad aspects, and this gives us the illusion of perfectionism' (p.318). During the interviews, however, there was some acknowledgement that factors in childhood might have shaped participants' lives more than they had originally considered. The 'blame' in participants' minds appeared to be that attributable to themselves and their drug use, and they did not engage with the past and its influence. This appears to relate to participants having little conscious insight into early childhood factors that may have shaped their sense of self. I suggest that this is a line of unconscious defence by participants unable to tolerate, or even bring into consciousness, the notion of an unsatisfactory maternal relationship. This is reminiscent of Freud's (1914) description: 'the patient does not remember anything of what he has forgotten and repressed, but acts it out. He reproduces it not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating it ...and in the end we understand that this is his way of remembering' (p.150). For me, this defence echoed the repetitive action taken in seeking solace from heroin as a substitute for maternal attention and emotional nourishment.

It seems evident that this group of individuals exemplifies the avoidant child attempting to cultivate self-sufficiency to avoid rejection, as Bowlby (1991) described it; in the analysis it appears in the sub-theme of 'mum-pleasing'. Short-changed on intimacy throughout childhood, the participants may have turned to people-pleasing to invite

intimacy from the mother and ward off rejection or abandonment. Other researchers point to the drug addicts' fear of intimacy (Bartholomew, 1990; Kaplan, 1992; Thorberg & Lyvvers, 2005). From these narratives I would suggest that they seem to depict a struggle with ambivalence, recognising their own need to be loved but expecting rejection or a lack of satisfaction, and so they fear intimacy because they perceive the probability of rejection as high. So, their accounts appear to describe feeling torn about developing trust and engaging in intimate relationships (as we could hear throughout superordinate theme 1: 'I was always the outsider', and superordinate theme 2: 'I wanted an ordinary mum and got Supermum'), and they have become adept at quashing these emotional needs and relying on themselves, no matter how great the strain.

It was never part of the remit of this study to classify an apparent level of attachment insecurity in heroin addicts – avoidant, dismissive, preoccupied or otherwise. But what does seem clear is that participants have a negative sense of self, as others have commented on (Goldberg, 2001; O'Keefe-Dyer, 2004; Radford, Wiseberg and Yorke, 1972). This will be considered in more detail later.

Another strong feature of participants' narratives is that they appear to place their mother's needs above their own, making allowances for how busy and often emotionally troubled she was. In fact, the emergent pattern seemed to be one of choosing not to give voice to their own needs. This could be revealing an unconscious belief that there was no permission to do so, and that to have done so risked upsetting the mother and rupturing the relationship. Thus, the child adopts the role of mum-pleaser to avoid maternal rejection by behaving well and not drawing any negative attention to themselves and concurring with the views of Powell (1969).

In addition to their concern for their mother's feelings, participants were highly sensitised to the thoughts and feelings of others in social situations, with strong expectations of

rejection. This features strongly in this study's theme of 'the outsider'. When one considers habitual drug use in isolation, one might readily see the addict as self-absorbed and uncaring about others, as other researchers have reported (Brems and Johnson, 2006; Vasileva, Petkova, Georgiev, Martin, Tersiyski, Raycheva, Velinov and Marinov, 2007). Findings from the current study, however, suggest that these individuals may *learn* to care less, as a consequence of repeated negative experiences; and/or they may use drugs to conceal their futile attempts to please and the pain this generates, ultimately attempting to desensitise themselves to the perspectives of others. What does seem clear is that their attachment experience seems to produce persistent anxiety, and culminates in a very negative self-concept and a fragile ego, making them very wary of interpersonal relationships. This finding concurs with the views of researchers such as Habib, Rai and Mishra (2006) and Khantzian (1985; 1990).

Worries about acceptance and rejection are reflected in Freud's (1926) theory about anxiety and fear of loss or separation: the idea that the infant's state of helplessness and dependent neediness creates the need to be loved. Freud believed that this need accompanies the child throughout the rest of its life. In a healthy relationship, the infant lays down a memory trace, following the experience of the mother as helpful and loving, and so is led to expect the presence of a helpful, loving figure. However, if this care is absent or inconsistent the child may grow to expect disappointment and cease to look to have his needs met. While part of our human learning is that some disappointment is inevitable, it seems that the participants in the present study may have normalised repeated failure to emotionally engage the mother as part of their everyday experience. When Fairbairn (1944, 1952, 1958) refers to the importance of surviving these failures, he points to the coexistence in the maternal relationship of disappointment and delight. What these participants appear to describe is that delight was in short supply, and that they may have adopted the practice of trying to please their mother in an attempt to

sustain the little emotional nourishment they derived from the relationship, or to procure more of it, and as an antidote to much-feared rejection.

The common references to attachment representations within these accounts leads us to consider these individuals as never having had their emotional needs met. This is not a picture of outright maternal neglect or abandonment, but of the child being kept at arm's length, wounding their sense of self.

2.2 What characteristics of maternal and paternal relations in childhood present in heroin addicts?

What struck me most in respect of parental relations was the lack of cohesion in the parental unit that the child perceived, with the mother and father seemingly having oppositional styles and levels of involvement; in the Analysis section this is highlighted in both the superordinate theme 2, 'supermum', and the subordinate theme 1B, 'being treated differently'.

All the participants appear to have experienced their mother as the dominant force in the household, the one who made the key decisions, and the person of whom the child was conscious of seeking approval, as outlined in superordinate theme 2, 'I wanted an ordinary mum and got Supermum'. The mother was also difficult both to reach physically and to connect with emotionally (to sit down and talk through personal issues and problems). This was in part because of her busy schedule, but it may also relate to intergenerational transmission of poor parenting. If this is the case, then any parental lack of emotional understanding could relate to the mother having no clear idea of what their child is trying to convey; having had an unsatisfactory childhood experience of emotional interaction and mental attunement with their own mother, they would themselves have had no emotional repertoire to draw upon. This is purely hypothetical

on my part, as I did not design the interview schedule to investigate this area. However, continuing with this line of hypothetical thought, I suggest that it is possible that, because of the mother's history, her own child experienced her as difficult to know and understand, so that participants' opportunities to engage intimately and mentally attune with her were at best very limited. This maternal connectivity has been flagged as crucially important to the development of self-concept and ongoing socialisation by a host of researchers, such as Fonagy, Gergely, & Target, (2007) and Isabella & Belsky (1991).

In all cases the paternal role was experienced as considerably more passive, and the father's day-to-day input into family decisions and interaction with their children was limited and in some contexts, such as Emily's, virtually non-existent. In the experience of two participants (Jackie and Emily), the father had perpetrated abuse upon his daughter, and this may partly account for the very low opinion these women had of their fathers. While two of the male participants (John and Scott) recalled their father's involvement in domestic abuse, they appeared less influenced by this conduct when making any character judgments; nonetheless their relationships with their fathers were emotionally distant. Several researchers highlight a physically present yet uninterested father as a psychosocial factor that correlates with the development of addiction (Andersson, 1991; Chein, Gerard, Lee and Rosenfeld, 1964; Shelder and Block, 1990).

The contrast between the powerful matriarch and the less involved father presented an image of a rather emasculated male. While there appear to be problems of attachment quality with the mother, the father's role seems to do little to plug the emotional hole for these participants, and his behaviour often exacerbates the child's feelings of helplessness (specifically in the context of physical or sexual abuse) and leads them to wonder if they are unlovable.

Abuse is widely reported as highly prevalent amongst substance misusers (Christo and Morris, 2004; Sullivan and Farrell, 2002; Reynolds, Mezey, Chapman, Wheeler, Drummond and Baldacchino, 2004). Abuse is present in only some of participants' accounts: neither Helen or Peter had experienced any physical or sexual abuse, either directly or indirectly. Others could be said to have experienced elements of psychological abuse (as in John's mother's veiled accusations about causing his brother's illness), but this was not specifically recorded or conventionally measured by this study. Other participants who had experienced vicarious abuse/trauma, for example witnessing domestic violence, might very well be left with increased feelings of internal conflict – even, with the young child's typical egocentricity, feeling that somehow their 'badness' had caused their parents to fight (Edelson, 1999), and externalising some of that behaviour in aggressive and antisocial behaviours (Hester, Pearson, Harwin, 2007; O'Keefe, 1994; Song, Singer and Anglin, 1998). This is found in the accounts of Scott, John and Emily. Thus, abuse/trauma was not an overarching theme in this sample, and cannot account for a single mediating factor towards heroin addiction in this study.

2.3 Are there themes in the narratives of these individuals that could mediate addiction or other maladaptive coping strategies in adulthood?

Of the many narrative strands which represent common ground between participants, the most prominent is that from an early age they felt like an outsider, the one who did not fit in, who was in some way unlike other people. This was particularly evident when they talked about school and socialisation, and during early adolescence their perceptions of separateness became so acute as to be unbearable. This finding echoes research that a shaky or flawed maternal relationship affects the child's sense of self and their ability to socialise (Manning, Allen and McElhaney, 2006; McElhaney, Antonishak and Allen, 2008). This impairs their ability to make friends and be open to emotional experiences. Particularly in the male participants (such as John and Scott), this social discomfort

appears often to be 'acted out', using aggression to mask feelings of vulnerability, as Marsh, McFarland, Allen, McElhaney and Land (2003) have found. In some cases, aggression is used with the specific aim of impressing their peers, as in John's account – the kind of aggression that Mattson (2003) describes as defensive rather than offensive.

The child appears to feel increasingly marginalised and alienated from the mother, family and friendships. Much of the literature points to heroin addiction as alienating the addict from others (Dodes, 2002; Goldberg, 2001), but this seemed already to have taken place in these participants before their drug abuse. This observation accords with the views of O'Keefe-Dyer (2004), who has also found that the already alienated merely become further ostracised by society and, I would add, further distanced from their families. What heroin seemed to offer these participants, therefore, is a cultural community, solidarity and acceptance; this corresponds with the views of other researchers (Peele, 1985; Potik, Adelson and Schreiber, 2007; Room, 1985).

Low levels and poor quality of communication in general, specifically concerning emotional problems and feelings of uncertainty, appear to feature strongly in participants' accounts of family life. These findings concur with those of other researchers, who point to a correlation between low emotional expression and high levels of anxiety (Fieldman, Woolfolk, and Allen, 1995; Moneta and Wong, 2002; Todorov, 2009). Thus the child's anxiety remains unchecked, and indeed accumulates until it has a significant negative effect. Moreover, participants seem to interpret this lack of communication as 'how one is expected to cope'. Self-reliance is adopted as a way of life, and this compounds the object-relations deficit.

I interpret so extreme a degree of self-sufficiency as the child's response to feeling emotionally detached from the mother and a perceived lack of permission, even inability to express their problems. There appears, however, to be an instinctive recognition that

'going it alone' might prove emotionally challenging and costly, and participants thus seem to adopt a people-pleasing mentality in the hope of gaining some acceptance. A turning point appears to arrive in adolescence, when participants seem unconsciously to acknowledge the futility of this strategy (when it does not bring the mother 'closer') and more specifically the teenager's desire for greater autonomy and socialisation and the psychic conflict this creates may represent too much for the adolescent to cope with.

Adolescence is a key time for any individual (Erikson, 1963). Operating from already shaky foundations, and under the strain of physical changes, maturing, negotiating intimate relationships and then leaving the structure of school, these participants appear to have sought a more positive sense of self, or at least a less negative one, or one that they could occasionally 'lay to rest', via drugs. In contrast with a more normative process of crystallising a sense of self, solidly constructed throughout earlier childhood and finding its 'wings' during adolescence, these participants appear to have developed self-sufficiency before their time, but their perceptions of their own maturity and independence seem superficial – a show put on for others' benefit. Beneath this façade there appears to be a soft underbelly of vulnerability and emotional unpreparedness to cope with the adult world. Participants seem to mistake the natural process of growth in adolescent autonomy for one where total self-reliance is called for; they seem unable to appreciate that we take our strength from being intimately connected to others we trust.

3. The transformative power of drugs

All the participants reported that their feelings of inadequacy and anxiety steadily increased in adolescence and failed to find assuagement. This seems to be why heroin, with its sedative qualities, seems a way to dowse these crushing feelings and provide a brief sense of liberation. The dependence stands in for the 'good babyhood', as Gerhardt

(2004) describes it, that they may have been denied and unconsciously acknowledge that they did not experience.

4. Mentalisation

4.1 Mentalisation in context

As mentioned already, the greatest surprise from this research relates to the prominence of mentalisation. When it malfunctions, it appears to leave a child with, at best, feelings of disappointment and confusion and, at worst, intense emotional pain.

The qualitative research process allowed me to incorporate mentalisation theory into the conceptual framework for understanding and interpreting the study's findings. This is an example of what I referred to in the introduction as being prepared to give voice to and make room for alternative explanations that had hitherto not occurred to me and yet spoke out from the data. Mentalisation has elaborated what some might have considered a plain vanilla explanation, concentrating on attachment theory alone.

Mentalisation can be summarised as the ability to understand one's own mental state and that of another (Fonagy, 1991), or as a type of mind-reading (Baron-Cohen, 1991), or as an advanced theory of mind (Premack and Woodruff, 1978). Peter Fonagy, together with esteemed colleagues (Fonagy, Steele, Moran, Steele and Higgitt, 1991; Fonagy and Target, 1997), has been at the forefront of the conceptualisation and development of mentalisation research, perspectives and testing (Fonagy and Target, 1997; Fonagy, Gergely, Jurist, & Target, 2002; Bateman & Fonagy, 2004). As mentioned above, the findings of the present study seem to pinpoint mentalisation as a major issue, with its strong implications for self-development and for attachment theory. As Fonagy and others suggest, there is evidence for the overlap of the constructs of attachment and of theory of mind (Humfress, O'Connor, Slaughter, Target and Fonagy, 2002; Fonagy,

Steele, Steele and Holder, 1997). The reason why this may be significant is, in the words of Humfress and colleagues (2002) 'that social cognitive processes may be context and relationship specific' (p.1), and that this coherence between the two constructs of attachment and mentalising seems to apply to the present study's participants in adolescence. So we can perhaps consider attachment (the notion of a secure base in infancy) as the foundations of the child's constructivist building, while mentalising provides the bricks and mortar for the construction of the child's sense of self. It is impossible to gain the same type of insight into the initial attachment relationship (such as Strange Situation testing of infants might allow) from adults' retrospective accounts. But, in the absence of an empirical measure (such as Strange Situation or AAI), this study's findings appear to point strongly to a deficit in the child's sense of self, resulting from sub-optimal emotional communication in the mother-child relationship.

For example, it may be that sheer uncertainty of how one's mother may respond, and the unpredictability of nurturing and intimacy, lead to a failure to mentalise and organise internal representations of the mother, and damage the chances that a robust self will emerge, as Fonagy and Target (1997) posit. Furthermore, they suggest, failure to predict or make sense of the mother's state can damage the growing child's emotional stability – a theme echoed more recently by Dunsmore, Bradburn, Costanzo and Frederickson (2009). Participants' narratives appear to carry many of the hallmarks of a lack of mental attunement, and suggest apparent emotional fragility throughout life – never more so than in superordinate theme 3: 'my search for a new, improved sense of self' and, more specifically, in sub-theme 2A: 'the unspoken, and unanswered questions'.

4.2 A sense of self

When I refer to a participant's sense of self, I would distinguish this from the construct of identity, a complex area that this study did not attempt to define. In this study, sense of

self refers to a person's perception of themselves which is first triggered by 'play' as a child with their mother, and as they increasingly participate in social interactions (in this case both within the family and externally). Borrowing from Mead's (1963) concept of the 'I' and the 'me', and based on a sociological understanding of the self, 'me' relates to the child's perception of how they are perceived by others. The 'known', and the person is aware of him/herself as an 'object' from the point of view of others, and this 'me' reflects the social mores and rules of the community. Thus, the 'me' can be summed up as the conscious perception of the person as the object. This in contrast with the 'I' – impulsive, the 'knower' and the self as 'subject'. It refers to how their perception of themselves is shaped by an individual in relation to others' attitudes towards him or her. Thus, one's sense of self is a combination of subject and object and is the essence of being social. The aspect of one's sense of self that I am particularly interested in, and which appears to surface throughout the participants' accounts, is the notion of the self that arises from introspection following social interaction and experiences.

My primary reason for considering Mead's (1963) work here is that I see parallels in the use of language in Mead's outlining of the process of the emerging self and in mentalisation theory (Fonagy, 1991; Fonagy, Steele, Moran, Steele and Higgitt, 1991; Fonagy and Target, 1997). Both refer to the importance of early socialisation and the ability to understand another's perspective and relate it to the self. And both highlight that, when difficulties occur in this process, and when one cannot perspective-take (mentalise) or integrate the subject and object, then the sense of self is weakened and the person may feel alien in a world where they find the emotional language and everyday communication confusing, even threatening. This is the overarching impression that the findings of my study seem to reveal about the participants' sense of self – a fragile sense of self, as Kohut (1959, 1977, 1994) terms it, not fully formed, too introspective, and apparently without the balance of the more libertarian aspect of the self, the 'I'. Instead, the 'me' seems to dominate.

Using these theories to shed light on the phase of self-development that seems to have faltered during the participants' adolescence, one can see how teenagers with such weak foundations might flounder when trying to expand their self-governance. Adolescence could be considered a 'second chance' for them to achieve a more robust emerging self, but this study's participants apparently found this period very difficult to negotiate. They appear often to have provoked negativity in others in order to receive back 'the familiar', the negativity that they perceive and 'know' and attribute to themselves. Goldberg (2001) has also found evidence of this process, and interprets it as providing individuals with confirmation of their low worth. The more confirmation of their negative self-image they receive, the more established their negative sense of self becomes, and the 'me' is dominant.

5. The role of the unconscious

Given this sociological framework for how one understands the sense of self, I feel that the notions of the unconscious and the ego can shed further light on why these individuals struggle with a sense of self and appear to feel that they do not fit in with others in social settings. While it was Lacan (1953) who defined the unconscious as 'the discourse of the Other' (p.379), Frosh (2002) brings this to life for me as he describes the functioning of the unconscious as the 'internal other' (p.394), which radically disturbs the notion that an individual is the master of him- or herself, and which opens up the possibility of a collapse in confidence in the self. Frosh underlines how painful and sometimes impossible acceptance of that 'other' can be. Considering the unconscious in such terms echoes the sentiments raised in the participants' narratives, when they strongly ward off unacceptable and painful notions about their maternal relationship, pay extreme attention to the views of others, often struggle to understand these perspectives and appear primed for the possibility of rejection.

Examining the mother-child relationship, as outlined by Laplanche (1997) and expanded by Frosh (2002), the 'other' represents the adult in the adult-child relationship, and the young child experiences the adult's message as enigmatic and exciting. This is due in part to the child's limited conceptual understanding, as it tries to understand what the adult is communicating or wants. However, Laplanche (1997) instructs us that it is not merely the child's limited conceptual understanding that makes the message difficult to fathom, but the notion that the adult speaks from their own unconscious. Traces of the mother's 'otherness' is thus introjected by the child. Moreover, Laplanche considers that not only does the child struggle with what their mother is saying, the mother herself may not know or fully appreciate what she is communicating. If her own maternal experience was dysfunctional, she may unwittingly communicate in a dysfunctional manner with her child. This picks up the thread of possible intergenerational transmission of parenting style – perhaps the residue of the mother's own fragile sense of self being handed on to the child.

For me, this concept of the unconscious and of the power of the mother to influence the child's sense of self is an important element to these participants' accounts. It strongly relates to mentalising theory, and embraces the concepts of both the Lacanian (1953) mirror phase and Winnicottian (1969; 1971) containment (emotional). As Fonagy and Target (1996) eloquently posit: 'Unconsciously and pervasively, the caregiver ascribes a mental state to the child, and lays the foundations of a core sense of mental selfhood' (p.461). This captures for me the sense of self that these participants appear to be lacking. It is, as Frosh (2002) beautifully captures, 'in this passing between (mother-child communication), it becomes clear just how much there can be no subject ('I') without the other; instead, it is *from the other* that the subject comes' (p.399).

Describing the ego as the central organ of consciousness, Schoen (2009) says that a weak ego results in an individual struggling to negotiate the inner and outer worlds of reality,

which impairs their ability to adapt, grow and change in relation to life's demands, as seen in the adolescent phase of these participants. Rather than acknowledge the often unpalatable unconscious, the ego identifies with a more palatable persona, and so the participant is in touch with a false self; these heroin addicts are put in touch with a 'personal shadow' (Schoen, 2009). This 'shadow' is believed by Jungians to dwell in the person's unconscious, and represents the hidden aspects of ourselves which the ego represses or sometimes never recognises. The more an individual identifies with this palatable persona, the more baggage gets stored in the shadow and, ultimately, the more defences are mobilised to conceal this unpalatable 'other' – as appears in participants' strong defence of the 'good mother'. Schoen (2009) positions addiction as the way in which the individual alleviates ego stress, and participants' narratives appear to reflect this notion, particularly when they seem to describe a sense of release when using heroin. Linda Schierse Leonard (2001) elaborates this idea, suggesting that the addict's shadow, this weak and needy 'other', is allowed to emerge during addiction and takes a 'free ride to paradise'. The participants' accounts strikingly echo these concepts of the unconscious and an addict's 'shadow'.

6 Methodological considerations and applications to practice

Although participants self-selected for this study, the homogeneity of the sample is interesting in itself. While I had set wide age parameters for recruitment (27 to 42 years old), participants tended towards the upper end of the age spectrum (a mean age of 39) and had far lengthier histories of heroin dependence than I had expected to find (an average of 18 years). (see Appendix VII for demographic information summary). It occurs to me that this may not be coincidental, and that those who volunteered to participate may have reached a stage in life where they accepted their former dependence and felt no need to remain guarded about it. It may be useful in future to compare a younger sample with the current findings.

The study did not include the participants' social class in the demographic information requested, but working class backgrounds and struggling financial settings were evident in several of the narratives. Lower social economic circumstances have been recorded by other researchers as correlating with addiction (Andersson, 1991; Fieldman, Woolfolk & Allen, 1995). However, I felt that it was important to learn about the lifeworld and the lived experience of the addicts who came forward for the research, irrespective of socio-economic status, which seems more aligned to the IPA principle of avoiding subjective judgements based on such demographic information. I also took a non-purposive stance towards education, but participants appear to have been both applied and able at school (on their own verbal report). I cannot claim that this is typical of heroin addicts, but it was strongly evident in these participants' accounts.

Perhaps the biggest methodological limitation surrounding this study is that it relies on mature adults' recall of experiences of being parented, so there is a concern about how much is accurately remembered. However, this study was never seeking objective truth; rather, it was exploring how individuals perceive their past experiences of being parented and how they remember feeling about themselves during childhood and adolescence. In addition, I was not probing specific traumatic or seismic experiences which might require specific recall of details. Rather, my aim was to catch a glimpse of the day-to-day parenting interaction as perceived by participants, and I believe this was achieved.

Self-concept effects permeated all accounts. While various dimensions were presented, a fundamental theme of a negative sense of self was remarkably stable across accounts. This study did not specifically examine identity because the interview schedule was not designed for this purpose and the subject of identity and social identity (Tajfel, 1978; Tajfel and Turner, 1979; 1986) is highly complex and somewhat controversial amongst researchers (Hogg, Terry and White, 1995; Stets and Burke, 2000). However, it appears to me that, to further our knowledge of an individual's struggle with addiction, it could be

worth while researching identity in heroin addicts and, moreover, identity threat that may arise (such as Breakwell outlines: 1983; 1993; 2000), or any identity shift that might occur (particularly during adolescence).

I cannot suggest that this study's findings can be generalised to the wider population of heroin addicts. All participants were white westerners. As participants were also drawn from the same hospital, any future study might benefit from using participants from across the UK to eliminate potential geographical anomalies, and to consider a more ethnically diverse sample. Overall, gender differences in the narrative accounts were not apparent. The same themes spanned both sexes. However, aggression was more prevalent as a teenage coping strategy amongst male participants, as is found in several general studies of aggression (Hess and Hagen, 2006; Maccoby and Jacklin, 1974; Tremblay, Hartup and Archer, 2005). In addition, participants did not reveal any self-harming (cutting, burning etc.) strategies prior to the onset of substance abuse.

Many researchers argue for continued research into addiction (Goldberg, 2001; Schoen, 2009), and some call for more specific work into heroin addiction, to which I add my voice. I believe this study offers evidence that therapeutic practice could benefit from aiming to understand better the formative world of the heroin addict, and seeking a more lucid picture of the factors that mediate heroin dependence. I believe my own understanding has been greatly enhanced, in my appreciation of the level of individual internal conflict, the degree of unmet emotional needs, the prospect that the therapist may need to assume the role of transitional object, as Potik et al, (2007) advocate, to help manage the object-relations deficit, and that mentalisation-based techniques may provide the basis for longer-term therapy.

I also feel that the study brings into sharp relief the significance of adolescent struggle with a sense of self. The findings suggest that this may be a key stage in the

development of addiction, and a time for therapeutic intervention and proactive measures. This would be in contrast with present practice, in which drug services and mental health professionals wait to react to the older adult with an already long-established heroin/drug career. I would like to see research focusing on some quantitative markers for a tipping point at which adolescents veer towards an addictive pathway. As for specific ways of working with heroin addicts, I draw on the views of Allan Schore (2001; 2003). He and others (Mosse and Lysaght, 2002) urge therapists to consider group work with addicted individuals alongside individual therapy, to re-socialise them and educate them about relationships and personal interaction in a non-threatening environment. He also advocates practitioners to embrace techniques of speaking to an addict's 'right brain', which he believes has been impaired in early childhood.

I also consider that the appearance of core characteristics of attachment and mentalisation deficits in these participants makes psychodynamic work an appropriate technique to use when treating heroin addicts (Read, 2002; Reading, 2002; Weegman and Cohen, 2002). Considering the entrenched views that they appear to hold of themselves, long-term therapy might provide a more secure base for them to begin reassessing their views of their lifeworld and a more positive self-evaluation. It is with this in mind that others recommend the use of psychodynamic techniques to enhance mentalisation capacity (Beretta, de Roten, Lecours, Michel and Despland, 2006; Holmes, 1996; 2008; Kramer, de Roten, Beretta, Michel and Despland, 2009). Moreover, it seems that this study confirms the advocacy of the general application of attachment theory in the psychotherapy of addictions (Reading, 2002) and, I would add, especially for heroin addiction. I concur with Zinberg's (1975) tripartite model, in respect of 'setting' as comprising perhaps the most important element in the aetiology of addiction, in the case of heroin addicts. Setting, in this context, represents the quality of interacting and relationships within the participant's developmental arena – their home. That their relationships are driven by innate need, just as Bowlby (1958) first observed, this study

suggests that this need increases when participants feel emotionally vulnerable, as they appear to describe, throughout childhood and especially during adolescence, due a lack of maternal attunement. Hence the relevance of the attachment figures in their early lives. Thus, while paying attention to this construct in future therapy, I would also be inclined to emphasise the importance of mentalisation.

