

The Institute for Clinical Social Work

LISTENING FOR THE FALCONER:  
TEENS, ATTACHMENT, AND PSYCHOPATHOLOGY

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By

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## ABSTRACT

This is an exploratory study using a mixed methodology into the subject of adolescent attachment and psychiatric hospitalization. Fifty participants ranging in age from 13 to 17 years, of mixed race and sex were randomly selected from admissions to a rural Midwestern acute care psychiatric hospital during July 2007 to February 2008 and administered a semi-structured interview. Their responses were recorded and classified for attachment style using a narrative analytic methodology derived from the Adult Attachment Interview protocol, and the results were analyzed for frequency and associations to four variables of interest. The highest frequency of narratives found in the sample population were those classified as Disorganized/Disoriented, suggesting that disorganized attachment representations are associated with vulnerability to psychic breakdown.

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## LIST OF ABBREVIATIONS

AAI:	Adult Attachment Interview
AmbPre:	Ambivalent/Preoccupied Attachment Style
AvDs:	Avoidant/Dismissive Attachment Style
D/U:	Disorganized/Unresolved Attachment Style
DSM:	<i>Diagnostic and Statistical Manual of the Mental Health Professions</i>
EAS:	Earned or Acquired Secure Attachment Style
IWM:	Internal Working Models of Attachment
S/A:	Secure/Autonomous Attachment Style
SS:	The Strange Situation Experiment

## CHAPTER I

### INTRODUCTION:

#### OF FALCONERS, PARENTS, TEENS, AND ATTACHMENT

Turning and turning in the widening gyre  
The falcon cannot hear the falconer;  
Things fall apart; the centre cannot hold . . .  
W.B. Yeats, *The Second Coming*

What binds the falcon to the falconer once her tether is loosed and she launches herself skyward? What causes her to return from that widening gyre to perch again tamely on the falconer's gloved fist? Is it training alone, simple consequence of discipline and conditioning? Or is it something like that invisible and ephemeral connection that in humans is called attachment?

Within the animal studies he reviewed for the first volume (Bowlby, 1969/1982) of his historic trilogy, John Bowlby found evidence of attachment in most non-reptilian animals, including birds.

The falcon of Yeats' poem was metaphor for the collapse of human civilization. That same falcon, whose use is borrowed for the present study, stands as metaphor for the adolescent launching into that flight toward maturity and adulthood we all must make. The adolescents of this study, however, do not find their flight an easy one; instead they are battered by turbulent winds, spun far away from the call of their falconer-parents (for

some, one suspects, that call was always faint, if ever heard at all). Spinning farther and farther away, “out of control”, “oppositional and defiant”, things have truly fallen apart, and the center—assuming there ever was one—has not held. The attachment so necessary for our adult ability to tolerate, modulate, and manage emotion; so critical to our capacity for self-reflection and empathy; so crucial in shaping our deepest relationships throughout our lives—for most of them that attachment has been damaged, and for some of them, broken.

The teens who participated in this study were randomly selected following their admission to a Midwestern acute-care psychiatric hospital. Ages range from 13 to 17 years; most were of poverty or working class socio-economic status, with a few from solidly upper-middle-class families. Admission criteria required that the adolescents be seen as of imminent risk to themselves or others, or both, or to be experiencing an active psychotic episode, although psychotic adolescents were excluded from this study. Typical admitting symptoms for these teens were self-harm (cutting being the most common, with other forms of self-mutilation occasionally present), suicidality (active ideation, suicidal gestures, or full-fledged attempts), self-destructive drug abuse or dependence, or other-directed aggression (including violent assault).

### History of the Problem

Early attachment is crucial in building the psychic structures that regulate emotional experience, intersubjectivity, and the ability to integrate affect and cognition. Fully developed capacities for affect regulation involve the acquired ability to self-regulate (soothe or stimulate) in the absence of attachment figures, to co-regulate in the

context of attachment relationships, and reciprocally regulate in mature attachment. These capacities, in turn, affect the ability to balance feeling with thinking so that both can be used in concert to guide our behavioral responses in navigating interpersonal relationships and the environment.

Repetitive experiences in infancy with our primary caregivers become patterned into the right-brain (implicit, non-declarative, procedural) memory system as models of relational interaction (Bowlby's hypothesized internal working models of attachment). Although each individual is largely passive and dependent in early infancy, the developmental progression is toward ever increasing active and autonomous function; the individual eventually comes to play an active role in eliciting relational responses from others. What began as an acquired adaptation to the (relational) environment becomes patterned into behavior that will subsequently influence the (relational) environment.

Early attachment experiences act as a foundation shaping our non-conscious expectations of self and other in relationship, and playing a fundamental role in our capacities for self-regulation, reflection, intersubjectivity, and sense of self. The reflexive patterns of response affected by these capacities set up recursive patterns of interactions throughout the life of the individual. In this way, early attachment shapes both resilience against and vulnerability to psychosocial impairment; "good enough" attachment in childhood creates internal working models which provide for "good enough" subsequent relationships and effective capacities for reflective function and affect regulation, while deficits in childhood attachment experience create internal working models which provide for unsatisfying subsequent relationships and negatively influence the capacities for affect regulation and reflective function. The present study

posits a relationship between psychic representations of attachment and varieties of impairment which result in psychiatric hospitalization.

Directly relevant to the current study are the issues of attachment style in children and parents, methodologies for classification, the internal representation of attachment experience, and the relationship of attachment to mental illness (defined in the present study as being diagnosed with a recognized psychiatric disorder as systematized in the *Diagnostic and Statistical Manual of Mental Disorders*, 2000, Revised 4<sup>th</sup> ed.—DSM IV-TR). What follows is a brief review of theory and literature relative to these areas.

### *Attachment Style*

Mary Salter Ainsworth's studies made the first formal classification of patterned relational behaviors (attachment style) possible. In her naturalistic observations Ainsworth initially identified three patterns of attachment behavior and their relationship to maternal caregiving behavior. (Bretherton, 1995) These were later validated through systematic study in the Strange Situation (SS) laboratory procedure. (Ainsworth, 1963; 1967; 1969a, b; 1979; n.d.; Ainsworth, Blehar, Waters, & Wall, 1978; Ainsworth and Wittig, 1969) The three infant attachment styles initially identified were those later to be codified as Insecure-Avoidant, or Type A; Secure, or Type B; and Insecure-Ambivalent, or Type C (sometimes referred to as "resistant," or "dependent"). Also observed were a small number of infants whose behavior did not appear to fall into any recognized pattern. These were simply called "other," or "cannot classify." Mary Main and Judith Solomon conducted systematic analysis of observations for infants in this latter category and arrived at a fourth attachment style, Disorganized/Disoriented, or Type D. (Main and

Soloman, 1986, 1990) A chart describing key features for each of the four attachment styles is found below. (Adapted from Goldberg, Muir, and Kerr, 1995, pp 1-15.)

Figure 1

Attachment Styles as Classified in the Strange Situation

<u>Type A: Avoidant</u>	<u>Type B: Secure</u>	<u>Type C: Ambivalent</u>	<u>Type D: Disorganized</u>
Minimal interest in caregiver; explores busily; minimal distress at separation; ignores or avoids caregiver on reunion. Estimated 20%-25% in general population.	Uses caregiver as secure base; explores freely when caregiver available; may not be distressed at separation but greets warmly on reunion; if distressed is soothed by caregiver presence, return to exploration. Estimated at 55-65% in general population.	Preoccupied with caregiver; minimal exploration; not easily soothed; both seeks and resists contact on reunion; may be angry or very passive. Estimated at 10-15% in general population.	Disorganized or disoriented with caregiver; classification with “forced fit” into one of other three categories. Estimated at 15%-20% in general population.