A key question is whether the use of an empirical measure such as AAI would support these findings. I would like to think that it would, to the extent of capturing the central themes of negative self and lack of emotional interaction with the mother, but I make no assumptions as to how the insecurity status of these heroin addicts might be classified.

7. Limitations of the present study and suggestions for future research

On the basis of this study's findings, I cannot claim that emotional dysfunction in the mother-child relationship causes heroin addiction, but this was not what I set out to do. The most that can be said is that problems in this area appeared present across all accounts, and that they may have helped to cultivate a negative sense of self which then led participants to search for ways of managing this, and one way they found was heroin –soothing, diluting anxiety and delivering a sense of community and belonging. I am mindful, however, given this study's methodological nature and small sample, that other individuals with similar early life experiences might be inclined to select other ways of coping.

It may be beneficial in future to study the present-day relationships of adult heroin addicts (using similar recruitment criteria to this study), and seek access to the lived experience of social and romantic relationships from adolescence onwards. One might then see whether there is evidence of their struggling with intimacy or whether this is overcome in later life. It would be particularly interesting to explore heroin addicts'

current relationships with surviving mothers. It might also be beneficial to study the mothers of this group of participants in relation to their own experience of being parented and any expression of intergenerational transmission.

It would have been interesting to run a parallel study, using the AAI measure, with another small sample of heroin addicts taken from across the UK, and then to have compared data and AAI classification of attachment and to examine convergence and divergence. If findings proved similar, that would be an argument in favour of therapists uncovering the early history of heroin addicts and obtaining a comprehensive picture of parenting experiences, the better to inform their therapeutic planning. A tool such as AAI might deliver nothing therapeutically essential beyond what a therapist's own foraging would uncover, or it could provide richer data and perhaps deliver it more rapidly (one 45-minute interview plus the coding process, compared with several weeks of analysis of transcripts using IPA). In that case, AAI protocol might provide a valuable adjunct to therapists' training with NHS drug services. One could also compare, via a longitudinal study, whether adding the AAI measure to psychodynamic therapy affects the therapeutic outcomes of heroin addicts.

I believe that it would also be useful to compare a group of stimulant abusers, studied in the same way (IPA), with the current findings to determine the existence of any common themes and to detect whether they had similar childhood relationships with parents.

One of the areas that I feel requires further investigation relates to parenting styles in relation to rules and boundary setting. There was a good deal of comment on this area within participants' narratives, and it appeared to be a contentious issue for all participants – especially during adolescence. It appears that rules were either inflexible, leaving the child frustrated by the inability to exert any influence over the parents; or that parents paid lip-service to the rules but did not enforce them, so that the child perceived

rules as being there to be broken. Timing constraints prevented this topic being accommodated within the analysis, but it may be beneficial to study it in greater depth, as it could relate to feelings of increased insecurity in the teenage years, potentially exacerbating any existing problems of negative self-appraisal.

8. Method and procedural reflexivity

While in any study there can be limitations where the research is restricted to a single interview, it is worth considering whether three interviews would be needed in any future research. While some researchers strongly advocate the use of multiple interviews in qualitative research (Seidman, 2005), others have reflected more deeply on this (Flowers, 2008). The latter, for instance, is concerned with how the researcher records and analyses the individual interviews. Flowers questions whether merging all three interviews and analysing them as one data set per participant (as I did) could lose the social context of the interview, and the relationship between the researcher and participant that builds across the interviews. While I can empathise with this point, I feel that three interviews one week apart hardly creates a huge temporal void, and as long as the researcher takes time-relevant notes at the end of each interview (as I did), some of this potentially valuable data will be captured. I agree with Flowers that this might become more problematic if there were more than three interviews, or they were separated by long periods of time.

Flowers also worries that participants may feel they gave the 'wrong answer' in one interview and then tried to correct it in a subsequent interview. I believe this is a valid consideration for any researcher, but in this case the questions were not so specific that participants might readily assume there was a right answer, and I was at pains to stress at the outset of each interview that there were no correct answers and that I was looking to understand experiences which would, by their very nature, be specific to them. Indeed, I

found it a benefit of the multiple interview approach that participants did reflect between interviews, often following a thread that they had started in a previous interview. It was as though they sketched an initial outline in the first interview and then coloured and shaded it in subsequent interviews until a clearer picture emerged, both for them and for me.

Inevitably, as Flowers (2008) points out, the route I adopted also involves considerable work for the researcher, but I believe that, for complex topics where one wishes to grant the participants room to manoeuvre and reflect, the benefits of rich and vital data outweigh the costs to the researcher.

One of the issues I wrestled with was whether I should return to participants with my analysis and have them validate themes and perspectives, an approach favoured by some researchers. With IPA, routine 'checking back with participants' or 'member validation' is not routinely recommended (Smith, Flowers and Larkin, 2009). While it would have been of value to have participants support or radically change my perspective on a theme, I felt that these individuals were emotionally fragile. Without an assurance that they were engaged in long-term therapy to ensure psychological support, to confront them with such insights into their maternal relationship could have been deeply unsettling for them. In particular, I was concerned that it would simply mobilise their psychic defences to refute what they might find intolerable. In such a case the process of interpretation might be threatened rather than enhanced. After discussing this at length with my supervisor, I decided against such a route. What I must now carefully consider is how best to present the summary of findings to which participants are entitled, without causing them distress. My initial instinct is that I should meet them, talk through the findings and allow them a chance to ask questions, rather than merely post a summary document to them.

IPA was at times an unwieldy method, because of its iterative nature, but I do feel that it produced the goods at the end of the day and met my research aims. In particular, it achieved my objective of keeping participants' experience central, while appreciating the multifarious influences on it, as Eatough and Smith, (2006) outline. Were I to run another such study, however, I would consider taking a multi-method approach, possibly using Foucauldian Discourse Analysis in addition to IPA, to unpack heroin addiction and childhood experiences further, and to attempt to access and interpret discourses that are culturally relevant to the participants. Another possible way of validating IPA findings would be to develop a questionnaire to be sent to therapists who are or have been working with heroin addicts, look at their experiences and emerging therapeutic themes, and check for convergence with the IPA themes. It would be useful to issue the questionnaire to therapists working in various therapeutic approaches, to determine whether there is any significant difference between the experiences of psychodynamic therapists and those from other disciplines.

Lastly, I refer to the interview schedule. I do not know whether a researcher ever feels they have the perfect schedule, and I acknowledge Linda Finlay's (2002a; 2003) observations that all researchers ask different questions, experience different relationships with participants and thus produce different responses. However, if I were to re-engineer the schedule for future use, I would ask more questions about the style of interaction between the parents and their outlook on rules and boundary setting – an aspect of the childhood experience that I had not considered important until it emerged in this study.

9. Personal reflexivity

I now appreciate that I began this research process rather naively, not expecting it to change me in any great way, and viewing it very much as a vital aspect of the qualification process. What I could not foresee was how this process would make me

reflect deeply, both on my role as a mother and on how I could best work therapeutically with heroin addicts, and on the growing importance that I would attach to qualitative research.

This research has challenged the very way I view my subjective world. It has uncovered prejudices that I was unaware of, that I had in some part subscribed to the popular notion of 'what heroin addicts were like as people'. It has likewise challenged my own way of parenting, and has made me ask whether I am sufficiently present for my own children at times, and whether, in the process of intergenerational transmission, I could be communicating to them a degree of emotional distance as a result of my own mother's parenting style.

As the research process developed, I became more aware of my subjectivity and my foreunderstandings, even prejudices, as Finlay outlines (2002a; 2002b; 2003). Recognising, as Giorgi (1994) contends, that subjectivity is ever-present, I found it a challenge to manage this and maintain the transparency of my process, so that as I formulated and interpreted findings I could be clear in my own mind 'where I stood' and what influences were upon me. In the words of Alvesson and Skölberg (2002), it was a 'question of avoiding empiricism, narcissism and different varieties of social and linguistic reductionism' (p.246) – no mean feat. I made every attempt to create well spaced periods in which to reflect on what I was doing.

The greatest struggle came during the analysis phase, when at times I felt that I would drown in a sea of detail and never produce any cogent themes. I had to appreciate that thorough analysis would take many weeks, and that it would not be a linear process. I would find myself constantly moving between parts and whole of transcripts, and listening over and over to interview tapes. I grew impatient with the initial stage of annotation, which felt laborious and robotic. The next challenge was to achieve a level of

objectivity in identifying the common themes and categorising them into themes and sub-themes. This phase required sheer stamina and a very clear paper trail. Initially there seemed to be hundreds of diverse strands in the accounts, but after some perseverance and, to a degree, relaxing into the process, I began to make sense of the data noise and to pare down the themes to the final three. At this juncture there was a huge temptation to try to demonstrate many elements and shape several additional themes, and I realised that this was probably a trap that has seduced many a novice researcher. I grew to appreciate that 'less would be more'.

Several sections within the participants' narratives seemed chaotic at first, and I struggled to make sense of them. In addition, I was aware that I might be taken over by the participants' disordered thinking. I often felt completely fazed by this occurrence, and sometimes it made me want to tidy up their accounts and package them in way that seemed more comprehensible. Respecting this urge, and ultimately naming it as their transference, helped me resist that temptation. I also appreciated that recalling the past can feel anxious and beleaguered, that these episodes constituted 'live' attempts by participants to make meaning, and that such activity genuinely requires 'an active and reflexive self' (Eatough & Smith, 2006: p.132) that is not fragmented or unduly negative.

The biggest challenge of all, however, lay in the interpretation phase. I wrestled with the meaning-making, attending not to fact but perspective, and trying to acknowledge that interpretation does not have obvious, straightforward rules; that it involved judgement and intuition as well as the careful unpicking of less explicit dialogue – between me and the participants; and that it called for close examination of my own thinking, to ensure that I was not wedded to a definite and intractable research position, a danger highlighted by Maranhao (1991).

I was acutely aware that I had no direct experience of heroin addiction, and so could not really know how participants felt and what sort of relief they derived from using heroin. At first I had worried that this would restrict my ability to research this topic, but I came to feel that it was an advantage. There was no temptation to position myself as an authority, and it naturally seemed to allow participants to steer me to the experiences that they felt were relevant.

While I have enormous respect for the NHS and the efforts of drug services in the UK, and for the commitment of the UK Government to make inroads into the growing problems of addiction, this study has made me seriously question the value of the official methadone maintenance strategy, which does not include any obligatory psychological therapy for the addict. Swapping an illicit drug such as heroin for a prescription drug seems sensible on the face of it, but taking heroin away from an addict (or the addict away from heroin) appears, from my therapeutic experience, to constitute also removing the routine, the ritual, the cycle of occupation (often including stealing to feed the drug habit) which keeps the addict's mind occupied much of the time. Without these elements the addict has more time to think, their thinking is clearer and they seem to get in touch with their psychic conflicts. In some cases there is even the appearance of grieving for the substance and the ritual – perhaps loss of the false 'good mother'? Failure to acknowledge the significant contribution that therapy could make in 'holding' addicts and teaching them alternative ways of coping seems to me to do them a disservice. Without therapy, it seems there is nothing to stop the ghosts of the past revisiting in force, and thus making any future relapse not only likely but perhaps more powerful than the preceding one.

In all, I have enjoyed this journey immensely. While I will not gloss over the academic and personal challenges it has presented, it has enhanced my psychodynamic understanding of the nature of heroin addiction, and has made me want to strive to do

better in a therapeutic setting. My journey began years ago when I was inspired by the insights of John Bowlby, and I now end with a quotation from him that encapsulates my unabated interest in his and Mary Ainsworth's (Ainsworth & Bowlby, 1991) indubitably major contribution to psychology, attachment theory, which I believe has direct relevance to heroin addiction.

'It is not surprising that during infancy and early childhood these functions (self-reliance, ego and superego) are either not operating at all or are doing so most imperfectly. During this phase of life, the child is therefore dependent on his mother performing them for him. She orients him in space and time, provides his environment, permits the satisfaction of some impulses, restricts others. She is his ego and his super-ego. Gradually he learns these arts himself, and as he does, the skilled parent transfers the roles to him. This is a slow, subtle and continuous process, beginning when he first learns to walk and feed himself, and not ending completely until maturity is reached. . . . Ego and super-ego development are thus inextricably bound up with the child's primary human relationships'. (Bowlby, 1951, p. 53)

Conclusions

It is sincerely hoped that this research will go a little way to shape the therapeutic input given to individuals with heroin addiction, and that practical application of this study's findings might lead to greater use of empathy and payment of greater attention to their early life experiences. It illuminates the intricate and complex nature of the family nexus, and in particular, the pivotal role of the mother. Whilst I cannot declare that this study has provided me with an unmediated window on heroin addicts' early lifeworld, it has proved for me a lucrative place to begin understanding this population better.

Attachment relationships appear fundamental to a child's sense of self, because of the central importance of the mother-child dyadic interaction – cognitive, physiological,

social and emotional. When it ruptures, or is 'built on sand', through a mother's failure to reach out emotionally to the child, the consequence appears to be for the child to seek self-soothing and cultivate self-sufficiency. This is not, however, to be confused with self-efficacy. It seems that this self-sufficiency in childhood is a strategy that naturally and unconsciously occurs to the child. As the child matures, however, we can consider this modus operandi to be a considerably maladaptive way of coping with emotional purdah. Such a 'way of being' seems to bring with it the heavy burden of anxiety and a negative sense of self.

It seems crucial to understand the sense of self, or the 'me' and the 'I' (Mead 1963), and incorporate it into heroin addiction therapy. The 'me' is the socialised self (how others judge/see me) and 'I' is spontaneous, creative, unpredictable. It seems that interaction and balance between the two are essential to the development of a robust sense of self (Mead, 1963). If the 'me' is insufficiently developed – insufficiently socialised – as I adduce in the case of these participants, it spells difficulties ahead for relationships and psychic growth. These individuals appear to have a fragile ego, and it may be that their malfunction is not an over-impulsive ego but a harsh and punitive superego. Heroin was compulsive for these individuals, and seemed to mark the end of a sequence of deterioration leading to entrenched negative views of the self.

From the outside looking in, and if one took their words at face value without attending to consistency in the narratives, participants' maternal care might appear to a casual observer as 'text-book positive mothering'. Paying closer attention, though, one finds that participants appear to have fallen prey to an insidious force – emotional detachment from the mother, where they mistakenly interpret the mother's physical presence as being 'present for them'.

I wish to stress that these findings do not necessarily indicate malicious, intentional maltreatment of children, but they do relate to a lack in the parent of the mental and emotional attunement which we term 'mentalising'. Acknowledging the aforementioned hypothetical consideration, it is possible that dysfunctional parenting may be handed down to heroin addicts by their mothers if the mother had the misfortune to receive similar parenting herself. Thus, she cannot be considered as acting consciously. For the mother is not trained to 'catch' herself and recognise how her own past experiences influence her behaviour around her child.

If people generate their sense of self via others (as Mead, 1963 suggests), then we psychologists may be able to help heroin addicts try to change. Methadone alone, in my opinion, will not fill the emotional void, and will be a poor substitute for human intimacy.

I would like to conclude with an expression of gratitude to the participants, who have taught me so much, but who have also shown me that there is so much more I still have to learn.

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Appendices

Appendix I: The meaning of the term 'addict' within this thesis

The preferred usages (by psychiatrists and medical professionals) refer to a person with a heroin dependency or with substance misuse. However, these are long-winded expressions, and not commonly used by members of this population themselves. Thus, this study uses 'addict', 'opiate-addicted' or 'opiate-dependent', terms which these individuals do not seem to find offensive or controversial. It also felt right to the researcher to retain participants' language when they are describing themselves, rather place a sanitised label on them and perhaps distort their own self-image. In fact 'addict' and 'junkie' are in common parlance among this population, and the term 'addict' is used by organisations such as Narcotics Anonymous (NA). The researcher also uses the term 'former long-term addict' as a way of recognising the achievements of these individuals who have remained clean of illicit drugs for a substantial period of time and so as not to be confused with individuals whose heroin addiction is still active. However, in reality, most individuals attending organisations such as NA consistently introduce themselves as addicts, even after 20 years of abstinence.

Although this study refers to 'heroin and/or crack cocaine' addiction, due to the common occurrence of co-usage within this population the shorter term 'heroin addiction' is the preferred usage throughout this research. Addicts who use both heroin and crack cocaine consider themselves heroin addicts who also use crack cocaine.

Appendix II: Information on heroin and crack cocaine

Heroin

Description

Heroin is a white, odourless, bitter crystalline compound derived from morphine (a natural opiate) and is a highly addictive narcotic. It can also be presented as a brownish powder or tar-like substance. Also called diacetylmorphine, it is a class A drug in the UK. It can be injected intravenously, injected into a muscle, smoked or snorted. Regular use leading to abuse can result in a severe physical and/or mental dependency. Street names for the drug are: big H, blacktar, brown sugar, dope, horse, junk, mud, skag, smack.

Effects of heroin

The short-term effects of heroin abuse appear soon after a single dose and disappear in a few hours. After an injection of heroin, the user reports feeling a surge of euphoria ('rush'), accompanied by a warm flushing of the skin, a dry mouth and heavy extremities. Following this initial euphoria, the user goes 'on the nod', a state alternately of wakefulness and drowsiness. Mental functioning becomes clouded, due to the depression of the central nervous system.

Tolerance, addiction, and withdrawal

With regular heroin use, tolerance develops. This results in the addicted individual requiring more heroin to achieve the same intensity of effect. As higher doses are used over time, physical dependence and addiction develop. The body adapts to the presence of the drug, and withdrawal symptoms may occur if use is reduced or stopped.

Withdrawal, which in regular misusers may occur as early as a few hours after the last administration, produces drug craving, restlessness, muscle and bone pain, insomnia, diarrhoea and vomiting, cold flashes with goose bumps ('cold turkey'), kicking movements ('kicking the habit'), and other symptoms. Major withdrawal symptoms peak between 48 and 72 hours after the last dose, and subside after about a week. Sudden withdrawal by heavily dependent users, who are often in poor physical health, is occasionally fatal.

Other known problems

Heroin can cause feelings of depression which may last for weeks. Attempts to stop using heroin can fail simply because the withdrawal can be overwhelming, causing the addict to use more heroin in an attempt to overcome these symptoms. This overpowering addiction can cause the addict to take extreme measures in the effort to get heroin.

Crack cocaine

Description

Crack cocaine is a solid, smokeable form of cocaine. 'Crack' is the street name given to cocaine that has been processed from cocaine hydrochloride to create a free base (the terms refers to the method of production) for smoking. Instead of the more volatile method of processing cocaine using ether, crack cocaine is processed with ammonia or sodium bicarbonate (baking soda) and water and heated to remove the hydrochloride, thus producing a form of cocaine that can be smoked. The term 'crack' refers to the crackling sound heard when the mixture is smoked (heated), presumably from the sodium bicarbonate.

Tolerance, addiction and withdrawal

Cocaine is a powerfully addictive drug of abuse. An individual who has tried cocaine cannot predict or control the extent to which he or she will continue to use the drug.

The major routes of administration of cocaine are sniffing (snorting), injecting (mainlining) and smoking. Snorting is the process of inhaling cocaine powder through the nose, where it is absorbed into the bloodstream through the nasal tissues. Injecting is the use of a hypodermic needle to release the drug directly into the bloodstream. The injecting drug user is at risk of transmitting or acquiring HIV infection or AIDS if needles or other injection equipment are shared. Smoking involves inhaling cocaine vapour or smoke into the lungs, where absorption into the bloodstream is as rapid as by injection. Smoking allows extremely high doses of cocaine to reach the brain very quickly and brings an intense and immediate high. It may result in the development of compulsive cocaine use even more rapidly than if the substance is snorted.

Cocaine is a strong stimulant of the central nervous system that interferes with the reabsorption of dopamine, a chemical messenger associated with pleasure and movement. Dopamine is released as part of the brain's reward system and is involved in the 'high' (euphoria) that characterises cocaine consumption.

The physical effects of cocaine use include constricted peripheral blood vessels, dilated pupils and increased temperature, heart rate and blood pressure. Cocaine's immediate euphoric effects include hyperstimulation, reduced fatigue and mental clarity; their duration depends on the route of administration. The faster the absorption, the more intense the high, but the shorter the duration of action. The high from snorting may last 15 to 30 minutes, while that from smoking may last 5 to 10 minutes. Increased use can reduce the period of stimulation.

Some users of cocaine report feelings of restlessness, irritability, and anxiety. An appreciable tolerance to the high may be developed, and many addicts report that they seek but fail to achieve as much pleasure as they did from their first exposure. Scientific evidence suggests that the powerful neuropsychological reinforcing property of cocaine is responsible for an individual's continued use, despite harmful physical and social consequences. In rare instances, sudden death can occur on the first use of cocaine or unexpectedly thereafter. There is no way of determining who is prone to sudden death.

High doses and/or prolonged use of cocaine can trigger paranoia. Smoking crack cocaine can produce a particularly aggressive paranoid behaviour in users. When addicted individuals stop using cocaine, they often become depressed. They may turn to further cocaine use to alleviate depression. Prolonged snorting of cocaine can result in ulceration of the mucous membrane of the nose, and can damage the nasal septum enough to cause it to collapse. Cocaine-related deaths are often a result of cardiac arrest or seizure, followed by respiratory arrest.

Opiates

Drugs derived from opium.

Opioids

Synthetically manufactured drugs with morphine-like (sedative) effects.

Marrying heroin and crack

Using heroin and crack cocaine together is a well-known practice among long-term addicts. The combination of sedative and stimulant creates a 'double hit'. Heroin users often add crack to their ritual to give them an initial lift. Crack users, however begin using heroin to achieve the opposite – to 'come down' gently from their crack-induced high. Taking both drugs in the same syringe is often therefore considered by addicted individuals to be a natural progression.

Some of the information within this appendix has been taken from
http://www.drugscope.org.uk/resources/drugsearch/

http://www.drugabuse.gove/drugpages/

Appendix III: Trauma definition

The word trauma originates from the Greek word meaning wound. In fact, it has a dual meaning relating to an external noxious agent and the body's response to that hurt. This conjures up the notion that psychological trauma can involve both an external cause in addition to the person's inner subjective experience.

DSMI-IV Definition (APA, 2000):

The person has been exposed to a traumatic event in which both of the following were present:

1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and

2) The person's response involved intense fear, helplessness, or horror" (pp. 467-468).
Note: In children, this may b expressed instead by disorganised or agitated behaviour.

Appendix IV: Summary of the Adult Attachment Interview (AAI) protocol

Measures such as AAI seek a compromise between a linear scale and one that considers a dimensional approach – in the case of AAI, by using a semi-structured interview that results in one of four possible classifications (secure-autonomous, preoccupied, dismissing and unresolved). Individuals are asked to provide five adjectives to describe their childhood relationship with their primary carer and to provide experiential support for their descriptions. Then they are asked to provide a current description of any changes and feelings they have about their parental relationships.

The interview comprises 20 open-ended questions and typically lasts around 45 minutes. It is considered to have high test-re-test reliability, at levels of 78% (Bakermans-Kranenburg and Van Ijzendoorn, 1993) and 90% (Benoit and Parker, 1994).

Appendix V: Definitions of attachment types and summary of Strange Situation protocol (Ainsworth, Blehar, Waters & Wall, 1978)

Secure attachment (based on Ainsworth et al., 1978)

The **secure style** (B) would typically witness the mother providing consistent care, the child seeking the mother's proximity and the mother being rated as loving and affectionate. The secure child shows mild upset on the mother's departure but is swiftly soothed upon reunion.

Insecure attachment (based on Ainsworth et al., 1978)

The **avoidant-insecure type** (A) sees the child pulling away from the mother or even ignoring her. The child appears comfortable without intimate relationships and tends to reject them (Bogels and Brechman-Toussaint, 2006). In this type, the mother is often rated as rejecting or ignoring the child's attachment behaviour. Thus the child shows indifference to the mother's departure and, upon reunion, avoids contact with her.

The **ambivalent-insecure type** (C) (Ainsworth et al., 1978) stays close to the mother, yet seems not to know how to respond to her. This type shows significant distress as the mother leaves the room, seeks comfort upon reunion but then rejects it. The parent is rated either over-sensitive or angry and rejecting.

Disorganised attachment (D) is a third insecure type that was added by Main and Solomon (1990). This showed the most insecure attachment pattern, highlighting a mixture of resistant and avoidant responses, clinging to and avoiding the mother, with the child appearing often confused or frozen upon reunion with the mother. These researchers hypothesised that this type of attachment was related to abused or neglected children.

Strange Situation Measures of Attachment (Ainsworth, Blehar, Waters & Wall, 1978).

This observation uses the following measures of attachment:

1. Separation anxiety: the unease the child shows when a parent leaves the room

2. Willingness to explore: securely attached children explore more widely

3. Stranger anxiety: security of attachment is inversely related to anxiety towards strangers

4. Reunion behaviour: insecurely attached children greet their parent by ignoring them or behaving ambivalently

Appendix VI: Interview schedule

1. How would you describe the family environment you grew up in?

2. Do you remember feeling that your childhood was similar to other people that you knew i.e. neighbours, schoolmates etc.

3. Which family member do you feel you are most like – your mother or father? In what ways do you feel similar?

4. How would you describe your relationship with your mother?

5. What was your mother's approach to discipline?

6. How would you describe your mother's emotional character? Were you aware of any medical or mental health problems she had as you were growing up?

7. How would you describe the way mum treated you and made you feel emotionally? Was her treatment of you consistent?

8. Were you aware of any medical or mental health problems she had as you were growing up?

9. How would you describe your relationship with your father?

10. What was your father's approach to discipline?

11. How would you describe your father's emotional character?

12. How would you describe the way your father treated you and made you feel emotionally? Was his treatment of you consistent?

13. What was the relationship like between your mother and your father/her partner (if applicable)?

14. How safe and secure did you feel as a child?

15. At what age do you recall 'taking care of yourself'? i.e. being left in the house alone; going to school unaccompanied etc. How did this make you feel?

16. Did you use any early coping strategies as a young person to deal with your emotions: i.e. cutting, eating restrictions/comfort eating?

17. In the early stages of using drugs, how did using drugs make you feel?

18. What was your earliest experience of using drugs? At what age and which drug (or alcohol) can you remember using?

19. How did you feel about yourself growing up – as a young child and through your teenage years?

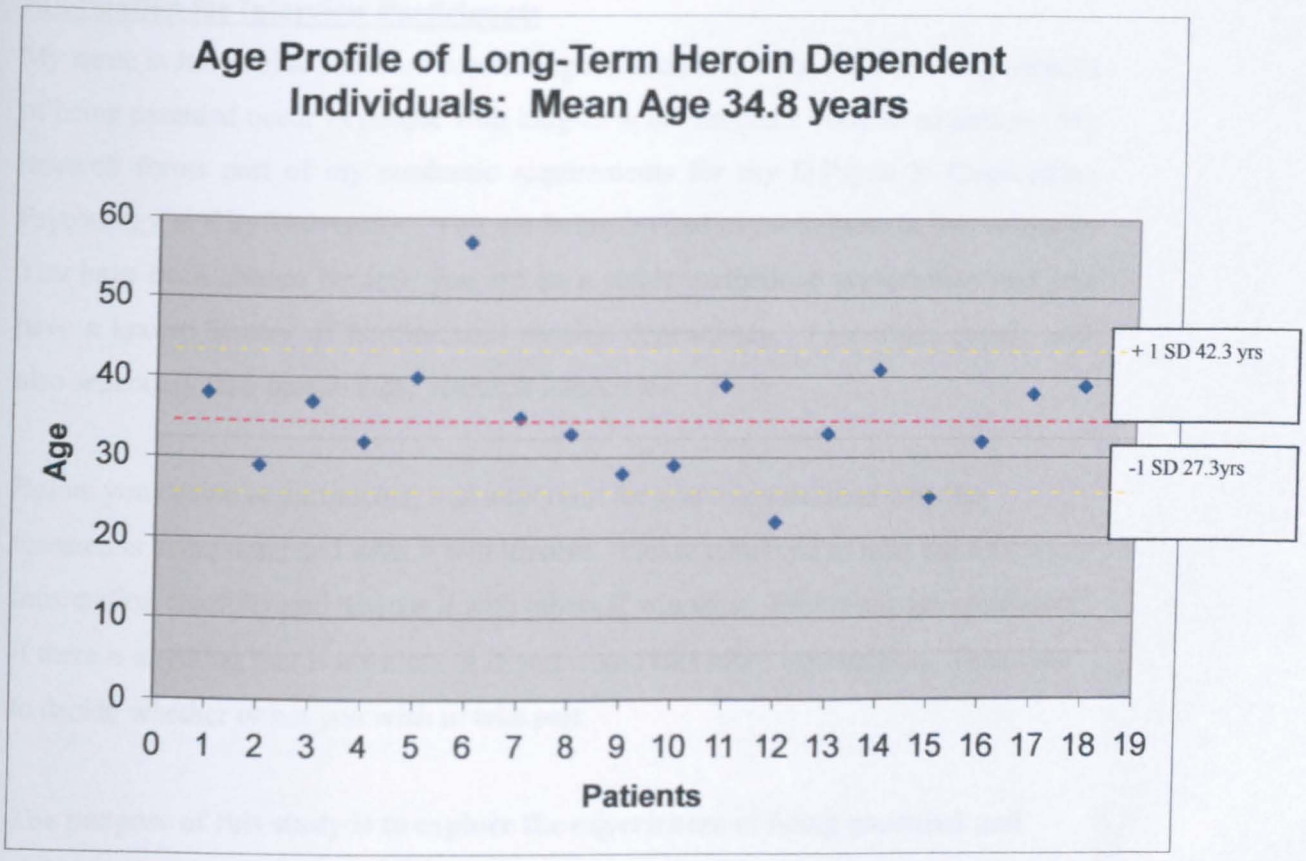
20. Did you have good friends around you growing up?

Appendix VII: Demographics summary table for participants

Participant Pseudonym	Gender	Age	Mother's age when born	Main carer	Position vs. siblings	No. of Siblings	Age of first using opiates	Stable Methadone PX without illicit use	Total time on Methadone PX	Length of addiction (illicit use)	Longest period of abstinence (without Methadone)
		Yrs	Yrs				Yrs	Yrs	Yrs	Yrs	months
Peter	M	41	29	mother	middle	1	14	2	20	25	zero
Jackie	F	37	29	mother	middle	1	19	4	13	14	9
Helen	F	42	39	mother	youngest	3	21	3	24	18	5
Scott	M	38	38	parents	youngest	4	18	2	35	18	10
Emily	F	33	30	mother	oldest	1	20	2	8	11	zero
John	M	41	30	mother	oldest	1	15	3	6	23	24
Mean		39	32.5				18	2.7	12.4	18	8

Appendix VIII: Age profile rationale for study sample

Age profile of long-term heroin/crack cocaine dependent individuals in psychological treatment 2006-2008 at the NHS Unit where this study was conducted.



Mean years	34.8
Median	34
Std. Deviation	7.5

Appendix IX: Information and Consent Forms

Information for Participants[1]

Study Title: A qualitative investigation into the experience of being parented in childhood and adolescence in people with long-term heroin/crack cocaine addiction

Information for Interview Participants

My name is Julie Paine and I am conducting research into what childhood experiences of being parented occur in people with long-term heroin/crack cocaine addiction. My research forms part of my academic requirements for my D.Psych in Counselling Psychology at City University. You are being invited to participate in this research. You have been chosen because you are on a stable methadone prescription and you have a known history of heroin/crack cocaine dependency. Five other people will also separately take part in these research interviews.

Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask the researcher if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The purpose of this study is to explore the experiences of being parented and childhood in people with long-term heroin/crack cocaine dependency. As a person stabilised on a methadone prescription your information is of great value to this study. Your recollections of growing up and your relationship with your family will significantly improve our professional understanding of the journey into addictive behaviours. By agreeing to participate in this study, I will tape-record three separate 1-hour interviews with you over a three-week period (one per week). The purpose of these interviews is to allow you to communicate your early childhood experiences and to explore the influences in your early life that may have influenced your decision in later life to use drugs and in turn, form an addiction. You will also be asked to complete a demographics form.

[1] NHS logo and address have been removed to safeguard the identities of participants

If you decide to participate, you will be paid a total of £45 in retail vouchers at the end of the third interview. The total of £45 represents £10 for the first interview, £15 for the second interview and £20 for the third and final interview. If you do not attend all three interviews, no retail vouchers will be given to you. Reasonable travel expenses that you incur to attend the interviews will be covered on each day of your attendance. The researcher - Julie Paine, funds travel expenses and retail voucher payments. The nature of the research requires participants to attend all three interviews. This will allow you to take your time when reflecting on your childhood and for as much information to be gathered without you feeling rushed. When all participants have attended three interviews each, the analysis can proceed as a fair and logical process.

I would like to emphasise that your participation is totally voluntary. Should you wish to withdraw from the study, or retract your contribution, for whatever reason, you are free to do so at any time. This will in no way affect your ongoing NHS treatment.

The researcher guarantees that the study abides by the Ethical Principles for Conducting Research with Human Participants set out by the British Psychological Society. The researcher thereby guarantees the anonymity and confidentiality of any information you supply. This research study has been approved by both the Ethics Committee in the Department of Psychology at City University, London, and by the Central Office for Research Ethics Committee within the NHS.

Possible risks of participating may be that you will feel vulnerable after disclosing memories of your childhood and you may wish to engage in follow-up Psychology treatment at the NHS unit where this research is being conducted. This will be automatically offered to you at the end of each research interview and will be given entirely free of charge to you. Should you require any psychological support between interviews, this can be arranged with the researcher, Julie Paine. A benefit of participating is that you may have some time to reflect on your childhood and the influences in your early life that may have contributed to your addictive behaviours.

You will be able to continue reflecting and receiving Psychological counselling should you wish to at the end of the research participation.
Taped interviews, transcripts, demographics forms, questionnaires and consent forms will be destroyed (shredded/deleted) when the study and assessment are complete. No information relating to the research interviews will be kept on file at Barnet Drug and Alcohol Service.

This research constitutes part of my Doctoral studies at City University. Therefore, when the analysis of the research has been conducted, a written thesis will be produced and the findings may also be published. However, no personal identifiers will be present in the write-up and your anonymity and confidentiality will be honoured at all times.

Before participating in the interview, you are asked to sign this consent form overleaf indicating your willingness to participate and have our interviews recorded.

If you have any comments, or wish or raise any issues regarding the conduct of the research, please contact Julie Paine at julie.paine1@btopenworld.com (Tel: 00000 000000) or Dr. Carla Willig at xxxxxxxxxxx.

Centre Number: Study Number:

Patient Identification Number for this trial:

CONSENT FORM

Title of Project: A Qualitative investigation into childhood experiences of being parented by long-term heroin/crack cocaine dependent individuals

Name of Researcher: Mrs Julie Paine

Please initial box

1. I confirm that I have read and understand the information sheet dated March 2008 ☐ (version 1) for the above study and have had the opportunity to ask questions. I have been given sufficient information to make an informed consent.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, ☐ without giving any reason, without my medical care or legal rights being affected.

3. I agree to take part in the above study. ☐

Name of Patient	Signature	Date
Name of Person taking consent (if different from researcher)	Date	Signature

I, Julie Paine (Researcher) agree to comply with the aforementioned statements.

Researcher Signature	Date

Julie Paine 1 copy for patient; 1 copy for researcher

Appendix X: Demographic information form for participants[2]

Please mark with a tick or complete the relevant item under each section.

1. Age

21-25	26-30	31-35	36-40	41-45
☐	☐	☐	☐	☐

2. Gender

Male	Female
☐	☐

3. Ethnicity (Please state)

4. What age was your mother when she gave birth to you (approximately)? Please state

5. Who had primary responsibility for your welfare as a child?

Parents	Mother	Father	Grandparent	Relative	Other (Please state)
☐	☐	☐	☐	☐	☐

.....

6. How many children were in your family? Please state

7. What age position were you in relation to your siblings? Please state in relation to each sibling i.e. sibling 1, sibling 2 etc.

...	Oldest child	Twin	Youngest child	Only child
Sibling 1				
Sibling 2				
Sibling 3				
Sibling 4				

[2] NHS logo and address have been removed to safeguard the identities of participants

8. **How old were you when you first began using opiates (Heroin/crack cocaine) excessively? Please state**

9. **How long have you been using a methadone prescription? Please state**

10. **How long ago did you stop using heroin? Please state**

11. **What has been your longest period of abstinence (no drug use)?**

12. **Have you ever undergone in-patient detoxification? If yes, how many times? Please state**

13. **When was the last time you detoxed? Please state**

Appendix XI: Debrief sheet for participants[3]

Form A: Thank you for taking part in the interviews.

The purpose of this study has been to investigate whether the emotional relationship with the mother has been instrumental in influencing a person towards adopting addictive behaviours. The study hopes to evaluate whether childhood issues are an important element to address in therapy when working with people with addictive behaviours. It also hopes to highlight that earlier intervention with young people and providing external emotional support may be of value in proactively helping to divert young people away from negative coping strategies and harmful addictive behaviours.

If you would like to receive information regarding the findings of this study upon its completion, please provide your address below:

.....

.....

.....

Postcode:.....

If after completing your participation in this study and reading the Debrief Sheet you have any further comments, or wish to retract your contribution, or raise any issues regarding the conduct of the interview, please contact Julie Paine at xxxxxxxxxxxxxxxxxxxxx or Dr. Carla Willig at xxxxxxxxxxxxxx.

Furthermore, if after taking part in this study you feel you would benefit from additional support, please consult Julie Paine to arrange appointments, or find a list of options below:

Samaritans	0845 909090	www.samaritans.org.uk
Nightline	0207 631 0101	www.nightline.org.uk
Narcotics Anonymous	0845 FREEDOM	
	(0845 3733366)	
	020 7730 0009	www.ukna.org

[3] NHS logo and address have been removed to safeguard the identities of participants

Appendix XII: Excerpt from participant transcript (Jackie)

Page 18

K: Well, when I was sort of a young teenager, I was a pain in the arse, you know. Sniffing glue and gas and all that kind of stuff that kids do and then soft drugs and stuff like that (laughs).
J: So how would you describe this transition?
K: An increasing pathway. Yeah.
J. Was anything else there, anything around food or self-harm or anything like that?
K: No, I've never been into self-harm and food, no...I never used food, not back then. I think we all use food, you know, when we're older, to a certain extent, you know. To reward yourself, or if you're feeling a bit miserable, to treat yourself or whatever, but no, I don't think I used food, I definitely didn't self-harm. I was quite popular at school, I mean, I had to be because we moved around a lot, you know and my middle brother got bullied very badly. Really badly. And um, my eldest brother, they tried to, but he didn't - he's a very different character to my middle brother, and he was more extrovert and he was used to fighting and getting into trouble and people left him alone and he had popularity and all that, you know, amongst a certain crowd and that kind of behaviour but F really was

Soft to hard drugs

Teenage pain

Increasing path

No self-harm

Food = comfort

Popular at school – had to be

Moved around/superficial friendships?

Brother bullied

Page 19

bullied mercilessly and he had really low self-esteem and he always felt that like, he always felt that, you know, my dad was laughing at him or thought he was a bit hopeless. He as well, is very academic. You know my middle brother, he's so unbelievably, mind-blowingly clever, but he's so sweet, you know what I mean, he would never assume that other people wouldn't know what he was talking about, you know what I mean and he left school with nothing, not a single CSE, O-level, he was the last year of CSE's and O's. Not one. Not one. And er,you know, and then, you know, he went and did GCSE's, cos they'd just started and did A-levels and he went to the LSE and then he went to D for his Masters. And he got nothing at school, nothing. Looking back, I think, fucking hell, we were really fucked up, you know. The other one, he got one CSE. I did better. My noticeable bad behaviour, that was another thing that pissed me off, my noticeable bad behaviour that came to the attention of my parents, that didn't happen until I'd really left school, you know, um, so there was no reason for it, it wasn't like, he was a shit because I was like that, you know, I mean I, I did better, I got 8 GCSE's or something, 8 A to C's anyway but they're a load of shit, they're a doddle. She got ten A-stars, I would fucking well hope so, she's got a brain in her head. I remember I did not open a book once, no revision, not at all, used to bunk off school quite a lot, you know, and I still got those. My

Dad was laughing at him

Sweet brother and clever

He achieved nothing academically

My bad behaviour

We were fucked up, couldn't anyone see?

Anger around achievement

I bunked off

parents weren't over the moon, cos although they were, well, she's got them, they knew that it wasn't a great achievement, you know, but it was obviously better than my brothers.

R: When you think back to the early experimentation of drugs, you know, glues and stuff, how did they make you feel? What can you remember the sort of effect being on you?

J: It was a good laugh. But I don't think I had any conscious idea back then. I think people say a lot of the time, oh, it was to block things out. I don't really think, you know, at that age, or even after that a lot of people do that consciously. You know, I certainly was not conscious of "that's why I was doing it". It was just good fun and a laugh and other people were doing it and...yeah, I don't think it was really until getting into gear and things that er...cos that was when I came back from university. That felt very good, you know, like you were obviously blotting things out in a way other drugs were not, not really. But yeah, that felt great.

They felt I should have done better

I was the best

Unconscious reasons

Good fun, a laugh

Felt great

Blotting things out that other drugs can't

Return from Uni = gear

Page 20

R: And just to be clear, we're speaking about heroin at this stage?

J: Yeah, sorry. Yeah, that felt great. That felt like an answer.

R: And what did you see it as an answer to?

J: It's hard to describe but it's just that overwhelming feeling of contentment and warmth and it's odd, you know, it doesn't put things to the back of your mind, they're gone, you know, and, like I say, it's very pleasant, you know? It's very pleasant, it's warm, it's cosy, you know, it's not like getting hammered or doing loads of buckets or getting pissed. Oh fuck when I sober up I'll have to deal with this. It really felt like, this is it, this is it, you know. I can't remember what I was looking for.

R: And what do you think you were looking for?

J: Just feeling better, feeling happy. I mean that goes quite quickly. But yeah, you feel happy. Not in the kind of way that you feel if you're taking uppers or E or something like that. Content.

Overwhelming contentment

Warmth

Different happiness – not like other drugs

This is it

Worries are gone

Happiness doesn't last

Doesn't matter what I was looking for

Contentment

Don't worry about consequences

Appendix XIII: Table of sub-themes extract

Jackie's Themes	October-08		Female
Theme	Sub-theme	Text Location Page, Line	Transcript Excerpt
Early relationship with Dad	Daddy's little girl	P1, L22	I was a Daddy's little girl to be honest when I was young
	close early relationship	P1, L23; P10, L33	we were very close. Wherever he went, I would go with him
	Growing emotional distance	P1, L25	he'd missed the transition from me being a little girl ...to twelve
	physical distance	P1, L20; P15, L13	we didn't see him very often ... once a year. He used to come for visits which wasn't very often, once a year or somet
	relationship deterioration	P1, L24;31	when my Dad came back finally from working abroad..things were not good ...we didn't have a good relationship .
	duality	P1, L22; P4, L35	Daddy's little girl. Why does he hate me?
	awareness of change	P14, L17; P15, L15	I sensed he was very different and quite uneasy when he came home. Things felt very different (when he visited)
	UK permanence	P15, L15	when he came back permanently that's when it really got bad
	damage limitation	P15, L39	you learned quite quickly what to do not provoke him and to stay out of his way
Superwoman Mum	head of household	P1, L30	she was pretty much the head of the household
	independent	P1, L27; P14, L29	she'd been without him for so long. She didn't expect to have maids...she found that difficult
	changed life	P1, L28	things had changed in my mum's life ...back at work, she had a career...
	the coper	P3, L21	mum ..had...not ever been this 'little woman'...she'd taken everything in hand
	strong	P3, L25	did it all on her own
	duality	P8, L23; P7, L34	she'd protect us from anyone or anything, but with him... If he'd ever done it to her, she'd have walked out the door.
	parental introjection/duality	P8, L12	(her father) doted on them (his children)...beat her mother ...all the time
	normal	P9, L4	my mum was pretty similar, I thought.
	shortcomings	P9, L4	She was a good mum...it was just this, you know...
			she did try to ...avoid it happening ...in her way and it upset her a lot. Another reason why I don't know why she didn't
	weakness	P9, L7, L32,28	him
	hardworking	P9, L20	(she) worked hard
	loves Dad	P9, L21	I mean she loves him obviously
	worries	P10, L5	I know what she worries about
	guilt	P10, L6, L12	I think she feels guilty about me. Made me feel that she did feel bad
	counsellor	P11, L10, L20	she did this counselling course ...that troubled her enough to write about it then
	dysfunctional childhood	P12, L40, L33	She had a really shit life. Her dad...who was a feckless waster who beat her mother really badly
		P12, L37	she was massively affected by growing up in that
	father's love	P12, L34	(her father) he was strangely very good to his girls...adored and doted on them
	opinionated	P18, L9	She had quite strong views on women...with partners who the kids don't like or who are not good to their kids
What made Dad that way?	poor childhood	P2, L28	he had a bit of a twisted mother
	emotional cripple	P2, L29; 30	you know he's a bit of an emotional cripple...he can't express things
	tense	P2, L31	things were incredibly tense all the time
	deterioration = bastard	P2, L32	things just got worse and worse ...he was just an absolute bastard to be honest
	temper	P3,L2,4; P7, L20	he had a very short fuse ...with all of use but it was worse with me. Dad's temper...it's not like it would flare
			after we'd done soemthing bad...it wou be something pathetic, like the milk left out of the fridge
	lonely	P14, L22	I think he liked it out there but he was quite lonley...he always had a maid
	duality	P15, L21	I never saw it (temper) directed at other people
	clever	P17, L7	my Dad...is a very clever man, always was, you know, academically
Who I used to be	Daddy's girl to hated object	P3, L17	I think part of it was missing the transition...he never saw us...I think he was a bit jealous of the closeness ...with mum
	the good one	P3, L7	while I was at school...I was the good one
	not like the boys	P3, L9	my brothers...were badly behaved at school...trouble with the police
	low self-esteem	P4, L6; P12, L6	(he) really affected our self-esteem. Self-esteem was low
	I'm responsible	P4, L6	I'm not blaming him for the choices we made
	worse with me	P3, L4	it was worse with me as I got older. His problem with me was so clearly bigger than the problem he had with the boys
	why me	P11, L27	what have I done wrong?
	unhappiness	P11, L31	we had such a miserable fucking life
	vulnerable	P12, L5	we were vulnerable to all sorts of things and miserable and unhappy and self-esteem was low.
	maids love me	P14, 27	I loved our maids..one in particular...she really love me
	difficult teenager	P18, L20	When I was sort of a young teenager, I was a pain in the arse
	argumentative teenager	P26, L20	about sixteen when we (mum) argued a lot
	free at 16	P27, L27	I could come in whenever I wanted, three, four in the morning..sleep out and things like that
I made his skin crawl	resentment	P3, L6	I always kind of resented that ...I was the good one
	hated me	P3, L12; 39	he just couldn't stand being in the same room as me...it was just horrible. Why does he hate me?
	rejection/abandonment	P4, L33; P5, L35	he ended up throwing me out. I came back from University and he chucked me out.
	similar temper and impatience	P6, L17	I have traits of my Dad. I've got a quick temper. I mean impatience
	sibling recognition	P6, L14	Oh they did...(acknowledge he was treating me differently). They did...when my brother attacked him
	violence	P7, L24,28	And although it didn't happen a lot, he did hit me. It was scary...I don't think he would have not stopped.
	role change	P10, L36	we were close (Dad)...which made it all the more confusing...I didn't feel like I've changed that much
	apparent cycle	P25, L29	within 30 seconds...swearing...and it could be anything...totally imagine things

What made him that way?	missed my transition	P3, L17	I think part of it was missing out the transition
	never saw us	P3, L18	of course, he never saw us...maybe once a year
	jealous	P3, L19	he was a bit jealous of the closeness we had with mum
	dysfunctional mother	P3, L31	his mother was a bit of a bitch...she just totally kind of pushed him out
	mother's exclusion	P3, L34	he was totally pushed out and treated very differently
	paternal feuds	P3, L31	he had these massive feuds with his Dad ...they wouldn't speak for years
	pity	P5, L10	I pity him now, actually
	no self-understanding	P5, L17	I don't even think he knows why...he's like that
	confusion	P6, L11	I still don't know why. we'll never know why...it's not like he's gonna talk
	abnormal	P8, L35	he was definitely not the norm. I knew that.
Conflicted Dad	loves	P5, L8	He does love us
	hates	P4, L39	Why does he hate me?
	sad	P5, L7	the consequences of the way he was..makes him very sad
	impotent	P5, L9	he can't do anything about it
		P13, L23	he would never change, I know that, he never will, would, couldn't physically couldn't change
	Jekyll and Hyde	P7, L1	people would meet my dad, and say how charming he was but ...h was a very different person ...popular at work
	self-control	P7, L32	I think he found it (temper) hard to control
	hint of pride	P16, L33	I found that out, but not from him ...he was showing my work (English essay) round work
	quieter around mum	P25, L35	it's still not pleasant when she's around...I can only manage short bursts (of him) when she's around
Idealised Mum vs reality	patched things	P4, L1	well, (she) patched things together
	good	P4, L1	mum was a very good mum
	can't fault her	P4, L2	there's not many things I could fault her on
	didn't protect	P4, L3	I do think that she didn't protect us from him
	blame	P4, L4; 14	I'm not blaming him....I do blame her for not protecting us from him
	inaction	P4, L25	I felt she should have done more
		P13, L19	if she said it out loud that would have made her think "now I have to do something"
	inadmission	P4, L26; P6, L8,L10	but she didn't actually admit it. She never admitted it...wouldn't even admit it.
	failed me	P5, 3	She failed me, actually.
	consequences	P5, L11; P9, L8	I pity my mother..she made her bed, didn't she? She did threaten to leave him ...he fucked off to America
	confusion	P7, L11;	Why din't she think she could do something...I have no idea. What was she afraid of?
	anger	P7, L5	and my mother was so fucking spineless. Now I think, ...what were you thinking?
		P16, L6	I did later get angry with her, more upset than angry. Not as angry as I feel now
	intervention	P7, 34	(she was) trying to get in the middle (me and him)
	parental introjection	P7, L36	her father beat her mother...jailed for it...happened all the time
	trauma	P8, L8	(she) remembers all that vividly...running to the police station
	denial	P11, L19, L30	she obviously knew what was going on...and still wouldn't admit it. Seems mad to me now that she couldn't see what
		P12, L7	I'm just incredulous she couldn't ask that...she could have stoppped it.
		P13, L19	like she physically couldn't bring herself to say it out loud
	excusing	P12, L1	maybe she didn't see that as a reason
	disapproving	P13, L4	her lips always used to go thin if she didn't approve. They'd go thinner and thinner
	expressed emotion	P13, L15	if she wasn't happy with something she would tell you and shout at you
	powerless	P13, L23	she knew he would never change...never will...never would
	upset/insecurity	P16, L10	it really didn't make you feel good about yourself...didn't make me feel good
Dichotomous mum - the ostriche	unfathomable	P12, L19	it's difficult to see what kept her there.
	transparent	P12, L29	other things she'd tell you...if she didn't like something or disapproved of something
	disapproving	P13, L4	her lips always used to go thin if she didn't approve. They'd go thinner and thinner
	approving	P13, L5	Not that she was disapproving she wasn't...all of the time but...she told you when she was happy or whatever
	favourite	P13, L10	she likes me the better...she used to say"I like you more than the others and I feel prouder of how you are...
	no favourites	P13, L10	my mum doesn't have favourites and she doesn't love one of us more than the other
	inaction	P13, L10	when she finally did threaten to leave him
	action too late	P13, L26	when she finally did threaten to leave him, of course I'd left home by then
	luck but..	P25, L24	she's great and I'm so lucky...but why didn't she do anything
	strong yet weak	P3, L33	I always see my mum as being so strong in some ways and I think how could she have been so weak

Appendix XIV: Example of initial master table for superordinate themes
(all participants)

Superordinate Themes	Subordinate Themes	Participant	Location
1. I was always the outsider			
	Not fitting in	John 4	P10, L15
		Helen 5	P19, L1-5
		Emily 3	P5, 37-38; P6, L1
		Peter 2	P16, L23-27
		Jackie	P33, L18-26
		Scott 6	P21, L29-32
		Scott 6	P36, L29-30
		John 4	P34, L12-13
		Helen 5	P3, L5-6
		Helen 5	P3, L24-32
		Helen 5	P3, L24-30
		Helen 5	P18, L3-5
		Helen 5	P18, L18-19
	Treated differently to siblings		
		Peter 2	P3, L23-27
		John 4	P2, L10-13
		Helen 5	P2, L17-22
			P5, L18-23
		Scott 6	P4, L20-21
		Scott 6	P10, L38; P11, L1-3
		Peter 2	P22, L13-16
		Jackie 1	P3, L4-14
		Helen 5	P22, L35-38, P23, L1-2
	Childhood Insecurity		
		Scott 6	P11, 22-23
		John 4	P10, L19-26
		Emily 3	P16, L9-11
		Emily 3	P5, L35-37
		Emily 3	P25, L19-21
		Peter 2	P1, L31-35
		Peter 2	P2, L4-6
		Peter 2	P12, L35-39
		Emily 3	P22, L25-28

Appendix XV: Second master table (clusters)

Clusters and emergence of superordinate themes and illustrative quotes

Superordinate and Clusters

1. I was always the outsider	Participant	Line reference	Quote
Not fitting in			
			I never had like, people that I grew up with, you know. I did have a best friend when I was in N..... .....and I had another best friend, H, who I actually lived with them at weekends cos my dad, my dad at one point was working in G for a short while, about six months or something, and he used to come home at weekends so I used to live at theirs for the
No friends around me	Jackie	P33, L18-26	*weekends.*
			I always felt a bit different and I had very few friends... I had to be pulled in. No, no, never one of the crowd, no...
	Peter	P16, L23-27	
			I always ache because I wanted a group of friends to see every night or any night, Saturday, Friday, when everybody go[es] out, call somebody and you know just, you're going to go out together, without issue, because you're a part of this gang, not in a bad way, just getting a group of people to hang out...
	Emily	P27, L4-7	
			Shyness, I think is the main thing, you know what I mean? Not fitting in, you know, that's
Not fitting in	John	P34, L12-13	*the main thing, that's what I think, you know?*
			...people at a sub-conscious level, you know, go for the person like them and she did, she became a magnet to me and we got very friendly and we used to put it down to the fact that we didn't fit in. She wasn't, I mean, she was half-Jewish but the fact, she'd just come over from Hungary, learning the language, blah blah blah, she felt she didn't fit in either and
	Helen	P19, L1-5	*that's probably why our friendship was so strong...*
			I did have lots of friends, but what I never used to do was bring any of em home. Cos my house was always in such a mess because there were so many of us and all that, so I couldn't bring my mates home and all that. So that used to put me out a little bit from
	Scott	P21, L29-32	*everybody else*

Being treated differently			
			That [violence] was with all of us but it was worse with me as I got older. Much worse with me as I got older and I always kind of resented that because at least while I was at school, you know, I was a good one, you know, my brothers... although they're very successful now, academically as well, you know, they left school with nothing, they were badly behaved at school, you know, my eldest brother was getting in trouble with the police while he was still at school and I didn't, you know, but he, he, he [her father] just couldn't stand being in the same room as me. He even admitted it, he even admitted it
Different to siblings	Jackie	P3, l4-14	*once. Finally, things were very tense. It was just horrible*
			She wasn't like that with my brother, with my sister it's different because it's a girl and ... you know, girls are different. But um, no she didn't she didn't show me that thing with my brother which she did with me, she was much more relaxed with my brother growing up
	Peter	P3, L23-27	*than she was with me...*
			My brother, he is different to me. His relationship was good with my father. He was a good guy [brother], he worked all the time, for a period he worked with my dad, both of them not earning anything and it wasn't really my brother, he isn't really a person that works a lot, you know, my brother but he wanted his own things, he wanted a car, clothes, but he wanted his life, away and he didn't really care too much what was going on in the house and it was always, my mum on his side and she was in the middle between my father
	Emily	P5, L4-10	*and me. She was always talking to my brother, not me.*
			my brother was too young for me to like play with or whatever, yeah. Then he got meningitis. And so...say me and mum it was like more more, er, my mum worried about my brother cos like he's you know, so it was more my mum going to the hospital (to visit
	John	P2, 10-13	*brother), it wasn't like we was that close, you know what I mean?*
	Helen	P22, L34-36	
			...my close friend Sally ... she was very much like me, you know, couldn't speak to her mum, but a lot of other girls were quite close to their mums – used to go shopping with them and all sorts, so there was a difference. But it never actually occurred to me as to
		P23, L1-2	*why there might be those differences. I just used to sort of accept them...*
			I mean they spent a bit of time and effort with the others, they went to the zoo and to the park and played football and I never had none of that, like I said before and it bugs me, you know whereas before I never used to think it did and it's only like recently, actually,
	Scott	P10, L38; P11, L1-3	*cos I never thought about it before, and I think maybe I did miss out a bit*

Childhood insecurity

Being on guard	Jackie	P7, L20-24	*Like the thing with my Dad's temper and things, you know, it's not like it would flare after I'd done something really bad at school, you know it would be something pathetic like the milk left out of the fridge or something.*
	Peter	P12, L35-39	*My first year in high school and mum, and one day I came home and saw her crying and I'm like mama don't, and I knew straight away that something related to me. Because if it wasn't me, she had the opposite [look], I never see her like that but I knew it was me because of the way she was crying. And I really felt, it's not the only, but I think it's one of the few times I really, really felt ...alone.*
On my own	Emily	P22, L25-28	*Well, the fact that he abused me for quite a long time I was scared, I didn't want to stay in the same, I didn't want to stay alone with him, you know that er, I can say it disgusted me. Bad, he made me feel ... bad. You know, I, I don't know if it was just his fault but I hated my house, my life, a part of it, he was a strong part of that...*
	John	P10, L19-26	*She [his mother] did two places [jobs] in the morning, she'd do somewhere else when I was at school or ... and I know she always did one in the evening so I'd be indoors, you know what I mean? I mean nowadays they'd call that neglect, wouldn't they? But like, as I say, like, I'd come home and do my homework and, as I say, and also, like, our house, in the morning, the [*street*] door was open [this was shared accommodation – a room in a house], the front door, yeah, and that was it, unless someone shut it after midnight. Anybody could come in and sit on the stairs you know what I mean, it was just a house and all that kept you from anybody was like a door like that [points to door], you know what I mean? A bedroom door...*
	Helen	P7, L27-30	*I think I would have been about 14. They used to go to my brother's for the weekend. Obviously I was invited, I mean I didn't want to go, of course and I remember...it was from about 14 I was left for a weekend alone*
Self-conscious	Scott	P11, L22-23	*Yeah, of course. You hate it, don't'cha, getting called Fatty and all that and all I could do about that was punching people who called me names ...*

2. I wanted an ordinary Mum and got Supermum

The unspoken			
No-one to tell	Scott	P9, L24-26	*...nobody used to talk to their mums and dads about your feelings and all that. It just wasn't done. Nobody I knew used to do it. None of my mates used to talk to their mums...*
	Emily	P2, L10-13	*I said I don't want to see [her father], I don't want to stay with him, I don't want to see him and I remember somebody telling me, somebody saying to me, how can you say that? He's your dad! But again, I couldn't bring myself to say that's the reason why...*
	John	P13, L16-18	*I wasn't about to say that [to his mother], I never could have got that out [the paedophile encounter], you know what I mean, you know? So I wasn't about to say nothing. So really, you're about the second person that ever heard that, you know what I mean?*
	Helen	P19, L25-27	*I felt, as I went through 12, 13, that sort of era, I seemed to just draw back from her [mother] and it seemed we no longer seemed to ... communicate very much*
	Jackie	P30, L13-16	*Yeah. I never used to. I never used to talk about it at all. I don't know if that was the right thing but I just felt it was a bit selfish to burden her with that, because, I mean obviously already she was thinking awful things anyway*
	Peter	P18, L23-24	*Er. Maybe I didn't express myself enough. Maybe I was too quiet. Maybe I took things more responsibly*
Unanswered questions			
Why didn't she help?	Jackie	P7, L4-13	*He was just a shit you know, just an absolute shit. And my mother was so fucking spineless, you know. I mean I used to think, I mean now I think what the fuck? What were you thinking? What would he have done if you had pulled him on it? He would have done fuck all, he would have done nothing. He worshipped the ground my mother walks on, he would have died if she'd left him. He would have died. Couldn't have coped without my mother. Why didn't she think she could do something, you know? [Her voice rises strongly in anger] I have no idea... No idea...*
Why did she do that?	Peter	P19, L25-33	*She still, she still was right, she still was right with that bloody jacket. I wish I hadn't bought that damn jacket, man, because that is something that is still in my brain, in a sense it's not in my brain because I've got over it but I still don't understand. It kills me. Why? ... And, I, really one day she's going to have to look me in the eye and say Peter, I took it and I threw it, because I, you know, tell me whatever you want, but don't just say to me, that jacket was horrible – that's what I can't understand, that. Oh my God...*

	Helen	P11, L17-20	*I didn't (get over it), because I couldn't forget about it, because I did feel, apart from the idea that my mum now knew I was having sex and taking drugs, I mean, how could she? That was private. She shouldn't have been reading that. And it's something that stuck with me*
Was I to blame?	John	P20, L29-33	*I threw it right up in the air, course where's it come down? It lands on my brother's head and sticks in [metal shovel], you know. And er, sometimes I basically wanted to be, nasty, and she would use things like that psychologically, you know what I'm saying? Like, it could have been something like that did send him over the top into schizophrenia, you know?*
	Emily	P1, L29-32	*I don't know why we were in bed together...I remember probably because my mum was out and I just remember him on me, kind of licking me and just generally be above me*
	Scott	P8, L32	*I never said to her, you gave me a right hump...she knew but I didn't say it, but she knew when she gave me the hump. So yeah, it is hard to talk to each other*
Always busy			
Too busy coping	Jackie	P3, L20-25	*And the way mum had kind of, not that she had even been this 'little woman' d'you know what I mean, but she'd, you know, just taken everything in hand, you know, she was working full-time, she had three kids, she had a house to run, you know, she was studying, you know, and she did it all on her own with no help [while the father was working abroad]*
	Emily	P3, L29-32	*It was really, really hard, and after [the age of] eight or nine when I knew there were problems [financial] and my mum was trying everything, she was working, she was raising a family, she was going around, speaking with a lawyer because we had lost everything we had...*
	Scott	P5, L15-22	*See, mum used to go, mum always had to work. Dad, never. So, then after going to work, she used to come home and start work again because she'd have to cook dinner for everybody and do the washing and ironing and all that. And with the old man being ill, even though he was there all the time, I mean I never went out and kicked a football around with my dad or anything like that. So, I don't even know what I'm trying to say, d'you know that? She was just busy, most of the time, mum, mum, and then she used to like, go to Bingo, after she'd done all that. So a few times, we used to get left with T [his brother] and he was a right bastard to us when we were kids.*
With her but unconnected	Peter	P1, L28-29	*I remember going to, you know, with my mum when I was four or five and she went to clean an office and I went with her*

	John	P1, L26-28; P2, L1-3	*I remember mum taking me home cos she'd do, like, two jobs and then something while I was at school, you know what I mean, yeah? So I remember getting up sort of early and she'd do cleaning, you know what I mean, like office cleaning? So, like, we'd be out, I should imagine, sort of like 5-ish, I imagine, yeah. I remember waking up, like you know, to move on to another factory, yeah and then, er... waking us up to go to school sort of thing...*
Mum-pleaser	Helen	P13, L15-17	*I have been a people-pleaser in life. I have noticed that. Um, when I get angry, I can't express myself as most people ... it just comes out. I do find it hard sometimes to say no to people...*
	Jackie	P31, L11-15	*I think as well, it probably just felt a bit indulgent telling her after [my suicide attempt], you know, it's like well, why would I tell her that? She knows I'm hideously depressed anyway, what's the point of telling her that? Like, see? See? That's how depressed I am, you know. And I didn't want to upset her, you know. So I didn't [tell her]...*
	John	P17, L38-40	*R: When you say not openly, do you mean you wouldn't necessarily share your worries with other people, you would kind of deal with them yourself?* *J: Yeah, yeah. We're both sort of like that, you know what I mean...*

3. My search for a new improved sense of self Good kid turned bad			
I had talent	Peter	P3, L31-33	*I was a good student, my brother wasn't interested, my sister not that much, and I was a really top grade student and I wanted to be a doctor, since I was four years old ..*
	Emily	P17, L30 36	*I had the dream of dancing... since I was five. I always regret not dancing. I should have gone to a professional school and you know, have a job, not being famous or anything ... everybody knew that was my thing, everybody recognised that and I even said I would go to the [dancing] school and I tried to, but that was, you know, in a different family [if my family had been different] where there weren't all these problems all the time...*
I could have been somebody	Scott	P22, L21-24	*When I was younger, I always thought I'd do well, to tell you the truth, I did. I always thought I was gonna do something meaningful and proper where everybody would know my name. And then, I suppose when I got ill and I got a bit bigger [that is, fatter], I lost a lot of security, I felt quite bad about myself .*
	John	P16, L26-30	*I mean I got an education, I know she was [my mother] upset cos the school wanted me to stay on and take O-levels but I was already working then, you know, I was bunking off school and working when I should have been at school, yeah? And um, obviously it's the same with anything, but with hindsight, I wish I'd took them, because the teachers thought I had a real chance of passing...*
Keep up appearances	Helen	P13, L23-26	*I got the idea that I was on the whole well-behaved, I was supposed to be intelligent, blah, blah, it was like somehow I didn't want to blot the copy-book, they [my parents] got this idea that that's who I am, then I can't destroy it, I've got to live up to that...*
	Scott	P6, L29-32	*...to tell the truth, I was a good kid up until I started not going to school [after a year-long absence due to illness] and then cos I had nothing to do, I started shoplifting, you know, and all sorts of other shit and just getting up to all things that they [his parents] still never knew about until I was sort of fifteen...*
	Jackie	P19, L13-18	*Looking back, I think, fucking hell, we were really fucked up, you know. The other one [her brother], he got one CSE. I did better. My noticeable bad behaviour that came to the attention of my parents, that didn't happen until I'd really left school, you know ..*
It's my fault	Peter	P7, L9-12	*I'm the one to blame. That's how I see it. I'm the one to blame because I'm the one who did it [drugs], nobody else, you know. I'm the one that brought into the family that big thing that affected my brother, my sister and everybody else. I'm the one...*

Turning towards self-reliance			
Experimenting	John	P39, L8-11	*I started [aged 12 or13] like listening to other people that used to say if you put an aspirin in Pepsi, right, you'd get drunk, right? So I tried that. I'm a, I would give anything a sort of go...*
Dying to get away	Helen	P3, L14-16	*When I was a young teenager, you know, we weren't really that close [her and her mother], I was quite a rebel by that stage, so I left home at sixteen so that was the end really. I used to see them [her parents] obviously, but not a lot...*
You have to cope	Scott	P17, L6-10	*I never really thought about how I coped [as a teenager] or anything... You got to. And if I don't cope [now], I'd rather just give up and go back on the gear or whatever, d'you know what I mean? So you gotta cope. Everybody has to, it was not just me. I don't think it's no different for me...*
	Emily	P24, L22-25	*I was just trying to look after myself [as a teenager] and I don't know what it was, now sometimes I think maybe I needed a support around, a mentor around... living in my house, you know... I think I wanted to do too much by myself...*
	Jackie	P18, L20-23	*Well, when I was sort of a young teenager, I was a pain in the arse, you know. Sniffing glue and gas and all that kind of stuff that kids do and then soft drugs and stuff like that... An increasing pathway...*

Transformative power of drugs			
Chilling	Scott	P18, L17-19	*It was just this, getting stoned. It's like when you have a drink, I suppose. You probably like having a glass of wine at home when you finish, to chill out and relax. It's the same thing, just stronger... Not thinking about anything... when I started it [heroin, at the age of 16], it was this little world and then you got accepted into it...*
No worries	Jackie	P20, L5-12	*It's hard to describe [taking heroin] but it's just that overwhelming feeling of contentment and warmth and it's odd, you know, it doesn't put things to the back of your mind, they're gone, you know, and like I say, it's very pleasant, you know? It's very pleasant, it's warm, it's cosy, you know, it's not like getting hammered or doing loads of buckets or getting pissed. "Oh fuck when I sober up I'll have to deal with this". It really felt like, this is it, this is it, you know. I can't remember what I was looking for.*
	Peter	P13, L28-34	*There was something in it that made me just close my eyes and it was like a relaxed state that I hadn't had for some time. And even though it was hard [at first] because, my god, it was, vomiting and very very unpleasant, the feeling was very unpleasant but, you know, the numbness that it gave me, that was something that, that's the thing that really, that got me, even though, at the beginning, I went through you know, getting used to it. But yes, I felt numb ... completely ... I mean, was it, was it as well, like peer pressure as well [that I was escaping from] with friends? Being shy and wanting to follow a group of friends that I had made?*
There's downside	Emily	P24, L35-42	*The heroin is quite strong, it makes you vomit and you know, well... but it looks like it, yeah there was yeah, a feeling of belonging, something like that... it made me feel... well apart from the physical side of feeling warm and everything alright, it was probably something grubby...*
Community	John	P34, L25-28	*Yeah, peers and like you know, I encouraged them to take it with me because I wanted to belong to something so I started my own sort of like member group so I would turn em on [encourage them to take the drug] because like I was getting gear (heroin) at the time, right, and I would sort of turn people on to sort of have friends, sort of thing, like I'd have my own little clique, I'd made my own little niche... So I had a place I fitted in, you know?*
	Helen	P15, L22-26	*Oh euphoric. Wonderful. This is the answer to life. If I just take this, I can be happy every day. That really is what it felt like. Oh the answer to life, it was what I found, and it was absolute euphoria, oh, a wonderful feeling. Couldn't imagine anything going wrong, anything worrying me. Just felt absolutely wonderful...*

Appendix XVI : Example of master table with illustrative quotes (for all participants)

Being treated differently

Participant	Page & Line No.	Quote
1	10, 15-16	Er ...I didn't really know anybody else really because my mum didn't let me go out and mix with the others, you know.
2	33, 18-26	I never had like, people that I grew up with, you know. I did have a best friend when I was in N..... .and I had another best friend, H, who I actually lived with them at weekends cos my dad, my dad at one point was working in G for a short while, about six months or something, and he used to come home at weekends so I used to live at theirs for the weekends.
3	18, 3-5	Erm, I always felt a little bit of an outsider because of the school and the people, though I was always in the mix, you know, the gang I used to go around with, I sometimes felt I didn't quite fit in
4	36, 29-30	I had friends sort of, when I went to school, who I used to go round with, but I didn't have friendships with them after school
5	24, 11-15	so I didn't feel accepted as I had the whole class against me and it was also my fault, I was really doing my best to get along with people but my thing was to want to be upset and again, when I was 13 or 14, with my best friend, they all went out one day with these cute guys and they lied to me basically and said they were doing something else
6	21, 13-17	I've been thinking especially about, um, how different I was from my siblings when I look back. You know, very very dissimilar in a lot...I know usually we are different people, you know, brother and sister are different, how they look, they act. We know that but, um, at the end, I think I was completely different

Appendix XVII: Additional transcript quotes (relating to the three superordinate themes)

(This does not constitute an exhaustive list of quotes of all those that could fit into these discrete categories. These are the quotes that were discarded from the finished analysis that is presented in this thesis).

Superordinate Theme 1: I was always the outsider:

Sub-theme A: Not fitting in

1 *Shyness, I think is the main thing, you know what I mean? Not fitting in, you know, that's the main thing, that's what I think, you know?*

John: 34, 12-13

2 *I never had like, people that I grew up with, you know. I did have a best friend when I was in N.....and I had another best friend, H, who I actually lived with them at weekends cos my dad, my dad at one point was working in G for a short while, about six months or something, and he used to come home at weekends so I used to live at theirs for the weekends.*

Jackie: 33, 18-26

3 *I just tended to not want to mix with them. You know, if I weren't with my friends I didn't want to be with my family*

Helen: 3, 5-7

4 *Er ...I didn't really know anybody else really because my mum didn't let me go out and mix with the others, you know*

John: 10, 15-16

5 *I had friends sort of, when I went to school, who I used to go round with, but I didn't have friendships with them after school*

Scott: 36, 29-30

6 *I did have lots of friends, but what I never used to do was bring any of em home. Cos my house was always in such a mess because there were so many of us and all that, so I couldn't bring my mates home and all that. So that used to put me out a little bit from everybody else*

Scott: 21, 29-32

7 *Erm, I always felt a little bit of an outsider because of the school and the people, though I was always in the mix, you know, the gang I used to go around with, I sometimes felt I didn't quite fit in*

Helen: 18, 3-5

8 *Yeah I felt like I didn't quite fit in. Although I was accepted, I felt I was still an outsider*

Helen: 18, 18-19

Sub-theme B: Treated differently

9 my brother was too young for me to like play with or whatever, yeah. Then he got meningitis. And so...say me and mum it was like more more, er, my mum worried about my brother cos like he's you know, so it was more my mum going to the hospital (to visit brother), it wasn't like we was that close, you know what I mean?

John: 2, 10-13

10 So I don't really remember them (siblings) being at home. Though I think I was a bit more spoilt, quite honestly. You know, I was known to be the spoilt one of the family, being the youngest of course. So I'd say if there was a difference, maybe I was a bit more spoilt than the others because they (parents) were then financially more able to, you know, having had most of the family grow up.

Helen: 2, 17-22

11 I remember at home, I never had to do any washing up, any household chores because I was going to grammar school... .....and I mean, my poor sister always had to do the washing up and everything so that was part of my mum spoiling me, you know, it's oh, don't make her do it, you know, my older sister would become very resentful about it

Helen: 5, 18-23

12 My brother, he is different to me. His relationship was good with my father. He was a good guy [brother], he worked all the time, for a period he worked with my dad, both of them not earning anything and it wasn't really my brother, he isn't really a person that works a lot, you know, my brother but he wanted his own things, he wanted a car, clothes, but he wanted his life, away and he didn't really care too much what was going on in the house and it was always, my mum on his side and she was in the middle between my father and me. She was always talking to my brother, not me.

Emily: 5, 4-10

Sub-theme C: Childhood Insecurity

13 So then we went and we stayed a week in the snow and and and I took a room with him and you know I thought, Oh my God I hope he doesn't betray me

Peter: 2, 4-6

14 Yeah. I can't do it. I just can't do it, you know? That shyness or I'm afraid of making a fool of myself, I don't really know. I take it very hard if somebody puts me down, you know what I mean?

John: 34, 35-37

15 I wasn't unhappy, there wasn't major things that shocked me really until I was 8, 9, 10, then it was all about money and crying and my dad drunk, all the time, all the time. I just hated my life

Emily: 25, 19-21

16 Like the thing with my Dad's temper and things, you know, it's not like it would flare after I'd done something really bad at school, you know it would be something pathetic like the milk left out of the fridge or something.

Jackie: 7, 20-24

17 I think I would have been about 14. They used to go to my brother's for the weekend. Obviously I was invited, I mean I didn't want to go, of course and I remember...it was from about 14 I was left for a weekend alone

Helen: 7, 27-30

Superordinate Theme 2: I wanted an ordinary mum, not Supermum
Sub-theme A: The Unspoken

18 I tried not to (talk to her about drugs) because I just felt that it was awful. It was an awful thing to hear. She worried enough as it was

Jackie: 30, 10-11

19 Yeah. I never used to. I never used to talk about it at all. I don't know if that was the right thing but I just felt it was a bit selfish to burden her with that, because, I mean obviously already she was thinking awful things anyway

Jackie: 30, 13-16

20 Yeah, there's a lot of that (not talking). A lot of that. Yeah. Yeah.... Yeah. I tried to kill myself as well and she never, she never knew about that for years. I never ... yeah.

Jackie: 30, 18-20

21 Er. Maybe I didn't express myself enough. Maybe I was too quiet. Maybe I took things more responsibly

Peter: 18, 23-24

22 He was very much in the background and sort of...he was always there but I really don't remember a whole lot of conversations with him, I just don't know why that is

Helen: 24, 4-6

23 But I wasn't telling her anything about my worries because I could not..... I wasn't, again this friend of mine with her mum "Oh I met this guy, going out and this and that", I could never do that

Emily: 3, 22-24

24 Bizarrely, he seemed very concerned when I got Hep C which I thought was really quite odd, it was the least of...To me, the least, I cleared that anyway, which was quite novel

then, before they knew what could really happen. I suppose he had Hepatitis maybe. But yeah, I never, as far as I was concerned, he could have been, I mean, he could have been blissfully unaware, you know, it created such upset in our lives, but he might as well have, for all it was never mentioned. You know, our situation or anything like that. And I don't think mum talked to him about it either although he knew what was going on and stuff like that

Jackie: 22, 26-36

25 No. I mean we take the piss out of my dad (with siblings behind his back) now but we never talk, you know, about how it was

Jackie: 6, 30-31

26 We never sat round and talked about nothing as a family. You just didn't do that then

Scott: 15, 28

27 even with my dad if it was anything deep, I wouldn't talk to him about it, it was just like general problems that everyone has growing up, you know what I mean

Scott: 30, 8-9

28 You felt sincerity. And that's um, those things, they touch me then. They touch me today but I did feel that erm and thinking about, thinking back, I think that's how I mean, I know now, now I know that I wish I had gone to him on other things, I know things could have, I could have had other things I know it now. Er...I didn't you know

Peter: 26, 2-6

29 Even though...even with him (dad), I wasn't as open as I would have liked, that's how...yeah, that's how it's supposed to be.

Peter: 25, 15-17

30 My brother used to speak to me a bit, but I'm not sure whether he was involved in mum reading my diary, so that, sort of after that, I didn't speak to anyone in the family about anything

Helen: 11, 33-35

31 I never asked her, right. I never asked her. But I always felt like, and maybe one day I will ask her because I always felt like, out of curiosity. Why not with my brother? And I'm sure it's because in herself, you know, looking now back I see myself as well, if I'm fair to the situation, I say to myself, you know, was she right? Because in a way I betrayed her, I took drugs. I betrayed my family and he didn't, so was she right in that I didn't deserve that autonomy

Peter: 27, 25-30

Unanswered questions:

32 But I think it was the fact that she <u>never</u> admitted it. She used to comfort me and that but she used to sit there and say <u>nothing</u>. Wouldn't even admit it (anger). I still don't know why, you know, we'll never know why

Jackie: 6, 9-12

33 She's mothering one more than the other (brother) and I think she trusted him more...but you have to give the trust as well, try to give the trust. I could have, you know. I could have behaved the same as my brother did, I dunno, I dunno. It's hard, very hard and...I mean, there is a lot of hate, on my side for thinking that, you know, hate, because in reality, I don't know what she thought or if her life influenced her, I don't know. So that's why I don't want to be too harsh. I've always tried to understand my mother. Always

Peter: 19, 15-22

34 I didn't (get over it), because I couldn't forget about it, because I did feel, apart from the idea that my mum now knew I was having sex and taking drugs, I mean, how could she? That was private. She shouldn't have been reading that. And it's something that stuck with me

Helen: 11, 17-20

Sub-theme B: Always Busy

35 but Dad, no dad, was working from, he left at about 4 or 5 in the morning and he'd come late

Peter: 3, 7-8

36 Dad is not there, he's working, when he comes home he's tired, he's not dealing every day with us

Peter: 11, 29-30

37 Erm, well we're very good friends but obviously when we were young, I don't mean, you know, these crap mums who say "Oh yeah, I'm like my daughter's best friend", I don't mean like that, you know

Jackie: 1, 27-30

Superordinate Theme Three: My search for a new, improved sense of self

Sub-theme A: Good kid turned bad

38 While I was at school, you know, I was a good one, you know, my brothers...although they're very successful now, academically as well, you know, they left school with nothing, they were badly behaved at school...

Jackie: 3, 6-9

39 I was very responsible. I was very responsible. My brother wanted a tennis racquet, it had to be the best racquet, if he wanted shoes, it had to be the best shoes. When I went with Dad to buy a racquet, I said Dad I just want this one, I knew it would be much cheaper, I didn't care. I remember now that I was very responsible at that time, I knew the financial situation. My brother was older than me, he didn't care, he wanted the best, he wanted you know. But no, I knew, I knew the position and I was responsible, I think

Peter: 5, 24-29

Sub-theme B: Turning towards self-reliance

40 Well, when I was sort of a young teenager, I was a pain in the arse, you know. Sniffing glue and gas and all that kind of stuff that kids do and then soft drugs and stuff like that... An increasing pathway...

Jackie: 18, 20-23

41 When I was sixteen I started to really stay out until 3, 4 o'clock, I was working in a bar in the city, so they kind of, really, they didn't know what to do to keep me home. I remember one night screaming and shouting, I didn't want to stay there (at home), I was happy there when I was working

Emily: 21, 29-32

42 My teenage years, it's a time of my life that I really don't remember fondly. I really hated them. I hated them. I don't, but I was, I think it was because I was shy as well. I was not a person to, you know, I, I got into things because I was naïve. Because I didn't know, I wasn't a precocious person, even sexually or I was not, I was very very naïve and sometimes things happened to me, that I didn't look for them, I, you know, do it on purpose and that, you know, with mum, she always created something, you know, some tension that er, yeah, I mean, I remember like, when I was 14, 15...

Peter: 12, 28-35

43 *I hit puberty, you know, I wanted more freedom, and I didn't really want security any more but obviously it was still there...*

Helen: 20, 19-20

44 And then by the time I got to fifteen, I was like, I wanted to be a rebel really, that was it, I just wanted to rebel, you know, even though I knew I was going against my parents and their values and everything, really I just wanted to rebel ...

Helen: 21, 6-9

45 Before my teenage years, I considered myself very ugly, I was still very skinny ... Then when I was around 13, 14, I went to puberty and I got taller and had a nice body, I put make-up on, so I saw the change in everybody and I actually thought I was very attractive...

Emily: 26, 19; 23-25

46 It's like parents like always say, "You got into a bad crowd", they always say that. But like, I was the bad crowd, you know what I mean? I was the one that started taking gear amongst my peers

John: 34, 18-21

Sub-theme C: Transformative power of drugs

47 it was a lot lot stronger, much more intense, which is obviously why it's such a powerful drug, when you initially take it, you feel, yeah, this is great, the answer to my life, if only it were that simple

Helen: 16, 1-3

48 I can't think, I don't think I can say that it [taking heroin] was specifically, you know, to get out of home. That's not how I feel it now. I mean, it may have been, but it certainly was, you know, for me to see a couple of guys one day, you know, sitting like this, I was wondering, you know, what is that? You know? Why is this guy so mellow and sitting down and so I think it was an attraction to me, wanting to be like that. I don't know if I can relate it in those terms, of home and... I can't relate it in those terms.

Peter: 14, 1-6

49 maybe it [taking heroin] would have happened anyway even if I had a beautiful network around, family. So, yeah, these things, these changes, influence towards the drugs. I think about it a lot, you know, first of all, I really wanted to try the drugs, it was something that straightaway I wanted to, at fourteen I smoked a cigarette and then I smoked a spliff, it was something I really really wanted to do and at eighteen I first had the possibility to try heroin, I did straightaway, even though I was aware I was throwing everything away

Emily: 24, 26-32

50 I wanted something about me that was different, you know what I mean. Um, not necessarily to fit in, you know, it was sometimes like to actually, like, be the one, you know, like the one that they like, I remember when I started taking drugs, yeah, I took it because like nobody else was taking it, so I had something different

John: 4, 21-24

51 I've gone in places where I could have had my throat cut or whatever, you know, but no, you don't think of that because you're in a good mood [after using heroin], you only get the bad mood if you're withdrawing, whereas with alcohol, it's the opposite way round, the more you drink the more violent you get, you know so like, I found I used to much prefer to be around people that would like be friendly, cos if you was on ...heroin, you'd be sort of like, very laid back and you'd be friendly

John: 31, 31-35

Appendix XVIII: Participant Demographic Summaries

Peter

Peter, aged 41 years, is the middle sibling to a younger sister and older brother. He first started using opiates aged 14 years. His length of addiction spans twenty-five years and over this time, he has never experienced a period of total abstinence without the support of Methadone. He has, in the past two years, finally been able to rely solely upon Methadone and abstain from illicit use.

Jackie

Jackie, aged 37 years, is a middle sibling, with two brothers either side of her. She first started using opiates aged 19 years. Her heroin addiction has spanned fourteen years and for most of this time, she has also relied on a Methadone prescription. She has been able to avoid illicit use for the past four years. Her longest period of being 'clean' (without Methadone) is nine months.

Helen

Helen, aged 42 years, is the youngest of four children, with two considerably older brothers and an older sister. She was 21 years old when she began using opiates and has been on a Methadone prescription for over twenty years. She has been stable on Methadone without illicit use for the past three years. Her longest period of being 'clean' is five months.

Scott

Scott is 38 years old and the youngest of five children, with two older brothers and two older sisters. Having first used opiates at around 18 years old, he became addicted to heroin for around eighteen years and has been stable on Methadone, without illicit use, for over three years. His longest period of being 'clean' is ten months.

Emily

Emily is 33 years old and the eldest of two children. She has a younger brother. She first tried opiates at the age of 20 years and developed an addiction to heroin for eleven years. She has been on a Methadone prescription for eight years and has abstained from illicit use for the past two years. Emily has never experienced a period of total abstinence (without Methadone) and has consistently relied on Methadone.

John

John, aged 41 years, is the elder of two male children. He first began using opiates aged 15 years, and developed a heroin addiction which spanned twenty-three years. He has been on a Methadone prescription for six years, and has refrained from illicit use for the past three years. John's longest period of being totally abstinent, including being Methadone-free, is twenty-four months.

Glossary of terms

Addiction: A chronic, relapsing disease, characterised by compulsive drug-seeking and use, and by neurochemical and molecular changes in the brain.

Craving: A powerful, often uncontrollable desire for drugs.

Detoxification: A process of allowing the body to rid itself of a drug while managing the symptoms of withdrawal; often the first step in a drug treatment programme.

Narcotics: any of a class of substances that blunt the senses, as opium, morphine, belladonna, that in large quantities produce euphoria, stupor, or coma. They are used in medicine to relieve pain, cause sedation, and induce sleep.

Physical dependence: An adaptive physiological state that occurs with regular drug use and results in a withdrawal syndrome when drug use is stopped; usually occurs with tolerance (see the next item).

Tolerance: A condition in which higher doses of a drug are required to produce the same effect as during initial use; often leads to physical dependence.

Withdrawal: A variety of symptoms that occur after use of an addictive drug is reduced or stopped.

All terms are taken from the NIDA (National Institute on Drug Abuse, 2007)

Section B

Professional Case Study

The use of formulation and transference interpretations in a man with an object-relations deficit

Contents

	Page
Section 1: Introduction to the case study	233
Section 2: The development of therapy	240
Section 3: Review of therapy	249
References	253
Appendices	257

1. Section 1: Introduction to the case study

Introduction and rationale for client selection

I have selected this client work to present as a case study, for its richness and complexity and because it relates to my specific area of interest: Experiences of being parented and predisposing factors for later addictive behaviours, set against a background of attachment theory predicated on the seminal work of John Bowlby (1951; 1958).

I consider this case study a good example of working with, and the importance of, an evolving psychodynamic formulation, which I use as a guide throughout therapy. I believe that it facilitates a firm understanding of the client's problems and perpetuating factors, and informs the planning of treatment.

In addition, the work with Alan[1] demonstrates the importance of transference interpretations in a client with poor object-relations. By addressing the therapeutic relationship directly, as Gabbard (2006) suggests, and interpreting distortions that appeared in the client's transferences, the therapeutic alliance blossomed, even though the client had rejected numerous therapists in the past. This concurs with the findings of Høglend (2004) that transference interpretations are preferable to other methods of treatment for people with a borderline personality diagnosis (BPD).

Theoretical orientation

A psychodynamic approach is suited to addressing the early conflicts in clients' lives, and bringing into consciousness the issues that need to be worked through in order to bring about positive change in their emotional lives. Formulation is an essential component at the outset of psychodynamic therapy, as Sperry, Gudeman, Blackwell and Faulkner (1992) posit. I regard it as an initial understanding that develops organically as the therapeutic relationship deepens. At its core is the importance of understanding the repeated maladaptive patterns occurring in relationships, by assessing the nature of the

1 *All personal identifiers have been removed to ensure the anonymity of this client.*

client's problems and difficulties and then analysing the client's material as pictures of relationships with objects.

Alan's current life could be understood in relation to insecure early attachments – as Klein (1932) dubbed them in post-Freudian terms, object-relations. Winnicott (1953; 1958) termed them 'transitional objects'. Alan's intra-psychic conflicts appeared to be firmly rooted in childhood and, specifically, the mother-child dyad. During infancy, neglect and abuse often generate maladaptive templates (internal working models – Bowlby; 1969; 1973) for relationships that form the basis of later relationships, as Horowitz (1991) outlines. Individuals are thus often drawn to people who appear far from capable of meeting their unconscious needs. Many addicted individuals struggle to regulate their feelings and, as Gerhardt (2004) describes it, they seek the 'good babyhood' - the absolute state of dependence. In this instance that was found, albeit temporarily, in substance abuse. My task was to position myself as a transitional object, as advocated by Potik, Adelson and Schreiber (2007), and to allow the client to experience intimacy without threat in the course of therapy.

Freud (1917) believed that transference reveals the client's hidden processes and thoughts. According to Jacobs (1998), working through transference allows the linking of the client's external and internal worlds via examination of past and present relationships. It is important to mine this area to understand a client's maximum point of pain or pattern of defensiveness, as Hinshelwood (1995) describes it. Care has to be taken to appreciate the resistance that individuals might have towards these painful recollections (presenting as a defence such as anger, as Sandler (1989) highlights), but nevertheless to work through it, as Greenson (1967) argues. Closely evaluating insights into the therapist's countertransference can provide a critical source of information, and I used these insights to formulate transference interpretations, as Hobson and Kapur (2005) advise.

The referral and context for the work

Alan was referred to Psychology Services by the alcohol nurse at the NHS Drug and Alcohol Unit where I work, with the aim of assisting him with his current relationship problems and to reduce his substance dependence. This followed an assessment by the Unit's resident psychiatrist and an attempt at detoxification (in-patient) that lasted only two days of the required 14. Alan was described as having borderline personality characteristics, and had experienced several psychotic episodes. The Unit prescribed him anti-depressant medication[2]. He outlined to me his heavy use of skunk (strong cannabis) and drinking around six cans of 9% proof beer every evening. After conferring with the Unit's psychiatrist, consultant psychologist and keyworker, and evaluating his appropriateness for psychodynamic treatment, in accordance with OPD (Operationalised Psychodynamic Diagnostics, 2001) criteria, and in consideration of his dysfunctional childhood, we agreed that the client was suitable for therapy and, in particular, psychodynamic work. He showed the ability to communicate his feelings and to articulate some experiences, and stated a strong intention of 'sticking with' therapy this time.

We always met in the same room, which has spartan décor, two facing chairs and a small side table. I consistently ensured that there were no papers or distracting objects, to promote the client's free-floating attention, as Freud (1900) coined it, and to convey my neutrality and anonymity.

Negotiating the contract

We agreed to hold one-hour sessions at the same time each week. The Unit places no restriction on the number of therapy sessions, so the client was able to consider the prospect of continuous therapy. Confidentiality and supervision were comprehensively discussed.

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2 *This client cannot take anti-psychotic medication, due to his prevailing medical condition.*

The presenting problem

Alan described himself as confused and susceptible to anxious states, which strengthened as his day progressed. He reported drinking alcohol and smoking skunk to suppress uncomfortable feelings and to induce sleep. He described feeling that his role was to please others, but that he was tiring of this, and he reported threatening nightmares linked to his past. His stated aim was to work through his feelings, and to understand what was causing his confusion and fuelling his anxiety and extreme outbursts of anger.

Combined, this material highlighted an opportunity to help the client develop awareness and understanding of how his past related to his present situation and behaviour, in order to facilitate change, as outlined by Jacobs (2004).

Client biography

(See also the genogram in Appendix I)

Alan is 38, has been unemployed for seven years and is married, with three children (aged eight, eleven and thirteen). He is of mixed race (Jamaican father, white British mother), and is consistently tidy in appearance.

Alan describes his childhood as a 'rubbish dump', frightening and filled with anxiety. His memories of his early life until the age of six are characterised by the sight of parental anger; he witnessed domestic violence and was himself subjected to beatings. His mother, an alcoholic (now deceased) was aggressive towards him, but he states that he loved her. Reflecting on two concurrently recalled early memories, Alan spoke of the terrifying ordeal of being sent out at night by his mother to buy alcohol for her; but also of feelings of happiness one day when holding her hand on the way to school. These contrasting recollections suggested an unmanageable inner conflict between anger and love towards his mother.

His father deserted the family when Alan was six, and they had no further contact until Alan was 21. His father remarried, and Alan has seven (black) stepsiblings, with whom he describes having an uneasy, distant relationship. His mother's alcoholism and family poverty led her to sexually entertain 'rough' men for money in front of Alan and his sister (in a one-roomed flat). As the older brother, Alan cared for his sister and also for his mother.

When he was seven, Alan and his sister were placed in separate care homes. Many times up to the age of 15, Alan recalls, he suffered verbal, physical and sexual abuse both from staff and from other residents. Once, he recalls, he met 'Bill' (an older member of staff), who was a caring man but failed to acknowledge Alan's abuse.

He met his wife (Jane[3]) when he was 18, after three years since leaving care during which he behaved aggressively, fighting and stealing – a period that he looks back on with shame. Jane was 15 when they met. Soon afterwards they moved in together. He describes her family background as dysfunctional and interfering. They have been together for 20 years and married for seven.

In those seven years Jane has threatened to leave Alan three times, stating that she is outgrowing him. The last time she planned to leave was six months ago, following her affair with someone at work. Alan describes having prepared himself for the break-up when she again changed her mind and asked to stay. He feels confused, hurt and angry, and links this last emotional episode with the acceleration in his drug and alcohol use.

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3 *Jane is the pseudonym used here for Alan's wife*

Initial assessment and formulation

(See also diagrammatic formulation in Appendix II)

When I first asked Alan why he had agreed to come to therapy, he grew angry and defensive. He explained how he had briefly tried several counsellors and psychologists over the past few years (never more than three sessions) and that they had been useless and failed to help him. This appeared to echo infantile aggression that he might have felt in his abusive parental setting. It suggested that the reality of working with me would be compared in his mind with his idealisation and fantasies. He referred to past therapists as having mistakenly blamed all his problems on his childhood, which he felt he had already dealt with. This indicated that he might be dissociating from his pain, as Roy (2008) highlights, and resisting talking about his past, and that he needed to feel acknowledged in the present.

In outlining his recent past and early life, he angrily blamed others for mistreating him, and his current family (including his father's family) for failing to understand him and consistently rejecting him. He found it hard to understand the thinking of others, and spoke about this in a supercilious, defensive way, which highlighted his ego fragility. He spoke angrily of his early life being 'shit', and referred to his many years in care.

He spoke of 'not belonging', referring to his black father and white mother and saying that the remaining black family spurned him. When he spoke of his failed detox attempt, he suggested that other in-patients were 'not his type'.

This client promoted in me a strong sense of attachment: I felt I wanted to comfort him, and I could relate to his deep sense of pain. However, I was also aware that these feelings could quickly switch towards irritation with him and a feeling of being suffocated by the clawing dependence of a small boy trapped inside a man's body.

To formulate, I observed this client's accounts of his past and present life, significant relationships, fantasies and non-verbal behaviour, and my own non-verbal responses and the feelings that were invoked in me. I came to the view that this client had an object-relations deficit relating to loss and abandonment in early life. Insecure attachment had fostered a fragile sense of self (Kohut, 1959; 1994), evoking in him a craving to be 'soothed' that he slaked, temporarily, in substance abuse. Now he was asking me to listen and understand because he was once again gripped by the fear of being rejected. His marriage appeared to be mirroring early object relations with his mother, to the extent that it constituted a repetition of his early trauma.

Overarching themes in his life were change, lack of control and rejection, generating feelings of impotence. These feelings were now intensified by his wife's recent infidelity, which reminded him of his mother's prostitution. He felt unloved and unlovable, against which his main defence was to try to please others in order to feel worthy, as Powell (1969) describes it.

Maternal love had been merged with pain, and so he felt a conflict between loss of the love object and fear of merging with it (as described by Call and Wolfenstein, 1976)) and turning against himself. This could generate ego defects. He thus felt in conflict about his current relationships, which suggested that he would continue to show ambivalence in sessions. He fought hard to conceal anxiety, anger and shame (which was mirrored in transference) and he often laughed through his pain. He was striving to be a man, but feeling like a child. It was difficult for him to show his distress, and a key defence against this was excessive talking, to avoid thinking – perhaps, like a small boy, he needed not to think, but just to be noticed by his mother.

Given the client's history and my formulation, I considered how the transference dynamic might play out across therapy. Due to his need for dependence on a good mother, it was probable that he would idealise me, as his female therapist, and look to me to guide and

nurture him. As I encouraged him to do the work himself in therapy, and avoided feeding his superego, he would be likely to feel disappointment with me and even grow angry at my failure to feed him directly. I would thus need to closely monitor his transference and be ready to interpret my countertransference, both to detect such occurrences and predict them, and to prepare to counteract them, a situation that, if handled badly, could fracture the therapeutic relationship.

Therapeutic aims

A key aim was to facilitate an exploration of the client's internal world, offering him insight into his relationship problems via carefully timed transference interpretations. This was intended to allow him to acknowledge his yearnings for dependence on others, and to illuminate his battle to achieve independence and maturity (as advocated by Gerhardt, 2004). Another aim was to create space in which he could become aware of how he punitively shut down his insecure feelings, and how these feelings stemmed from a false or incomplete self (as Winnicott (1956) suggests), not from a lack of willpower, as the client himself believed. We agreed that part of our work would address the current difficulties of his life, and his coping responses (including increased use of drugs and alcohol). A perceived key challenge for me was to uncover his unhelpful defences which would be dislodged during the therapeutic process, and their roots in the past (as described by Sandler, 1989), and to provide a forum in which he could connect with how he had transformed these negative feelings into ways of dealing with reality, as Breuer and Freud (1895) postulate. A primary goal was to provide a healthy human relationship to assist him with his emotional regulation.

Section 2: The development of therapy

Alan attended his weekly appointments punctually, and quickly engaged in the therapeutic process, bringing rich material and talking constantly. He was both articulate and intelligent. *(See also appendix III for detail of therapeutic techniques applied)*

Key content issues

Alan delivered his material in great swirls of dialogue containing much anxiety, anger and chaos. His content was often broken and, in Lacanian (2001) terms, his over-expressiveness and incessant chatter emphasised his psychotic side. He talked to avoid thinking (a defence) and regularly showed ambivalence in sessions (love and hate towards his mother and his wife, for example, and needing people yet believing he could do without anyone).

His anger was rooted in his childhood abuse and neglect, and appeared primarily to connect with women – his alcoholic mother, who had failed to care for him and abandoned him, and his deceitful wife, who was threatening to leave him. The relationship with his mother, his feelings around her and the way in which they were manifested in his current life, were being re-enacted in his marriage. Evaluating his use of projective identification – using me as the mother or wife figure – was important to gain an understanding of his internal world and his search for the perfect 'object', as Summers (1994) outlines. Transference interpretations were key to attempting to get a real sense of this internal world.

His use of drugs and alcohol as substitute soothing strategies (as described in the research of Flores, 2006), and his dependence on them, mirrored his lack of dependence in the mother-child dyad. He had been the carer for his mother and sister as a very young boy, and, because he lacked the experience of dependence, the transition to maturity and independence was proving extremely difficult for him to negotiate.

The area of sex and intimacy was another key issue within his therapy. He had withdrawn sexually from his wife since her infidelity. The clue to this lay in his fantasies of her having sex with her lover, which he linked with childhood scenes of his mother having sex for money in front of him and his sister.

Following a two-week holiday, I returned to work and found Alan voicing extreme anger towards women and declaring fears about hurting someone. He said that he understood why some people snapped when their lives became more than they could tolerate. I was concerned at this change in tone and at his level of anger, and discussed this at length with the NHS team, fearing that his anger might be channelled towards his wife. However, I feel I missed his real underlying communication in the actual session, which related to his fury with me for abandoning him for two weeks.

Reflecting deeply on how I had felt in the session, I recalled how frightened, small, vulnerable and impotent I had felt in the moment. I recognised this as Alan's transference, mirroring how the desperate young boy had felt as his mother perpetually let him down, and how he experienced 'losing her' to alcohol and how completely alone and abandoned by her he had been left feeling. He was re-experiencing these early life conflicts, triggered by my two-week absence and I could sense him oscillating between absolute terror giving rise to anger, and his love and longing for the good mother.

Alan then cancelled his next appointment with me, phoning to tell me he was too busy. When I later interpreted this with him, I gained a clear indication that this was his way of punishing me for my absence. I appreciated that his idealisation of me, that I would 'always be there for him', had been ruptured. I worked to allow him to accommodate the notion that he could survive without me, and that constancy was not something we could always expect from others, no matter how much we craved it. He responded well to this framing and our appointments continued regularly as before. This had presented an interesting learning curve for me.

The therapeutic process

Aside from this 'holiday' session, which was an important point in the therapeutic process, I have chosen to focus on three important moments of insight during the five months of work. The first is that, within the space of three sessions, Alan displayed

evidence of being stuck in an early psychotic phase of development, in which he has destructive feelings towards his mother and becomes frightened of them. Klein (1957) referred to this as the victim-persecutor dyad (see Appendix IV for a diagrammatic representation; Clarkin, Yeomans and Kernberg, 2006), and it seemed likely that at some point these feelings might be directed at me. At the time, he projected these feelings on to his wife. Following her infidelity, she was more closely aligned with the 'dirty mother' towards whom Alan felt anger. I found further evidence for this hypothesis in his display of high levels of paranoia and of feelings that others were closely watching him and judging him harshly. Evidence of an object-relations deficit came when he spoke of having to adhere to multifarious demands (often unreasonable ones) from others, which caused him pain and threat, and even jeopardised his life (catastrophising, as Apollon, Bergeron and Cantin, 2002 maintain). This is a theme that Lacan (2001) steers us towards in discussing the psychotic structure of a 'master-slave' discourse.

The transference dynamic began to mirror my early formulation. Alan appeared at points to idealise me as the 'good mother', and sought my guidance, but grew impatient and angry at my silences (leaving him to do the work). I had to manage this carefully, to avoid creating a dependency on me, but also to avoid his rejecting me if I failed to match his ideal. An example of this came when he asked what sort of job I thought he could do in future. When I did not deliver a concrete answer, he grew cross and said he was beginning to question why he was coming to therapy.

At this moment, I was aware of Alan's transference in his rage towards me, as he identified with me as the 'mother figure'. I could sense that underneath this anger, lay extreme fear. Once again, I was aware of how vulnerable and immature I suddenly felt, and how for some minutes I felt disorientated and confused about what I should do next. This reflected how Alan was accustomed to feeling – the unbearable 'not knowing' and failure to find the 'answer' and comfort from his mother.

We overcame this difficulty when I acknowledged the confusion he might feel about a job, after having been unemployed for so long. I interpreted his frustration as coming from a lack of choice in his life to date, so that the idea of choosing might now feel overwhelming. He responded to my acceptance of that vulnerability and dropped his defensive stance. While his initial transference suggested I had failed him on one level (to give direct advice), thereafter he appeared to respond to my empathy and articulation of a conflict that felt deeply challenging to him.

The second significant moment was during our fifth session together, when Alan began to reveal more of his undifferentiated self. He displayed extreme anxiety about a lack of real identity and of not knowing who he truly was or who he should be. This, as Mahler, Pine and Bergman (1975) propose, typifies the symbiotic stage before the individual has gained autonomy and independence from the mother, and relates to this object (mother) as a whole. It highlighted the requirement to integrate the object and 'I', as Klein advocates (1957), to prevent the client from unconsciously recreating these relationships with significant others such as his wife.

He talked constantly about his wife and her inability to appreciate his needs. Although he often began by declaring that he did not wish to talk about her, in early sessions he seemed unable to talk of anything else. This suggested that there was much about this relationship that he had to explore and resolve within himself. In evaluating my countertransference, I was aware that Alan often presented himself to me as a needy boy, sometimes to the point of not really existing as a whole person and not being a man, and that, as a result, I swung between wanting to nurture him for his legitimate need to be loved and to scold him for his inability to grow up.

The third point to note came in our twelfth session together when, having worn precisely the same clothes to each of our preceding sessions (shoes, t-shirt, jacket and trousers), he wore a different outfit and spoke more of himself than of his wife. He started to express

how he was feeling and how she made him feel. He opened for the first time a plastic file that he had brought to every session, and used it to refer to points he wished to discuss. This was an important shift in the client, and it appeared to mark his preparedness to begin exploring more of his internal world. I took care to pay particular attention to his transference and to the feelings he evoked in me at this juncture, as Jayne (2005) advocates, to gain a deeper understanding of his problems and his difficulties in connecting with his feelings and navigating relationships. This time he made a profound connection between his past and current lives, relating his wife's infidelity to the 'whoring ways' of his mother. Alan was extremely nervous about revealing these thoughts to me, and perhaps feared my disapproval. Through his transference and projective identification, it felt as if I was the wife at several points during the session. He was saying things to me that he had been unable to say to her face. This appeared to mirror the frustration he might have felt as a child, loving his mother while hating her treatment of him and her behaviour around men.

Difficulties in the work

This was a complex and challenging client to work with, but there were several particular difficulties that were important to tackle. The first related to encouraging Alan's own reflexive process (mentalising). In early sessions he seemed unable to do this, either from session to session or by linking his past to his present, but this gradually improved.

Working through his resistance to the past was essential to move him forward, but pace felt important, not to make too many connections too soon, and to avoid alienating him from therapy as past therapists had done. I generalised from theoretical and research perspectives in our early sessions. For example, I pointed to research (such as Gerhardt, 2004) showing that people who had had neglectful mothers were often adept at shutting down on their real emotional needs in later life.

The overarching difficulty was to contain his anxieties and, at times, my own feelings of being overwhelmed by him. I had to carefully examine, as Jacobs (1999) insists, my own emotional responses (countertransference). As I did, I literally saw pictures in my head of how he had interacted with his aggressive mother and pandered to her whims, despising and fearing her alongside his desperate desire to be loved by her. Shades of this relationship style were also evident in his marriage. He took pain and rejection from his wife, while clinging to the hope that things would improve one day and he would relax and enjoy his marriage.

Another difficulty related to the constant challenge for me of assisting Alan to strengthen his ego and dilute the harsh and punishing superego. This was frequently tested during the transference-countertransference dynamic as he craved my guidance and idealised me as the 'all knowing', but came up against the reality that I was nothing more than an ordinary person and that he in fact held many of the answers to his own questions.

It also highlighted the need for intense supervision for me and for self-care, as he exposed me to more of his disturbing past and to my own feelings around childhood abuse and violence. I was aware, in my own internal supervision, of sometimes dwelling on his material, a risk mentioned by Casement (1990). This highlighted a need to download and work through some of the emotions I was feeling around this client's material, which I did in both personal therapy and supervision.

Use of supervision

My supervision around this client was at several levels: peers, my line manager (who works integratively) and specialist psychodynamic supervision. Specifically, I focused on how the client left me feeling in sessions, and how emotionally conflicted I could feel at times.

I discussed the prospect of him 'rejecting me before I could reject him', as he had done with therapists in the past, and his feelings about a female therapist, given his anger around female abandonment. However, this did not seem to present an initial obstacle. Supervision also helped me to hypothesise how the client's feelings might surface, both manifestly and unconsciously. In particular, I considered at length his transference and his idealisation of me, and whether he would attempt to merge with me. In so doing, he might have been considering what he would have to do for me to make himself 'the good boy' at times when his ego felt fragile and his superego loomed large.

Supervision greatly assisted my concern around Alan's expression of anger towards women and his fear of hurting someone. It was in talking through how I had really felt as he spoke and analysing his content more deeply, that the idea emerged that he was indirectly expressing his anger towards me and his disappointment at me leaving him for two weeks (as above in the 'Key Content Issues').

Changes in the formulation and the therapeutic plan

While there were no massive shifts away from my initial formulation, there was some finessing. In Alan's periodic attempts to manipulate his wife and frequent efforts to play 'hide and seek' games with me, I saw growing evidence of BPD, which I had not seen in my initial assessment, and about which the Psychiatric assessment had been rather vague. Further evidence of BPD presented, with Alan regularly getting lost in his language, as McCrae and Costa (1996) highlight in the five-factor model. In addition he showed limited ability to understand different points of view (failure to mentalise, as Bateman and Fonagy, 1994, frame it), and he attempted to dominate his wife's and others' thinking.

Recurring references to his masculinity raised questions for my early formulation, regarding his perception of being a man. He had experienced a violent role model as a

young child, and had notably lacked a constant male role model as he matured. I thus considered the importance of what Alan thought it meant to be male, and what sort of conduct was acceptable around women. This continues to be an area of work for us. In supervision, I discussed the potential benefit of allowing Alan to relate to emotions and physical urges that he may have not had a chance to explore or recognise as he grew up.

Changes in the therapeutic process over time

Changes to the therapeutic process were gradual and designed to be sensitive to the client's sense of self and his ability to reflect and tolerate his past material. After considerable space and silence had been allowed in the first few sessions, we were gradually able to move towards my making connections with the past without him angrily rejecting them out of hand. Latterly he has begun to feel sufficiently safe to disagree outright with connections or hypotheses that I present, and to form some of his own conclusions. These are becoming less concerned with blaming others and seeing the world as set against him, and more self-reflective, which I feel is a very positive step towards mentalising.

The hate-laden dyad (illustrated in appendix IV) was evident in early therapy, but it began to dwindle and give way to the legitimisation of his needs to feel dependent on and loved by a longed-for mother, as Clarkin, Yeomans and Kernberg (2006) suggest.

Talking about sex marked a change in the process, and strengthened the alliance. He seemed surprised that a woman might ask him about this aspect of his life, but he appeared relieved to be able to talk about it and share his concerns. Alan did not connect intimacy with sex, and revealed that his marital sex was without tenderness, reflecting his mother's behaviour with sexual partners. He was able to acknowledge my interpretation connecting past with present, although I could detect (non-verbally) that it stung him to do so.

We continued to work on exploring the breaks in his stories, which were frequent in early therapy, to add fluency to his accounts and to make his identity structure more stable and logical to him, as Hill (2001) suggests. He is now able to view his idiosyncratic sense-making (such as, "I'm pathetic and weak, and I should not have tolerated this rubbish from my wife") more objectively and comment upon it, to understand its foundation in his childhood and his relationship with his mother, and the repeating patterns in his current life, and to make these meanings and interpretations more flexible and understandable to himself.

Section 3: Review of therapy (as at February, 2009)

I continue in my work with Alan. He regards treatment as continuing for the foreseeable future. I am pleased with the movement he has made in the past few months, not least of all because he is bringing more of himself to our sessions, he is more reflexive, and he is less resistant and defensive towards his past. In the past month, he has stopped smoking skunk and he has halved his alcohol intake (to three cans a day).

Evaluation of the work

I have found the work educational and stimulating. A complex personality with a truly horrific early life was never going to be straightforward, but using my formulation and transference interpretations to guide and shape my work with Alan has had a positive effect.

While I have not pandered to his early desire to ignore his past, I was patient in making connections, and my early interventions were made in terms of a broad research perspective, which appeared to make them more palatable to Alan. I think this demonstrated that I was working at the client's pace. By acknowledging his fear and his resistance to his past (regarding it as his 'power'), I was able to tolerate many of his responses and, as a consequence, to craft more useful interventions.

I realised the value of 'holding' him, as Khan (1969) advocates, allowing space, time and emotional permission for the client's 'being'. Use of silences, I feel, delivered mutual benefit. Specifically, they allowed Alan to reflect, and they afforded me space to analyse his transference and my countertransference, without which my ability to predict, respond and interpret would have been impaired.

I found it instructive to read the therapeutic signposts that came in the form of projective identification, an idea first introduced by Klein (1946). The client gave me stage directions for a particular role (how the good mother should be, as Ogden, 1982, outlines) as he enacted his inner world in search of his lost object (as Summers, 1994, highlights) and in pursuit of an answer to his basic question: "Why didn't I deserve my mother's love?"

I found it helpful to consider Alan as scared of images from his past (like ghosts) and detection of his fantasies surfacing, as time to talk about them. I consistently asked how he felt and how therapy was feeling for him. I processed our past together, sometimes asking how he imagined I might have felt, or how he hoped I might feel when he disclosed material. This appeared useful to Alan, to help him actualise and to mentalise how others might think.

Supervision also helped me to reflect on Alan's reference to past violence towards women. It seemed important for me to be able to help him contain these feelings, to interpret when they were specific to me, to seek the support and advice of other professionals within the NHS team, and to explore my own feelings about this in supervision and personal therapy.

Specific learning from working with this client

This work has greatly helped me appreciate the theoretical approaches to patients' resistance about the past and its connections with the present, and how to put this into practice by using the formulation as a signpost and transference interpretations as speed bumps in the road to slow down the client and encourage reflection.

I have learned that transference interpretation can be high-risk, but offer high rewards. With this client, pushing too hard or too frequently ran the risk of alienating the client and having him reject therapy, as he had done in the past. However, the rich seam of material that flowed from interpretation told me much about how conflicts in our relationship shed light on his external relationships, both past and current.

In considering what I might do differently with the benefit of hindsight, I believe that accessing process and content even more determinedly, as Bramley (1996) advocates, would have enhanced therapy. Had I paid closer attention to his reaction to my two-week absence and how it made me feel, I might have seen his annoyance with me, instead of generalised anger towards women, and possibly used this transference more productively. However, it has also shown me that not seeing things 'in the moment' does not result in all being lost and that, following a period of reflection, these interpretations can usefully be incorporated into future sessions.

Using my observations of him effectively playing 'peek-a-boo' (being invisible, as he may have felt in childhood), and evaluating my countertransference, provided insight, as it felt like his way of symbolically possessing the mother (me) and having some control over the love object. As referred to above, Alan shows a lack of 'mentalisation'. He did not learn reciprocity from his neglectful biological mother, and so I appreciated how hard it was for him to make an adjustment to handle the two-way relationship that therapy provides. This game-playing, I feel, illustrates the difficulty he feels in understanding his emotions and impulses when he tries to 'bring himself' to sessions.

Summary and conclusion

This work confirms my belief in attachment theory and object relations, and in working psychodynamically with suitable individuals with addictive behaviours. It also brings into sharp relief the genuine difficulties that clients face in breaking well-worn patterns. To my mind it would not have been sufficient for this man to engage in a programme of substance reduction and to employ relapse prevention or motivational interviewing techniques. I believe he needed to understand what his needs and conflicts were and their origins, and why he used substances as a substitute. Psychodynamic therapy offered him a direction. He has already modified his substance intake, despite my not having worked on a deliberate reduction programme. However, I have to respect the possibility that this could still be an attempt to present himself to me as a good boy, rather than something that has occurred as a natural or sustainable product of his therapy.

Each of our therapy sessions has differed from the others, with different aspects of my own personality and my blind spots becoming apparent, just as Lemma (2003) points out. Being mindful of this, and remaining fully invested in the process, provides the best outlook for therapeutic movement, by encouraging the client to acquire new abilities to deal with his realities and regulate his emotions. Overall, I feel this work illustrates my journey towards a more open-minded and reflective use of psychodynamic therapy, as Lucas (2006) posits, and a move away from the more mechanical approach that I detected in my early trainee work with clients. Formulation and use of transference interpretations have been the cornerstones of this work, and I believe they have been competently used in this context of object-relations deficit.

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Appendices

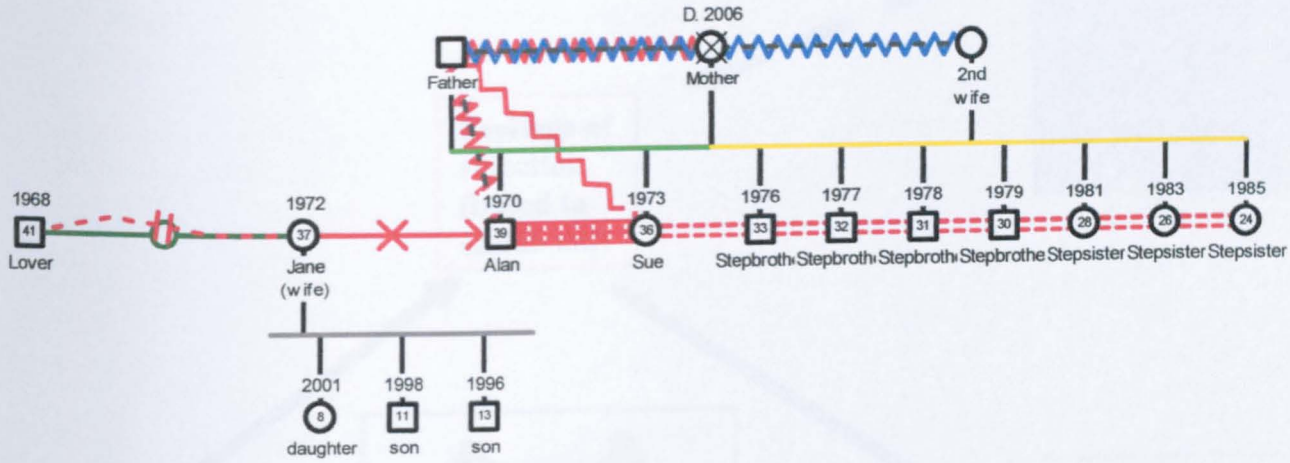
I. Alan's family genogram

II. Graphic representation of the formulation for Alan

III. Therapeutic techniques applied in the work with Alan

IV. Diagram of object-relations interactions for defence in borderline personality disorders

Appendix I: Alan's* family genogram



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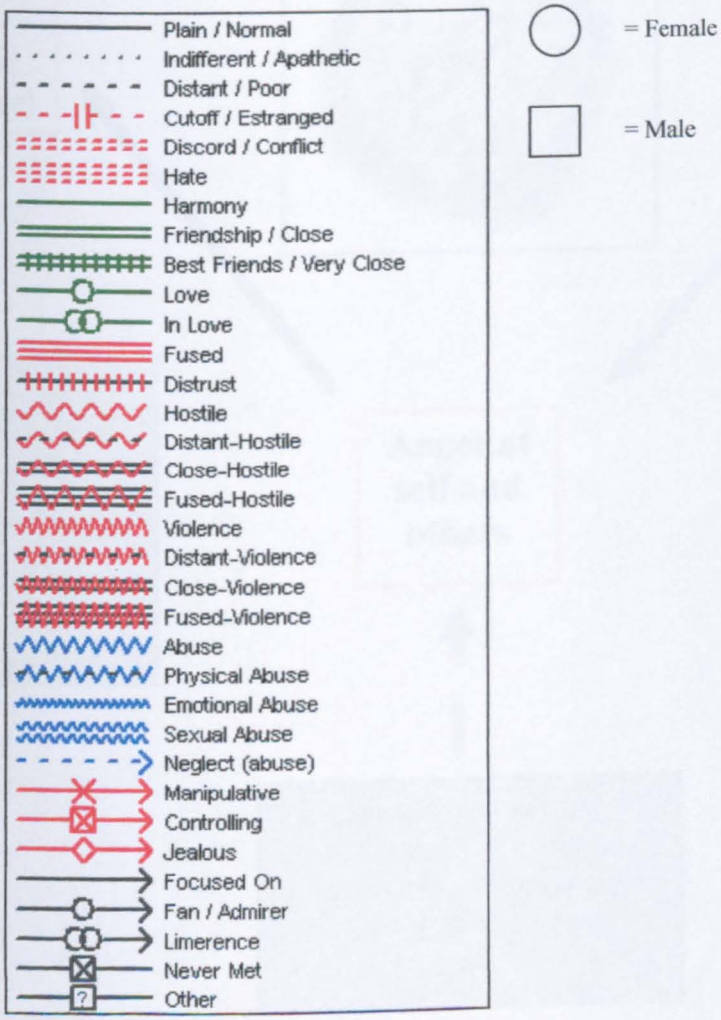
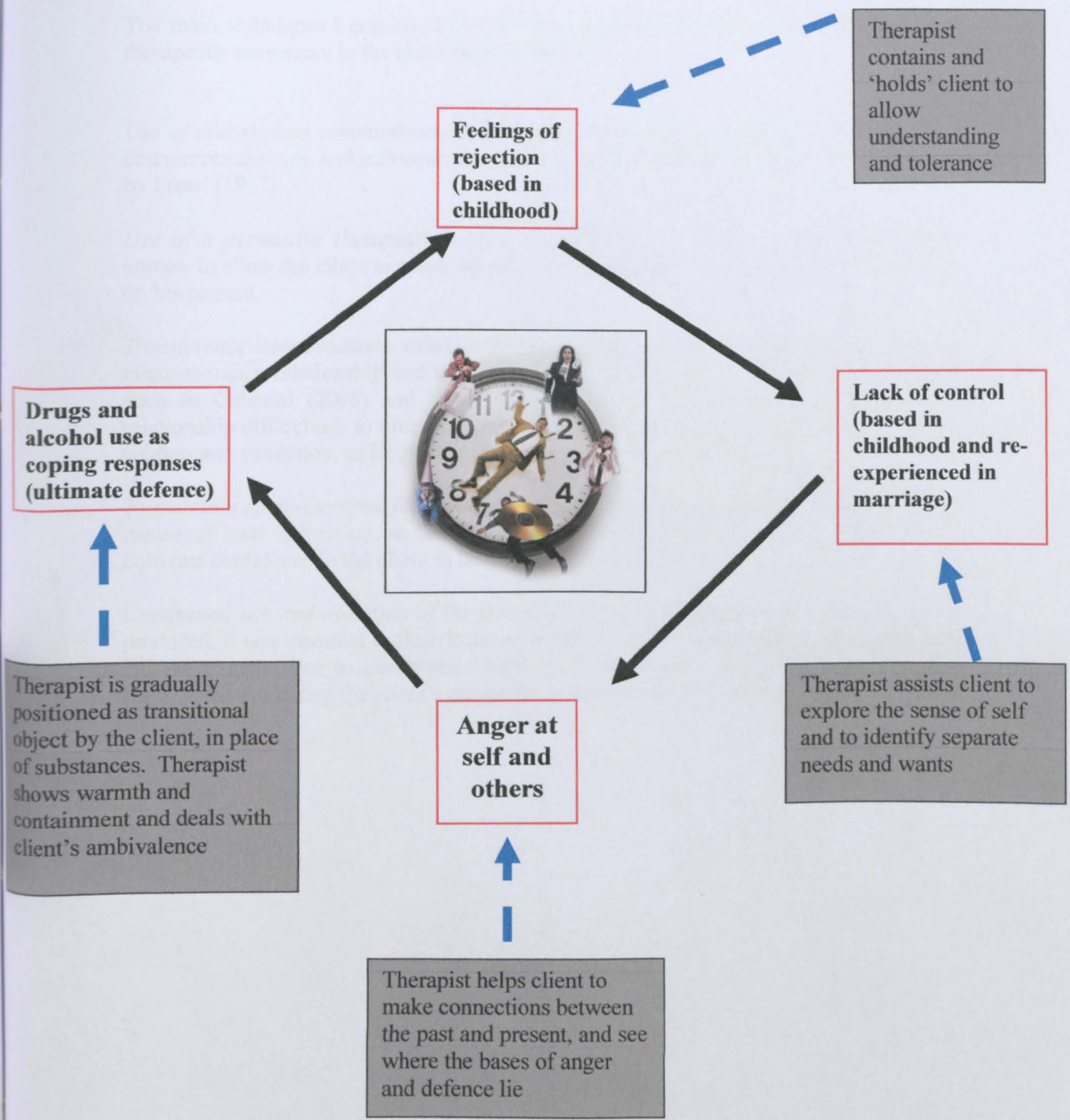


Appendix II: Graphic representation of the formulation for Alan



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Appendix III: Therapeutic techniques applied in the work with Alan

The main techniques I employed in order to execute the treatment plan and encourage therapeutic movement in the client were as follows:

Use of unconscious communications, at different levels acknowledging transference and countertransference, and reflecting on my own reactions and interpretations, as advocated by Freud (1937).

Use of a permissive therapeutic stance, carefully using silences, as Meissner (2001) argues, to allow the client to speak openly, and creating a space in which he could reflect on his content.

Transference interpretations, using transitional objects theory to make links between the client-therapist relationship and the client-other relationships, as posited by researchers such as Gabbard (2006) and Yager (2008). It was imperative, given this client's relationship difficulties, to time interventions carefully against a background of empathy, support and validation, as Høglend's (2004) research has demonstrated.

To maintain client-therapist focus, so as to fully understand the client's internal world by means of total immersion, as advocated by Sundberg (2001) and many others, and to cultivate confidence in the client to be himself.

Continuous use and evolution of the formulation; while an initial formulation had been produced, it was essential to flesh it out or modify it on the basis of new information and clinical observations, to ensure maximum use of its value in the process of informing therapy and predicting the client's responses, as Hinshelwood (1991) recommends.

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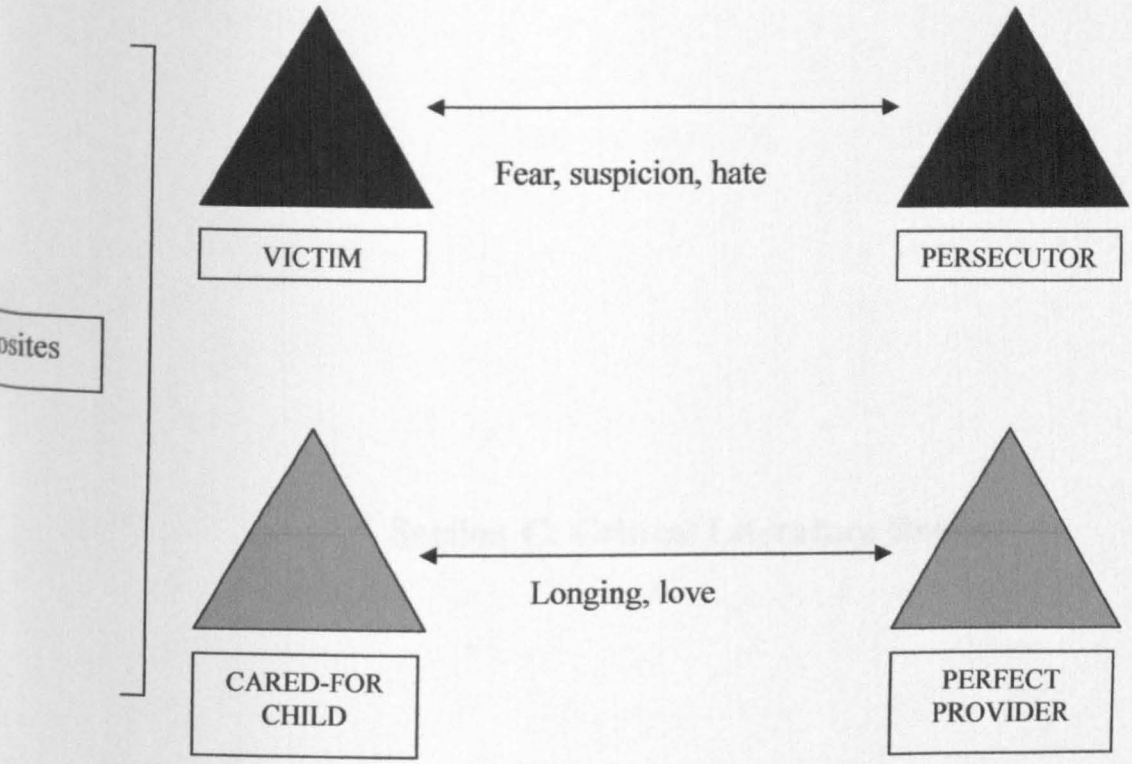
Appendix IV: Object-relations interactions for defence in borderline personality disorders



Source: Clarkin, Yeomans and Kernberg (2006).

These dyads coexist but are totally disassociated from one another.

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Section C: Critical Literature Review

Attachment quality: is it a therapeutically valuable construct when counselling adults with addiction?

"Home is where we start from." (Winnicott, 1986)

Introduction

Carl Jung (1933) once said "If one lives the second half of his or her life by the same rules as the first half there will be inevitable problems" (p.37). The main focus of this review is to explore whether damage to the child's self in the first years of life may leave indelible marks that propel it towards addiction in later life. The key purpose is to assess whether parental attachment insights can inform and benefit the therapeutic process. To that end, this review will explore theoretical literature and empirical evidence that infer a link between attachment dysfunction and addictive behaviours in adults. The perspective on this complex area of addiction will be on alcoholism and substance dependence, to provide a selection of studies that highlight methodological approaches and some of the problems that beset researchers when investigating individuals with addictive behaviours.

This review will summarise attachment theory, examine its theoretical and empirical links to adult addiction, and consider whether attachment dysfunction is an antecedent or a determinant of addiction. In so doing, it will try to validate attachment as a construct that can be put to beneficial use when counselling people with addiction. It will also consider whether a formal measure of types of attachment (such as the Adult Attachment Interview: Main and Goldwyn, 1991) is helpful to the therapist. Furthermore, the review will examine the relevance to counsellors of attachment information, and will ask what is the most therapeutically valuable position that the therapist can adopt.

1. Attachment relationships and their function

1.1 What is attachment?

Attachment is the affectional bond said to be present from birth between child and primary care-giving adult (Bowlby, 1951). Schaffer and Emerson (1964) described it as "....a close emotional relationship between two persons, characterised by mutual affection and the desire to maintain proximity" (p.3). The child's desire to remain close, seek security and ensure survival is posited to be an innate system in human infants (Bowlby, 1951). There is broader support for this notion in the findings of ethologist

Konrad Lorenz's (1935) studies of imprinting in geese, where he observed a social bond that was not merely feeding-related. Further support comes from Harlow (1961), who found in a study of baby rhesus monkeys that, faced with a frightening situation, they clearly preferred the 'comfort' of a man-made cloth monkey to a wire effigy.

Attachment theory (Ainsworth and Bowlby, 1991) was built on the central pillars of John Bowlby's (1951, 1958, 1959, 1969, 1973, 1980) work on maternal care, separation anxiety and loss, and was expanded upon and empirically tested in the work of Mary Ainsworth and her colleagues. This led to the development of a paradigm known as 'Strange Situation' (Ainsworth, Blehar, Waters and Wall, 1978), which is extensively used for classifying infants' attachment to their mothers or primary caregivers via separation and reunion procedures (see section A, appendix V of the thesis for details of this procedure. In relation to this doctoral study, insecure attachment is hypothesised to predict maladaptive emotional regulation, in sharp contrast with secure attachment, which is hypothesised to result in openness to emotional experiences (Main, Kaplan and Cassidy, 1985; Main, 1991; Slade, 1999). Two key stages in the development of attachment are implicated in the development of addictive behaviours (Flores, 2003): infant-caregiver, and adolescent-peer.

1.2 The infant-caregiver relationship

Attachment theory (Ainsworth & Bowlby, 1991) suggests that the child uses the mother as a safe base from which to explore, returning to her for reassurance and protection. On the basis of these early experiences the child forms an 'internal working model' of the self (Ainsworth et al, 1978). Maternal sensitivity and responsiveness to the child's needs is thus regarded by Ainsworth and colleagues and others (Bowlby, 1969; Bowlby, 1988; Thompson and Raikes, 2003) as a key determinant of attachment quality.

Bowlby (1951) also believed that the maternal bond was the strongest bond experienced in childhood, due to feeding ties and the mother carrying the baby in pregnancy. He suggested that the level of security that the child enjoys with the mother lays the basis for personality development.

Harris (1998) and Field (1996), however, criticise both Bowlby's perspective on personality development and the effects of attachment on later relationships, and Ainsworth's preoccupation with behaviours formed in infancy. In particular, Harris argues that they place too much emphasis on the influence of the parents over the child's personality and behavioural outcome. She thus rejects the assumption about nurturing, declaring that peers matter far more than parents. This position runs counter to the views of attachment and child development that are generally held in the psychological field today. Moreover, one could suggest that peers constitute a second, adolescent, stage of the nurturing process.

1.3 The adolescent-peer relationship

As children approach adolescence, they begin to develop greater independence, and their relationships with peers become more important and influential. In healthy development this also coincides with a reduction in their reliance on parents – what Allen and Land (1999) refer to as 'making their own way'. This new way of behaving is said to be predictive of their romantic attachments and eventual interaction with their own offspring (Shaver and Hazan, 1988, Allen & Land, 1999). In the context of attachment theory, adolescence is viewed as a critical period during which healthy relationships provide security and a context for growth in social competence, and lead to the development of relational prototypes (Seiffge-Krenke, 1993). In general terms, researchers tend towards a view that the urge for reliable attachment (usually from a parent) recedes in a secure individual as they develop peer relationships built on solid biological attachment foundations and a supportive system of meanings and values, but that, in those with less robust attachment experiences, adolescence becomes a very tricky period to navigate and can result in profound feelings of loneliness (Weiss, 1991). There is also considerable evidence that individuals who later become addicted begin substance misuse in adolescence, such as those who begin with cannabis before going on to illicit hard drugs (Georgiades and Boyle, 2007). This implies significant potential relevance for early counselling intervention with vulnerable young people, helping them to gain a greater sense of their self and worth. Principles of working with such individuals, and evidence to support counselling interventions based on attachment theory, will be discussed later.

1.4 Consequences of dysfunctional attachment

While Bowlby (1958) believed that many psychiatric disturbances could be attributed to deviation in developmental attachment, most of the literature relating to consequences of attachment presents us only with a theoretical analysis, or even a purely intuitive perspective. Empirical evidence is sparse, and what does exist is hard to consider as causal.

Issues commonly presented alongside addictive behaviours, such as depression and anxiety (Christo and Morris, 2004), are often wrapped up in a negative view of the self (Bogels & Brechman-Toussaint, 2006), thus implying insecure attachment. For example, longitudinal studies have shown two kinds of link between poor attachment and depression (Radke-Yarrow, Cummings, Kuczinsky and Chapman, 1988). First, depression can present in those who are insecurely attached; and second, depressed mothers of young children can predispose their offspring to mental health problems and problems of conduct. A seminal study by Rutter (1981) showed maternal deprivation, dysfunction and depression having a negative effect on children's conduct. The most frequently reported outcomes related to delinquency in adolescent males.

An etiological model from Barlow (2002) suggests that the level of uncontrollability that the child perceives in relation to social interaction and separation predicts the level of anxiety it will develop. However, Bogels and Brechman-Toussaint (2006) highlight the lack of empirical support for this assumption. They suggest that, while there is evidence of association between attachment issues and childhood anxiety, the exact nature of the association is unclear.

This lack of empirical support for a causal relationship between addiction and dysfunctional attachment is a recurring theme in this review. Nevertheless, researchers have made the case for a link. For example, Thorberg and Lyvers (2005) found that clients enrolled in substance addiction treatment programmes had statistically significantly higher scores than controls for insecure attachment and low self-efficacy, which the authors interpret as a possible reflection of a predisposition to substance

problems. Other studies have found associations between insecure attachment and high levels of alcohol consumption or drug abuse (Ognibene and Collins, 1998, Finzi-Dottan, Cohen, Iwaniec, Sapir, and Weizman, 2003). However, in many of these studies, variables such as social class and availability of drugs may have generated observed effects, prohibiting researchers from claiming causality.

1.5 Types of attachment and their measurement

Originally, Mary Ainsworth (Ainsworth and Bell, 1970) defined and tested three types of attachment types: secure, and two types of insecure attachment – avoidant and ambivalent/resistant. The weightings in these categories of the children tested were 71%, 12% and 17% respectively. Her findings cemented these categories, and they are still widely accepted today (see Section A, appendix V of the thesis for full descriptions.)

Main and Solomon (1990) added a third insecure type – disorganised attachment. This showed the most insecure attachment pattern, a mixture of resistant and avoidant responses. These researchers hypothesised that this type of attachment was related to abuse or neglect.

Ainsworth's (1985) caregiving hypothesis strongly suggests a correlation between quality of care and quality of attachment – the more attentive, expressive and reassuring the style of parenting, the more secure the child. This, she claims, provides a platform for secure personality development and adult attachment. However, she has several critics. Lamb (1978) questioned the validity of Ainsworth's study, suggesting that it could be measuring heightened stranger anxiety and not security *per se*, and it remains possible that Strange Situation measures trust or child temperament rather than attachment. Field (1996) criticises Strange Situation and attachment theory for testing only momentary stressful situations, for being limited to behaviours with the primary attachment figure, for including only overt behaviours in its paradigm, and for failing to consider multiple attachments at different stages of life. Kagan (1994) offers an alternative hypothesis, that the child's temperament dictates the quality of attachment.

It is difficult to find any empirical testing sufficient to confirm or deny such theories. However, there is a wealth of literature offering intuitive support for the idea that attachment depends on an interaction between caregiving and temperament, with caregiving as a primary determinant (Flores, 2003; Schore, 2003). The conclusion may have to be that Strange Situation remains the most reliable paradigm that psychologists have at their disposal when working with young children, given its extensive use and the repeated pattern of results over several decades.

While one can argue about the basis of attachment theory, and about the measurements offered by the Strange Situation testing model, it has nevertheless been used as a launch pad for other measures of attachment in adulthood. There are two key methods of assessing attachment – self-reporting and interviews – but many different assessments are used. Examples of self-reporting assessments are The Experiences in Close Relationships Scale (Brennan, Clark and Shaver, 1998) and the Relationship Status Questionnaire (RSQ) (Bartholomew and Horowitz, 1991); while examples of interview methods are the Adult Attachment Interview (AAI: George, Kaplan and Main, 1985; Main and Goldwyn, 1993) and the Adult Attachment Projective (George and West, 2001). The RSQ is one of the most often used, due to its ease of administration for clinicians and its deconstruction of attachment on two continuums (working models of self and of others, either positive or negative). This 20-question interview asks subjects about their childhood experiences in relation to significant caregivers and any trauma or loss, and about their experiences with their own children. Scoring relates to the level of coherence in the client's narrative. In essence, this test enables the researcher to identify the client's emotions as the story unfolds.

However, all measurements of attachment present potential difficulties when assessing adult addicts. Many long-term alcoholic and drug-dependent individuals are prone to memory impairment, have difficulties in emotional regulation and often struggle with reasoning (Moulton, Petros, Apostal, Park, Ronning, King and Penland, 2005; Wells, 1982). All of this may be symptoms of their long-term addiction, rather than precursors to addiction. In addition, it is unclear from the literature whether one's attachment status

persists across the lifespan of people with addictive behaviours, or whether there is a degree of malleability that might allow them to adopt a more secure status and embark on more satisfying relationships with others, or indeed whether addiction changes their former attachment representations. Thus these assessment tools may present many confounding factors when working with an addict population. Very little research appears to have been conducted into how psychologists might explicitly gather attachment information within the therapeutic area of addiction without sacrificing validity and reliability. Moreover, because methods like the RSQ are based on a top-down process of asking clients a set number of key questions, it appears questionable how vulnerable they are to subjective interpretation. This in turn begs the question whether long-term counselling therapy with an attentive and empathic therapist could make such measuring tools unnecessary, or whether the two may be complementary. This will be addressed later in this review.

In summary, these measures appear to raise three key questions for counselling psychologists, which this review will attempt to answer: First, how useful is the information derived from such a tool? Second, how does one use the information therapeutically? And third, is it necessary or more beneficial to use a testing measure, rather than continued empathic-based therapy?

From the research on attachment reviewed here, three findings seem particularly noteworthy. The first is that the attachment status of a prospective parent predicts with around 80% accuracy the attachment status of their child to that parent (van Ijzendoorn, 1995). Second, individuals display a strong continuity in patterns of attachment from infancy to childhood, adolescence and adulthood (Main & Goldwyn, 1993; Hamilton, 2000). Longitudinal studies support the consistency between adolescent and adult attachment styles (Holmes, 1996). Finally, adults categorised as insecurely attached appear to have the greatest difficulty with day-to-day life issues and interpersonal relationships, particularly with securely attached individuals (Shaver and Mikulincer, 2002). However, these studies utilise normal populations, and it is therefore questionable whether findings generalise to people with addictive behaviours. Nevertheless many of

the findings do appear intuitively compelling, and anecdotal evidence of these findings is often witnessed by therapists treating addicted individuals. Many adults presenting addictive behaviours show an inability to cope with life – that is, they use maladaptive or unhelpful strategies (Flores, 2003). But, importantly, the literature offers no firm guidance as to whether this is a cause of addiction or merely a symptom. Thus, relying solely on a retrospective adult attachment measure may still leave psychologists with a less than clear picture to work with therapeutically.

2. Addiction

2.1 Addictive behaviours

Addiction is often described as representing a coping mechanism – an attempt at self-repair and regulation of affect (Eigen, 1999; Russell, 1998; Schore, 1993). It seems pertinent for counselling psychologists to understand this substitution and lack of psychic structure, and perhaps allow for them in the therapeutic approach. The question of how they might do so is addressed later.

While this review concentrates on alcohol and drug abuse, it would also be legitimate to consider in the same light such addictions as smoking, eating disorders, self-injury, sex addiction and compulsive shopping. It often happens that clients in treatment for one of these addictions turn out to have multiple addictive behaviours, and this presents a specific challenge for therapists. Kohut (1977) was one of the first to find that, while a client was being treated for one addiction, it was frequently replaced by another, indicating a deficiency in self-structure. The question remains whether this deficiency can be primarily attributed to early attachment experience, but it does indicate that counselling psychologists may need to address something at a deeper psychic level, rather than just the addictive ritual.

2.2 What is addiction?

Addiction is perhaps best defined as a behaviour over which an individual has impaired control, with harmful consequences (Cottler, 1993). Unfortunately for many people

living with addiction, while they often appreciate the risk to physical and mental health and social relationships, they have lost control over the behaviour and find themselves unable to stop (Heather, 1998). Thus, one can reasonably state that addiction appears to be at the very least a disorder of motivation, and possibly a form of psychiatric disorder.

2.3 The significance of childhood trauma for addictive behaviours

Notably, there is a high incidence of childhood trauma among the insecurely attached, and such trauma is strongly implicated with addiction. While, as stated above, one cannot with certainty point to attachment insecurity or maternal dysfunction as direct causes of addiction, they are significantly implicated, along with traumatic childhood incidents. A study by Christo and Morris (2004) investigated the relationship between traumatic events and active substance misuse. Out of 55 participants, 80% reported at least one trauma according to DSM-III-R criteria. This is well in excess of the lifetime prevalence of 55.7% found in a large-scale study of individuals in the US general population (Kessler, Sonnega, Brome, Hughes, and Nelson, 1995). However, such data do not tell us whether those traumas predisposed the subjects to addiction, or whether there is a temporal consideration – that is, whether the times when the traumas were experienced affected attachment or influenced addiction, or indeed both. In addition, researching such a link is made difficult by the host of potential confounds that surround the subject of addiction: poverty, social class, family dysfunction, the level of social support for victims, the child's gender and age, and so on. For instance, NIDA, the National Institute for Drug Abuse in the US, reports (2007) that two-thirds of clients of drug abuse treatment centres say they were physically or sexually abused as children. While the figure seems high, those confounds have to be considered.

However, while several research studies have shown a significant correlation between childhood trauma and abuse and adult substance addiction (Christo & Morris, 2004; Sullivan and Farrell, 2002; Reynolds, Mezey, Chapman, Wheeler, Drummond and Baldacchino, 2004), we still lack weighty statistical evidence that this is a causal rather than coincidental relationship. Not all childhood abuse victims go on to develop an addiction, or at the very least an overt addiction where treatment is sought.

2.4 The significance of attachment for addictive behaviours

Major theorists in the area of attachment and addiction, such as Flores (2003), suggest that vulnerability of the self is a consequence of development failures and early environmental deprivation. This, Flores claims, leads to a weak psychic structure. When this is the case, he suggests, some individuals attempt self-repair by means of addiction, which in turn exacerbates their dysfunctional attachment styles. This cycle places prolonged stress on that already weak psychic structure. This view appears to resonate with the published opinions of counselling practitioners, among whom self-repair is sometimes tellingly referred to as 'plugging a hole in the soul'. According to Mellody (2004), this hole is characteristically found in adults without experience of balance and boundaries of love and of emotional nourishment, and who have not achieved a fulfilling, secure interdependence. Thus, one can look upon an addict's relationship with his drug as attachment, offering him the secret secure base and masking his negative self-concept.

3. Evidence of a link between attachment and addiction

This section offers a critical analysis of some of the recent research evidence supporting a link between attachment and addiction, by reviewing a representative sample of both quantitative and qualitative studies. These studies have been selected by the researcher to demonstrate some of the difficulties surrounding categorisation of addicts as 'insecure', and examining some inherent confounds when taking a quantitative research approach.

3.1 Maternal overprotection correlates with insecure attachment

De Rick and Vanheule (2007) conducted a four-month-long quantitative study of attachment styles in 101 alcoholic in-patients at six Belgian psychiatric hospitals specialising in alcohol addiction. Patients were excluded from their sample if they presented organic disorder, acute psychotic symptoms or abuse of substances other than alcohol. Individuals were tested using six separate measures. Between eight and 20 days into treatment, they were tested with the European version of the Addiction Severity Index (ASI: McLellan, Kushner, Metzger, Peters, Smith and Grissom, 1992). Three weeks after the beginning of treatment – to avoid the effects of intoxication (upon arrival)

or detoxification (during the 14-day detoxification process) – patients were given five self-report questionnaires:

- The Adults Attachment Style Questionnaire (AAQ – Dutch version: Verschueren and Marcoen, 1993) was used to measure their general attitudes towards adult attachment relationships.
- The Parental Bonding Instrument (PBI – Parker, Tupling and Brown, 1979) measured participants' perceptions of the parenting they had received.
- The Bermond-Vorst Alexithymia Questionnaire (BVAQ) measured ability to recognise and name emotions (Bermond-Vorst, 1998).
- The Spielberger State Trait Anxiety Inventory (ZBV – van der Ploeg, 2000) was used to measure anxiety
- Finally, the Assessment of DSM-IV Personality Disorders (ADP-IV: Schotte and De Doncker, 1994) was used.

The study considered four key questions:

- Can meaningful sub-groups of attachment style be differentiated in adult alcoholic in-patients?
- If so, how do these sub-groups relate to perceived parenting?
- Can attachment sub-groups be differentiated on the basis of the severity of their alcohol addiction (clinically assessed)?
- And do the different attachment styles correspond differently with psychiatric symptoms most commonly found in people with alcohol addiction – anxiety, depression, DSM-IV personality traits and alexithymia?

In answer to the first question, 66% of the subjects were labelled insecurely attached, broadly corresponding with the original weightings found by Ainsworth et al (1978) (see subsection 1.5 above). With regard to perceived parenting, only maternal overprotection was found to be a statistically significant predictive factor for insecure attachment. Securely and insecurely attached subjects were found to differ from each other only in

that the latter showed more psychiatric symptoms. Severity of alcohol problems did not reflect in the cluster analysis of the ASI scores and attachment status.

It was also found that the insecurely attached alcoholics showed significantly more evidence of schizotypal and depressive personality traits, implying a negative self-concept. Researchers proposed that depressive personality traits can be indicative of a negative self-concept, while schizotypal personality traits highlight social inadequacy, difficulties with interpersonal relationships and suspicion of others. Overall the researchers interpreted these results as representative of an impoverished internal working model of the self and others. This, they asserted, could be understood in the context of an over-controlling and intrusive parenting environment.

There is an adequate sample size in this study, drawn from six separate residential detoxification units, and the researchers were rigorous in both the number of measures used and the statistical analysis of data. Importantly, this is one of few studies that has attempted statistical validation of the perceived link between attachment and addiction. However, while the researchers implicate attachment dysfunction as a precursor to alcoholism, it cannot be stated as causal. Pointedly, the dysfunction was related to only one type of maternal approach – over-controlling. Moreover, one-third of the alcoholic patients were considered securely attached, indicating that attachment is not the only pathway into addictive behaviours (or at least into alcoholism), or that insecure attachment is more difficult to detect in adults from a retrospective account.

A drawback of this study is that it does not offer a finer-grained analysis of more subtle types of attachment. It is interesting that a more binomial data pattern did not emerge, with, say, childhood abuse at one pole and over-control at the other. This might mean that the measures used were not sophisticated enough to detect such characteristics, or that the sample was not broad enough. Another possibility is that there is a need for a fifth attachment category, reflecting a suffocating, over-controlled environment for the child.

It is difficult to say how far these results can be generalised, either to a wider alcoholic population or to a wider community of adults addicted to other substances. This study had a strong gender bias (70% male), which could have weighted the data towards overprotective mothers of boys, and thus failed to penetrate other styles of parenting, such as abuse or neglect. Other studies have shown that females with a history of childhood sexual abuse are three times more likely than others to have alcohol-related problems (Wilsnack, Vogeltanz, and Klassen, 1997). In addition, the researchers excluded multi-addicted individuals, who might have shown a higher rate of insecure attachment. There may also be some anomaly arising from the use of patients only in the Netherlands, so introducing further cross-cultural validity would be an important next step.

Closer analysis of De Rick and Vanheule's methods highlights a particular area of contention. Patients were subjected to the ASI between 8 and 20 days into their treatment. Alcohol detoxification is typically recommended at 10 to 14 days (NICE, 2005): some patients may have been less coherent and more distracted by physical withdrawal symptoms than those tested later. The researchers do not say what proportion of their sample was tested at which juncture. A more even approach to testing that deliberately avoided disadvantaging some patients could add to the validity of data. For the sake of good housekeeping, it might also have been wise to run a control group to detect significance against adults without addictive behaviours. A further good practice could be to reduce self-report measures (and thereby reduce subjectivity), and insert other, more objective techniques, such as a semi-structured interview. An interesting additional research avenue could be to compare similar testing results on adults with other forms of addictive behaviours – in particular, drug dependence. It would also be worthwhile incorporating a follow-up protocol, distinguishing those remaining abstinent from those who relapsed, and comparing their attachment status and its degree of correlation with relapse.

3.2 Influence of the maternal role on adolescent drug misuse

McArdle, Wiegersman, Gilvarry, Kolte, McCarthy, Fitzgerald, Brinkley, Blom, Stoeckel, Pierolini, Michels, Johnson and Quensel (2002) attempted a large-scale study (n = 3,983) of family structure and family functioning in relation to adolescent substance abuse, while considering possible gender differences. They used a cluster sampling method to obtain a representative sample of 14- and 15-year old schoolchildren from five separate European locations, including the UK. Gender proportions were broadly equal. All participants completed a questionnaire relating to lifestyle, substance use, family structure and relationships. Information was gathered on several illicit drugs – cannabis, amphetamine, ecstasy, LSD and tranquillisers – and a dummy drug, 'relevin'.

The questionnaire was derived from ESPAD, the European School Survey Project on Alcohol and other Drugs (Hibbell, Anderson, Bjarnason, Kokkevi, Morgan and Narusk, 1997), using a tick-box format – questions such as "Who can you talk to if there is something bothering you?" requiring yes/no answers to a menu of alternatives.

Using bi-variate analysis, researchers found that children living with both parents were less likely to have used drugs in the past year than those from other forms of household (such as single-parent). They also found a lower incidence of drug use among adolescents who indicated parental supervision and confiding in parents or grandparents. Living with both parents, confiding in the mother (not the father) and parental supervision each significantly predicted drug abstinence. No gender effects were uncovered. The researchers astutely chose to perform logistic regressions to remove potential confounds of social class, drug availability and delinquency. The findings were very similar, with significance only arising on factors such as the use of more than one substance, allied to their availability, and delinquent behaviour.

The rate of drug use was measured at 42.3% in children where there was an absence of family structure or 'qualitative variable' (confiding or supervision), while in children

where both parents were present it was 16.6%, and in the presence of one parent it was 32%. The researchers' interpretation was that living with both parents and being in a socially and emotionally supportive environment were significant insulators against the likelihood of drug use, irrespective of whether the qualitative variable in the relationship was confiding or supervisory; the mother relationship was cited as the most robust indicator of adolescent drug use. The high rate of use in single-parent families relates, they suggest, to social changes having distanced adolescents from the influence of adults.

The value of such a study is in its scale and pan-European reach. From the perspective of attachment theory, the role of the mother appears significant, although the nature of that relationship was not probed in depth. Mindful of the De Rick et al (2007) study described above, it would be interesting to detect subtleties of the family attachment profile and rates of childhood abuse – although, in the context of this study, ethical considerations would probably have ruled that out. While the researchers did attempt to remove key confounding variables, there is always the prospect of some data pollution from cultural interpretation of questions about secure attachment and maternal relationship in adolescence. To expand further, we are not told whether availability of drugs, drug use in the family or peer-group influence were of significance, and it would seem that experimental and problematic users are not distinguished.

There is considerable evidence to suggest intergenerational transmission of addictive behaviours, such as that found by Wallace (2000) in a study of adult crack cocaine smokers with alcoholic parents. Wallace also found evidence of dysfunctional family links. Thus, what is being attributed to attachment quality in McArdle et al's (2002) study may be more aligned with social learning from parents, and the questions investigating relationships were perhaps too general. The researchers stated that the father relationship did not seem to have the power to insulate against drug use, but this was not argued through in the study, and does not appear to add to the existing knowledge on paternal attachment. In fairness, however, this study was not specifically designed to

assess which parent had greater influence, so this can be viewed as additional data that would be interesting to follow up in subsequent studies.

To summarise the key findings of these two quantitative studies, it would appear that poor-quality attachment is significant for, and adversely affects, alcoholic adults and drug-using adolescents, while the maternal role is highly influential. Of interest are the over-controlling factor found in De Rick et al's (2007) study and the confiding/supervision role in McArdle et al's (2002) study. Again, there needs to be a more qualitative explanation of what these roles really constitute. The term 'dysfunctional/insecure attachment' is perhaps insufficiently broken down in these studies, and more generally in the field of attachment research. This research also suggests that drug use in adolescence may in part be triggered by insecure attachment, and that this impoverished sense of self may continue through to adulthood, as seen in the alcoholic in-patients in De Rick and Vanheule (2007).

It is worth contrasting these results with qualitative study data published in the past few years, such as the two following studies.

3.3 Dysfunctional parenting: a catalyst for addiction

Etherington's (2007) qualitative study has been selected because it is one of the few that does tap into the finer-grained analysis of addiction and of addicts' life experiences. Kim Etherington's study considered attachment theory and the experiences of eight addicts. She investigated intergenerational transmission of poor parenting, and whether individuals who had developed an inferior sense of self went on to be poor parents. Her research paper provided excerpts from interviews with three adults ('John', 'Josie' and 'Becky'). At the time of the interviews, they were all in a lengthy abstinence phase, having formerly been substance-dependent for several years (unspecified by the researcher). Etherington spent many hours taping and transcribing the life stories. She was able to unpack issues of emotional abuse and neglect, traumatic loss and lack of

responsiveness – factors often difficult to detect in quantitative studies (as seen above). She provides support for the concept that parental dysfunction may have many different shades.

Importantly, she chose abstinent or recovering individuals rather than current substance users or dependents. This may have allowed respondents to talk more freely and avoid the shame, denial and stigma that existing users often feel, and which, if concealed, can jeopardise data quality. Crucially, the three individuals were at a stage where they were able to fully admit their former dependence, recognise its effect on their lives and take responsibility for it. Mind-altering substance use was therefore no longer a confound. Etherington may thus have come closer to a real sense of truth than other studies, because participants are likely to have felt less need to psychologically defend themselves. As Barnard (2005) suggests, abstinent individuals may experience a changed sense of self over the passage of time.

Etherington recorded the participants' experiences of being parented and their own parenting behaviours, gaining a rich insight into their attitudes, feelings, thoughts and values. Importantly, she also gauged how 'failing as a parent' might be assessed differently with the benefit of hindsight when underlying intentions of parenting were identified. Two of the three individuals had undergone treatment and a rehabilitation programme, while the third, Josie, abstained of her own accord and later self-referred for counselling.

Common factors in all three life-stories were emotional abuse and neglect, sexual abuse and violence, abandonment and low self-worth. Difficulties in forming intimate, trusting relationships were evident in all three accounts. Insecure attachment is a label one can reasonably apply to all three.

In John's case, an inattentive single mother often left him to fend for himself. Afraid much of the time and socially isolated, he started using cannabis aged 13, and progressed to illicit hard drugs and addiction soon after. When, having become a father, he was refused visitation permission because of his drug-dependent lifestyle, he experienced an epiphany and took the decision to seek treatment.

In Josie's case, having longed for a close emotional relationship with her distant father, she blamed herself when he chose to leave his marriage. This left her feeling torn between her father and her unresponsive mother. Aged 14, she began using alcohol and switched to cannabis aged 17, when she also became pregnant. As she coped with single parenthood and her drug habit, she remembered the distressing feelings associated with her own childhood neglect, and felt determined not to subject her young child to the same ordeal. She subsequently made a decision to be drug-free.

Becky experienced violence and verbal aggression in her household, and had an alcoholic father. At the age of four she was sent away to live with a mentally ill and emotionally unpredictable relative, promoting feelings of abandonment. In adolescence she sought affection from boys and was introduced to drugs and alcohol aged 14. As her drug misuse escalated, she suffered an abortion and then violence at the hands of a boyfriend while still only 15 years old. Soon after becoming a mother and becoming involved with the criminal justice system, Becky was given 12 weeks of primary treatment. This helped her to identify herself as a mother and start taking responsibility again.

Etherington (2007) considers that all individuals need to find their 'rock bottom' after the experience of a parental environment lacking in emotional nourishment and security. She found that this can occur with a life-changing event, such as becoming a parent, as happened to all three of the participants described here. At such a point, individuals may be more open to and better able to consider issues surrounding their own childhood and the behaviour of their own parents, and to understand better what they had tried to find in substance abuse that the world seemed unable to provide. Etherington further suggests

that treatment of drug misusers should involve helping them to narrate their life stories in ways that assist them to form more secure identities, and thus propel them towards a fundamental change in their addiction.

A problem with any qualitative study such as Etherington's is the small sample size, which prohibits generalisation to a wider population, and the subjective nature of its interpretation. However, there are some striking similarities in the backgrounds of these three individuals. The shorthand for all three is that they felt isolated, unloved and unsure of their role in life. It is an adequate demonstration of the egocentric way in which children try to account for the bad things that happen, typically internalising the blame and shame. A potential confound that the study seems not to have considered is the degree of cognitive impairment that may have resulted from long-term substance abuse, and whether it affected the recall of childhood memories. However, the lengthy interview process suggests that participants were able to recall defining childhood events, and were not just telling some vague story of bad parenting. Nevertheless, it is hard to say from this study whether these individuals have truly developed a robust sense of self that would not surrender to future crises. A longitudinal study of all three participants, recording any relapses, could be highly informative. In addition, knowing what type of treatment had been administered, and for how long, might provide valuable insights for the therapeutic community.

3.4 Reflecting on poor parenting and countering intergenerational transmission in female addicts

This qualitative study by Polansky, Lauterbach, Litzke, Coulter and Sommers (2006) illustrates the potential danger of other people's thinking influencing the cognitions and perceptions of participants. These researchers used semi-structured individual interviews of female addicts, and they present evidence of a link between faulty attachment and addiction.

The US researchers used the AAI to assess attachment relationships in an all-female population who were already part of a drug and alcohol rehabilitation programme. The age range was from 18 to 64 years, which seems very wide, in view of changing attitudes to drug use over the past three decades and the different parenting practices of different age groups. It might have been more appropriate to use a larger sample within the age spectrum and to segment the data by age band, or to focus research efforts on a particular sub-group, such as adults who had only recently become mothers. It might also have been more revealing if sub-groups had also been defined, by type of drug, addiction severity and length of use. It seems all participants were grouped together regardless of these factors, so that users of stimulants and sedatives could have been part of the same sample, which strikes me as less than ideal. The study tracked six weeks in the lives of women who met once a week for a group therapy session. The semi-structured interviews were conducted after these sessions, which may not be an ideal time. The danger in this method is that it can introduce the confound of 'other peoples' thinking' spilling into individual content, resulting in a misleading homogeneity of themes. Allowing some time to elapse could enable the client to reflect on the group session, and might have generated more diversity of opinion and more robust data. Life events, mental illnesses and other potential confounds were not recorded. This is a typical illustration of studies in this field, where the link between attachment and addiction is not robustly established, largely through inadequate control of external variables.

In their study (n=7) the researchers also found that becoming a mother had made participants reflect on their own experiences of being parented. The study suggests that this link may not often be available to the client's conscious awareness. Subjects recalled incidences of feeling unloved and insecure, and fears of exposing their own offspring to similar experiences. The authors suggest that there is a requirement for parenting-based treatment strategies, based on attachment theory, for adult addicts, and that this could provide a good source of support and increase their own maternal sensitivity, warmth, affection and responsiveness.

Notwithstanding the reservations expressed about the four studies outlined, they do provide considerable evidence to suggest that there is a link between attachment and addictive predisposition. The qualitative work helps us understand the real experience of the individual and the indelible marks left on them by their childhood. Such qualitative depth is analogous to the therapeutic approaches that some therapists might undertake. In all, this work suggests that attachment may well be a therapeutically useful construct for a counselling psychologist to work with when treating adults with addiction.

4. Evidence of the relevance to therapy of the attachment construct

This section looks through the lens of attachment to examine theoretical perspectives on, and studies of, the counselling of adults with addiction. It will then outline an assessment of the benefits and restrictions of using the attachment construct.

4.1 Allan Schore: inspiring the attachment system in therapy

Over the past decade, not only has Allan Schore steadfastly maintained that secure attachment is a fundamental precursor of mental health, he has also produced substantial neurobiological evidence about the nature of the right brain in relation to emotional regulation in humans. He confirms that this is the key location of attachment processing (Schore, 2001). Interestingly, in his many publications Schore is one of the few people to link a lack of emotional regulation in the right brain with the predisposition to addictive behaviours (Schore, 2001, 2002, 2003). However, neurobiology is a vast area of research in its own right, and for the purpose of this review the focus will be on his theoretical position on the importance of recognising attachment deficiencies in patients, and on how this affects the counselling process.

Schore (2003) points to the significance of the therapeutic alliance, arguing that the way in which the client forms attachment is crucial to the therapeutic process. While the interactive dynamic between therapist and client is common to all therapies, as others would testify (Safran and Muran, 2000; Bradley, 2000), Schore particularly emphasises

the parallels with psychoanalysis, where unconscious factors are specifically sought. He maintains that if therapists allow attachment information to bring them to a better understanding of the client's non-conscious dyadic affect mechanism, there is a prospect of using this mechanism to help mediate a positive alliance. This should teach the client how to regulate affect, and thus generate an improved sense of self and self-control. Such understanding would therefore bring about affect-focused, developmentally orientated treatment.

If one considers deficits in social cognition as arising from impoverished attachment in childhood, the kernel deficit that Schore (2003) refers to is in self-regulation. This deficiency in self-regulation, both in intensity and duration, is manifested when clients display difficulties in dealing with situations involving such emotions as shame, rage, excitement, panic and helplessness. This is attested to by other researchers, such as Fonagy and Target (1997), who use the umbrella term 'mentalisation' (ability to see another's perspective and use reflexive functioning). However, many of these studies leave outstanding the question of whether such problems are already present prior to drug use or have resulted from substance dependence.

In drawing a parallel between his 'right brain' views and psychotherapy, Schore suggests that the therapist should attempt to re-mobilise fundamental stages of development that have been interrupted in the patient's early life. In essence, Schore (2002) maintains that the therapist should strive to reach the common ground shared by emotion-transacting mechanisms – those between the caregiver and the infant (in secure attachment) are effectively replaced by the therapist-client relationship. However, there is a danger that a therapist could collude with the client and promote dependence on the therapist, instead of cultivating their independence.

An additional perspective cited by Schore (2003), and also by Sable (2000), is that the therapist should carefully attend to the client's physiology and non-verbal cues and act as his emotional regulator. This seems to imply more than just empathy, and is allied to

Freud's (1916-1917/1953) thinking about the ability to have one's unconscious react upon another person without it being in either party's conscious awareness. However, Schore (2003) urges the therapist to work both objectively and subjectively to reach an in-depth understanding of the client's dysregulating symptomatology. In the view of Bruschweiler-Stern (1998), the implicit relational knowledge acquired by the therapist represents the core of change in the client. In psychoanalysis this would probably be expressed in terms of the therapist being responsive to critical countertransferential reactions. However, Schore (2002) does not advocate a particular mode of therapy.

Schore emphasises that the therapist has to be much more than an interpreter of the disordered client's unintegrated early attachment experiences. Rather, he suggests the therapist must dysregulate prevailing right brain states and provide feedback to the client via insight-orientated interpretations. He asserts that during long-term therapy the client's right-hemisphere brain cycle can revert to a growth phase, due to the life-long plasticity of the orbito-frontal cortex. Thus, longer-term therapy could expand the conscious right brain and deliver to the client an earned secure attachment (Schore, 2003).

To conclude, Schore (2003) places the therapist in a critical role, not only of assisting the client to think differently and more securely about himself, but also effectively of inspiring the attachment system in the right brain to regenerate. He emphasises that it may serve therapists well to demand more neurological information about how that can be achieved.

Schore's reluctance to propose precise therapeutic techniques is a key shortfall. Overall, however, where Schore (2003) refers to the therapist dysregulating right brain states and feeding back to the client, the pattern sounds not unlike Cognitive Behavioural Therapy principles. Attending to the client's bodily states is common to most therapeutic approaches. Noting the synthesis of verbal and non-verbal cues from the client is a hallmark of good therapeutic practice, as is implied in the approach of many therapies, including Rogers' (1957) person-centred approach. However, one of the concerns about

placing the therapist so centrally and asking them to 'speak' to the right brain is that, without clinical measurement and clear guidance, the client may be at the mercy of the therapist's subjective interpretation of attachment, which could be misread, misjudged or wrongly emphasised. Overall, Schore's work strongly supports attachment theory, backed by neurological findings, and he firmly outlines the therapeutic principles, if not the absolute technique.

4.2 Attachment type predicts the therapeutic alliance

Few practising psychologists would argue against the importance of the therapeutic alliance as a foundation for good therapeutic practice. Meier, Donmall, Barrowclough, McElduff and Heller's (2004) study considered whether it is possible to predict the early therapeutic alliance in the treatment of addiction. This study took a sample of male subjects at the start of residential rehabilitation for drug misuse, and assessed counsellors' and clients' ratings of the therapeutic relationship at intake and then at one, two and three weeks.

The researchers used an intake assessment comprising a battery of scales, including motivation for treatment, coping strategies, attachment style and psychological well-being. Six measures were used. Assessment of the early alliance between counsellor and client was conducted weekly using the Working Alliance Inventory (WAI-S: Horvath and Greenberg, 1989). The Coping Behaviours Inventory (Litman, Stapleton and Oppenheim, 1983) was used, together with the Relationship Questionnaire (Bartholomew & Horrowitz, 1991), and psychological symptoms were measured via the Addiction Severity Index Psychiatric Scale (McLellan, Luborsky, Woody and O'Brien, 1980). The Treatment Expectations Questionnaire (Liese and Beck, 1995) collated clients' negative thoughts about treatment. With respect to treatment confidence, researchers posed three key questions: respondents had to rate how likely they were to stay with the treatment programme, whether they thought they would make important changes in their life, and how likely they would be to use drugs again three months after the programme ended.

Researchers found that the best predictors of the therapeutic alliance were client pre-admission variables such as social support, secure attachment and motivation, and, to a lesser extent, counsellor characteristics. Intuitively it would seem likely that more securely attached individuals would have experienced successful social engagement, and so be more disposed to develop a positive relationship with the counsellor. Variables such as length of drug use, treatment history and demographics did not go a long way towards explaining counsellor-rated alliance, but motivational measures such as external pressure and desire for help did. These findings concur largely with those of Connors, DiClemente, Dermen, Kadden, Carroll and Frone (2000), albeit the latter study found a bias to male counsellors correlating with early alliance, whereas Meier's et al. (2004) did not.

One key finding was that the level of clients' psychological problems was negatively correlated with early alliance, suggesting that counsellors found their role more challenging with the more troubled clients. High levels of psychological problems (one in five people) are typically found in the drug treatment services (Marsden, Gossop, Stewart, Rolfe, and Farrell, 2000). The staff were counsellors rather than psychologists, and it may be that they were insufficiently trained for this task. In addition, 54% of the counsellors in this study were themselves former addicts; while they were experienced personally, this finding may suggest that treatment of addiction requires something more than empathy. It was unclear from the study whether and at what stage the counsellors who had been addicted revealed this to their clients. Finally, there was an inverse correlation between how counsellors rated themselves and their level of experience of counselling – that is, the more experienced counsellors rated themselves lower.

Once again there is evidence from this study that secure attachment, good social support and client motivation are the ingredients that best predict successful therapeutic alliance. However, the evidence regarding the counsellor was inconsistent and vague, and there appear to be several potential confounds in this work. The key issue of informing the client about the counsellor's former drug use should have been controlled for at the outset

of the study. It is impossible to detect whether this genuinely mattered to clients, or whether the counsellors who were former users were also better at their job or had personalities that invited clients to relax and disclose.

The finding that experienced counsellors rated themselves poorly does not really add to our knowledge. Without knowing whether their experience made them more cautious about rating the alliance and their expectations of client outcome, we simply do not know what to make of it. A further methodological issue is that confidence questions were asked only once in the study. This could result in misleading data. A follow-up at three months, to check whether intentions had been fulfilled, could have been useful to counsellors. Moreover, researchers reported that a large number of clients dropped out of the study without explanation. In addition there do not appear to have been controls in place to detect the length of time that subjects had been abstinent at the time of entry to the Rehabilitation Unit. This suggests that certain individuals may still have had substances in their systems, which could have affected their cognitive ability when completing the tests. Perhaps urinalysis would have avoided this potential confound. In short, the study again emphasises the importance of the therapeutic alliance, but it does not expand our knowledge of therapeutic practice.

4.3 Group therapy: potential to repair social network deficits in insecurely attached addicts

Philip Flores has written extensively on the subject of addiction and attachment. In several papers (Flores, 2001; 2003; 2006) he emphasises that the essential requirement for treatment of adult addicts is to target the affective bonds and repair the inevitable disruptions that are present in many substance abusers. He also strongly advocates group therapy.

The principle he urges therapists to employ is to help the client develop the capacity for healthy interpersonal relationships. He and others have already demonstrated that there is

an inverse relationship between addiction in adults and the ability to form healthy relationships (Flores, 2001; Walant, 1995). Another important recommendation for therapists is to treat adult addicts from a longer-term perspective. He intimates that there is no quick fix; and other research confirms that the more there is therapeutic continuity (use of the same therapist), the greater the improvement (Leshner, 1997).

Flores (2003, 2006) strongly argues that it is virtually impossible for the therapeutic process to begin before the client has detached himself from his addictive relationship with substances and has attached to the therapist in a drug-free state. This, he states, is due to the likelihood of impaired ability in the substance misuser while he is still using, which exacerbates the client's difficulty in forming healthy interpersonal relationships. This makes intuitive sense, but it also goes against the Harm Minimisation Model (launched in 1998) that is championed by the UK government. Many substance users undergoing psychological treatment are on methadone prescriptions (often at high doses) and/or using illicit drugs. Flores' position is that these substances – legal or otherwise – can undermine the therapist's attempts to move clients forward.

Many theorists and researchers in the area of addiction refrain from recommending any particular therapeutic approach for addicted adults. Indeed, the extensive Project Match Study (1997) showed substance abusers who were classed as treatment-receptive (around 30%) responding positively to any kind of therapy. Flores (2006) suggests that group therapy using attachment principles offers the client something more concrete than other approaches, but he does not go so far as to favour group therapy over individual therapy, nor indeed to firmly recommend both. He is sceptical about organisations such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), which offer a form of group support therapy to people who want to rid themselves of addiction: he considers that they do not specifically arm clients with an ability to build interpersonal relationships, that many adults with addiction do not want to go to AA, and that of those who do, few benefit.

However, in Flores' view, under the right circumstances the group facilitates first-hand experience of interactions and shared opinion – a view endorsed by many other authors, such as Rice (2003), and Ormont (2001). Flores' recommendations for the therapist facilitating group psychology therapy are to encourage clients to recognise the deficits in their social network and relinquish old attitudes, and to allow them to experience conflict and resolution, and understand how they can correct their dysfunctional interpersonal patterns.

Flores strongly advocates the recognition of attachment styles and coping behaviours that result from childhood experiences, and recommends that therapy equip the client with a new set of social tools via a process of consistent self-repair. Once again, the quality of the therapeutic alliance is heavily emphasised. Flores (2006) also suggests that the therapist must be adept at recognising and repairing relational ruptures. The therapist needs to be mindful of the deceit the client may engage in to avoid the therapist knowing that some kind of 'failure' has occurred, such as a relapse or general dyssynchrony.

Importantly, Flores (2006) advises the therapist to be alert to crises in the client and to recognise that the attachment systems open up most when clients are in crisis – a view also presented in Bowlby's early works (1969, 1973, 1980). Thus, delicate areas for the therapist to manage in relation to attachment theory relate to shame, hurt and aggression, either in individual settings or in group settings when relations deteriorate. He also invites the therapist to discover how their own attachment difficulties contribute to the resolution of ruptures in the therapeutic setting, and to avoid responding defensively in an effort to conceal their own discomfort.

While these therapeutic principles shed more light on areas that the therapist needs to be aware of and work with, they again fall short of telling therapists how to engage the client in mentalisation exercises and reflexive functioning. Flores (2006) does suggest that attachment-orientated therapy embraces the principles he outlines, but also that it is more important who the therapist is than what the therapist does. However, Flores is

advocating many overtly directive principles that appear contradictory to some therapeutic approaches (person-centred, for instance).

Helping the client to recognise social and interpersonal deficits seems a key issue, and it may be appropriate to use group sessions to acclimatise the client to these areas, but Flores makes no mention of how much exposure a client needs, nor of the structure of the sessions or the gender make-up of the group. Thus, a lot of fine detail is omitted that would guide therapists. Finally, it may be that the author's recommendation of group therapy reflects the nature of his own (group-based) clinical practice, rather than significant statistical evidence.

5. Summary

The study of child development has been enriched by the works of Bowlby (1951, 1958, 1959, 1969, 1973, 1980) and Ainsworth et al (1978, 1991), providing psychology with valuable insights and ways of categorising attachment styles. However, it was not Bowlby's intention to make a direct contribution to therapeutic practice. Since then, the field of attachment has been heavily theorised about, while there have been few studies in the area of attachment and addiction. Of those studies carried out, many link the experience of dysfunctional parenting with addictive behaviours, and strongly suggest that attachment is a potentially valuable construct for the counselling psychologist to work with. The evidence presented in this review does suggest there is an inverse relationship between addiction and healthy interpersonal attachment. However, it is still unfathomable in studies to date whether poor attachment caused addiction or whether addiction led to difficulties or deterioration in attachment in adulthood (Hofler and Kooyman, 1996; Caspers, Yucuis, Troutman and Spinks, 2006). On the other hand, it is clear that dependence on alcohol or drugs presents both an obstacle to and a substitute for relationships (Hicks, Lewis, Murray and Behrens, 2007).

Without scientific evidence from many studies, it is hard to make an absolute case for the inclusion of attachment considerations in any therapeutic approach, but the

overwhelming theoretical bias of the literature suggests that it could present vital insights into the capabilities of clients and the most helpful ways to ease them out of their addictions.

On the other hand, focusing on attachment theory alone is to deny other, potentially important aspects of the client's context, and it could be seen as too great a driving force during the therapeutic process. A possible concern is that a therapist could unwittingly create a climate of over-dependence that would directly work against the outcome of the treatment, by creating in the client a confusion between caregiving and therapy.

Theoretical views of the importance of addiction as an attachment disorder tend to rely heavily on intuition. Few studies delve deeply into this area, or provide us with any clearer guidance than the unproven assertion that bad parenting is implicated as a causal factor but not the sole cause.

Of more practical help is the observation that clients may need to be abstinent before attachment work can begin (Flores, 2006). They need to detach from the substance and build a solid therapeutic relationship, and they need to gain experience of how to maintain healthy attachment when conflict arises. Adult addicts are notoriously inadequate in conflict resolution (Flores, 2006). The therapist must therefore be careful to avoid triggering intrusive childhood memories and heightening the client's vulnerability to substance relapse. They must also encourage the client to develop a social network to support a change in themselves and to begin developing a supportive social structure that allows this change to be sustained.

When it comes to treatment, intuition-based recommendations abound, but most of the authors in this field are not recommending tried and tested therapeutic techniques. Most speak in generalities of a 'way of being' as a therapist and the crucial role of the therapeutic alliance. Flores (2006) and Schore (2003) perhaps take us closest to counselling practice, but even in these cases, though the ingredients may be delivered, the cooking procedure is left unclear.

6. Conclusions and future directions

6.1 Considerations for methodology

Many of the studies referred to and detailed here do not demonstrate an unequivocal link between attachment and addiction. To continue probing both the relevance of the attachment construct in therapy and the process that should be involved, it needs to be further validated by means of tighter methodology.

The ways of considering attachment as a construct appear to fall into two camps: either one clinically measures the client's attachment style (as Ainsworth et al., 1978, advocate and Hazan and Shaver, 1987, recommend viewing romantic love as a property of the attachment system in adults, or one looks for the discourse cues in therapy. A mixture of the two does not appear to have been tested. Sampling is often opportunistic, and randomised controlled trials are virtually non-existent.

Where studies have produced statistical evidence of a link between attachment style and addiction, and of compelling reasons for using attachment-based principles in therapy, it is often surrounded by confounding variables that have not been adequately controlled for (Meier et al., 2004). That the data can be confounded by so many potential variables – from social class to the continuing presence of addictive substances in the client's system – is probably one of the reasons why opinion appears to be divided in the therapeutic community as to the value of attachment as a construct. Control groups are often absent, making it hard to generalise any findings – for instance, a finding among alcohol dependents may not apply to other forms of addictive behaviour. Another possible weakness in these studies is that the three original insecure categories of attachment do not seem to accommodate over-controlling or enmeshed relationships between parent and child, suggesting the need for a fifth type of attachment in adults. One further alternative is to consider attachment style in adulthood as being more of a continuum, as opposed to fitting into discrete categories – which questions the validity of the original construct. Finally, while there are critics of attachment theory and of the implications for its use in adult therapy, there is no persuasive evidence to justify commentators objecting to its therapeutic use.

6.2 Causality

Due to the many variables and their potential to confound, it has been found difficult to prove outright that the link between attachment and addiction exists, but many studies do identify a link. Hence, one cannot yet state that dysfunctional parenting causes addiction, but only that it is implicated. The question remains whether the deficiency in psychic structure that is often found in addicts is primarily attributable to attachment dysfunction.

6.3 Measurement

Many of the formal measurement tools appear to take too much of a top-down approach (asking a framework of questions), and they may procure answers that dilute reality (the answers may not be truthful). Equally, addicts who are still in the recovery process at the time of testing may still be chaotic, and thus respond more forcefully to structure and any suggestion from the experimenter than non-addict respondents. This possibility was highlighted in the critique of De Rick et al's (2007) study. It is unclear just how much value the practitioner of addiction therapy can derive from a subjective, retrospective account framed by a questionnaire.

Meanwhile, UK Government departments continue to stress the importance of 'catching' addiction early on. The more recently developed tool designed to assess middle childhood attachment, the Childhood Attachment Interview (Shmueli-Goetz, 2001; Target, Fonagy and Shmueli-Goetz, 2003; Shmueli-Goetz, Target, Fonagy and Datta, 2008), may begin to assist us in this effort. It may act as a useful screen for detecting children with potential mediating factors for addiction, enabling them to be fast-tracked to therapy before addiction becomes full-blown.

Meanwhile, it is by no means clear whether a therapist should automatically take a formal measure of attachment quality, or whether it would have a meaningful impact within therapy and on the therapeutic outcome. The calibre of attachment information generated depends on the assessment tool used, and it may provide psychologists with an incomplete picture. In other words, it may be better not to take a formal measure of attachment quality than to do so using an unreliable assessment tool. Qualitative

accounts, because they are about the lived experience and are idiographic in nature, may provide a more lucrative vein of information on parenting experiences. If studies were more longitudinal in orientation, they might help us to define more clearly the key factors that push the child towards an addictive self-repair path.

6.4 Gaps in research knowledge

There are, perhaps, two particularly important gaps in the knowledge about attachment and its relationship with addiction and particularly, heroin addiction. One is in its measurement. The other is in identifying how best a therapist can help the client to repair their sense of self and go on to form healthy interpersonal relationships.

This suggests that two key areas of research are ripe for continued investigation. The first is to seek an attachment measurement tool that evolves from free-flowing discourse and is then quantitatively validated. This could be difficult research to put into effect, but such a tool would be useful in a therapeutic context, particularly if the information could be used to tailor the treatment approach. The second is to investigate how therapists should work with attachment deficits in the treatment of adults with addiction, using the attachment information generated from measurement tools.

More large-scale, preferably longitudinal studies need to be conducted to distil how counselling psychologists can best work with attachment material. There is also a need for studies of the outcome of attachment-based psychotherapies, not only to guide therapists on technique but also to determine what doses and types of psychotherapy will lead to successful outcomes in the addicted population. In addition, further work comparing the role of the mother with that of the father would seem valuable in relation to addiction. Multiple-addicted populations should also be studied, to determine whether they show higher rates of attachment insecurity, and what parenting and interpersonal factors are present, to help therapists work with such complex and chaotic individuals.

Another area that is not well served by the attachment literature relates to constellations of personality traits amounting to attachment disorder – specifically, maladaptive traits

that are found in personality disorders (Fonagy, Target, Gergely, Allen and Bateman, 2003). Researchers appear at odds with one another as to which attachment classification fits best, and, while links between insecurity and addiction are interesting, they do not constitute cause and effect (Schindler, Thomasius, Sack, Gemeinhardt, Kustner and Eckert, 2005). If more longitudinal research were available to validate the notion that insecurity is a significant mediator of addiction, this would be an even greater reason for earlier psychological intervention in young adults, and could assist therapists in identifying the likelihood of addictive behaviours in later life.

Finally, further research is needed into the attachment styles of therapist and client, how they interact and how they expedite or impede the therapeutic process. Many addiction counsellors are themselves former addicts, and it is unclear whether this is a therapeutic asset or a potential liability.

6.5 Conclusions

Attachment theory appears both relevant and instructive when working with adult addicts. The theoretical underpinning seems more than adequate, despite the lack of evidence of causality, and many of the links adduced between attachment and addiction are intuitively compelling (De Rick & Vanheule, 2007; Etherington, 2007; McArdle et al., 2002). Damage to the child's self in the early years appears often leave indelible marks that can create problems with interpersonal relationships, and may leave individuals more vulnerable to addiction, as was found in Etherington's (2007) study in recovering addicts. Repeatedly, the significance of the maternal role looms large in the literature. Whether that relates to overprotection or abuse, the insecure attachment link to addiction is strongly implicated (McArdle et al., 2002; De Rick et al., 2007).

While many therapists would probably acknowledge attachment difficulties in clients, and indeed are urged by some researchers to take attachment representations into account (Caspers, Yucuis, Troutman and Spinks, 2006), it is far from clear that all would attempt to work with that material when treating adults with addiction. This may be less to do with resistance or unwillingness and more about how they design interventions to

embrace these representations. Nevertheless, theoretical perspectives from the likes of Schore (2003) and Flores (2006) strongly suggest that attachment insights can inform and potentially benefit the therapeutic process. More research demonstrating therapeutic validity could give therapists confidence to use the attachment construct more widely, or less diffidently. There is insufficient evidence and technical clarity to guide therapists working with attachment in addiction treatment.

The literature discussed in this review points strongly to attachment as a valuable therapeutic construct when counselling adult addicts (Schore, 2003; Flores, 2006). On the evidence reviewed here, attachment dysfunction or insecurity can be considered an antecedent, if not necessarily a determinant of addiction. What is now required is more hard evidence about attachment and addiction, how they interact and their respective roles; and, second, more empirical research to identify and validate an approach that is capable of helping practitioners to meet the addicted client's therapeutic needs.

It is unclear whether any of the existing measures of attachment can enrich the qualitative information that arises from skilful therapeutic discourse. Moreover, because of the top-down nature of the information gathered from existing measurement tools, it is unclear how therapists should employ specific techniques. Thus, whether one chooses to use a measurement tool or not, empathic-based therapy with interventions informed by knowledge of the client's attachment background may still serve clients well. Whether it is enough remains questionable, given the high rates of relapse in the addicted population in treatment. However, if Schore's (2003) right-brain plasticity argument holds, therapists need greater instruction in how to speak to it and galvanise change. Such research into the practical applications of Schore's work would surely present a very exciting therapeutic avenue.

The area of literature reviewed here has parallels with the field of resilience-building in young adults, where heavily traumatised and poorly parented children do not necessarily progress to adult mental health problems (Hall and Pearson, 2003). It is unlikely that all

insecurely attached children go on to form addictions. Understanding why this is so could benefit techniques in prevention therapy.

Norcross (2001) and Flores (2006), however, suggest that the therapy matters less than the therapist. Consensus points to the critical importance of the therapeutic alliance when dealing with adults with addiction (Schore, 2003; Meier et al., 2004). However, specific recommendations, such as to establish the therapist as a reliable emotional and physical base (Heinz-Brisch, 2002), need to be converted into practical techniques for day-to-day use; the transition from theory to therapy still appears open to individual interpretation. Indeed, a very real danger in substituting caregiving with the therapeutic relationship (Flores, 2006) is that it creates a dependence in the client instead of promoting healthy interdependence.

Overall, the most therapeutically valuable position the therapist can adopt is perhaps best summed up as a triad of influences (empathy, trust and mutual holding), as advocated by Kestenberg and Buelte (1977a, 1977b). If the therapist assumes a role as regulator of the client's affect, and stimulates repair of the client's self and of deficits in their social network, as Schore (2003) recommends, then the client's chances of moving towards healthy interpersonal relationships and moderating or extinguishing addictive behaviours may be improved.

The overall conclusion of this review is that attachment quality is a valuable construct when counselling adults with addiction, but that ways of measuring it and, more importantly, ways of incorporating it into therapeutic techniques, have considerable room for improvement. There are research opportunities for unique studies and for innovative measures that can be put to constructive use in addiction therapy.

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