Initial reviewers of SS data believed that the children who would ultimately be classified as Type A (Avoidant) were exhibiting the “healthier” attachment behaviors

because of their apparent independence when left without their mothers. Ainsworth, however, disagreed. Before she had created the SS design and become convinced of the diagnostic relevance of separation/reunion interactions between mothers and infants, Ainsworth had originally believed (based on her naturalistic observations) that security of attachment was best indicated by a balance between proximity seeking and exploratory play. (Bretherton, 1995)

While Type A children were capable of exploratory play, they did not appear to engage in proximity seeking behavior, and in fact seemed oblivious to their mothers' proximity or absence. Ainsworth maintained this behavior was indicative of attachment insecurity because of its imbalance. Subsequent attachment research correlating attachment style with neurobiochemical measures of stress arousal (Hertsgaard, Gunnar, Erickson, & Nachias, 1995; Grossman, Grossman, & Schwann, 1986; Spangler and Grossman, 1993) have provided physiological validation for Ainsworth's view. Only Disorganized/Disoriented infants show higher arousal indices (as measured, for example, by comparison of cortisol levels in saliva or blood) than Avoidant infants. That is, although their outward appearance is one of non-distress, Type A infants show strong biochemical evidence of being as aroused, or more highly aroused, than their Type C (Ambivalent) peers who do evidence observable signs of emotional distress. (Bradley, 2000; Schore, 2003a).

Ainsworth noted that each of the three initially identified attachment styles was correlated with different patterns of maternal caregiving sensitivity. It was not until Main's development of the Adult Attachment Interview classification system for adult attachment that these observations, along with the corresponding caregiver correlations

for disorganized infants, were codified into a formal classification system. The four identified patterns of adult attachment style are Dismissing, or Type Ds; Preoccupied, or Type E; Secure/Autonomous, or Type F; and Unresolved/ Disorganized, or Type U. Below is a chart providing brief characterization of each of the identified adult attachment styles. (Goldberg, 1995)

Figure 2:

Attachment Styles as Classified in the Adult Attachment Interview

<u>Type Ds: Dismissing</u>	<u>Type E: Preoccupied</u>	<u>Type F: Secure</u>	<u>Type U: Unresolved</u>
Attachment concerns dismissed from consideration; claims of no recall for childhood; idealization of childhood without supporting detail; cut off from emotions or dismissive of their significance. Estimated at 20-35% in general population.	Confused and preoccupied with details if past; lack of objectivity; passive and vague or angry or conflicted or unconvincingly analytical. Estimated at 10-15% in general population.	Coherent and collaborative in discussing attachment; interactive dialogue; thoughtful; perspective on past whether positive or negative. Estimated at 45-55% in general population.	Lapses in monitoring or reasoning around topics of attachment or trauma; classification accompanied by "forced fit" into D, E, or F category. Estimated at 15-20% in general population.

### *Methodologies of Attachment Classification*

“Attachment” is a theoretical construct. The origins of this construct are found in the work of John Bowlby and Mary Salter-Ainsworth. Ainsworth, and later her colleague Mary Main, created methodologies for assessing attachment quality through quasi-experimental, laboratory design (SS) and narrative analysis (AAI). Today, research in attachment theory continues to expand, and methods for assessing attachment quality can be loosely divided according to focus on one of three related, but separate, domains of study: infant-caregiver attachment, adolescent/adult attachment, romantic attachment. (Crowell, Fraley, and Shaver, 1999) The present study will take as its focus the domain of adolescent attachment in a non-romantic context.

Attachment research can also be categorized according to its use of one of two types of research methodology. These two different methodological approaches to attachment research can be characterized as either inferential or self-report.

As attachment is a theoretical construct, it cannot be directly observed but must be inferred. Ainsworth’s earliest attachment studies, although soundly based on naturalistic observation, were inferential in nature. Certain patterns and types of behavior were observed that Ainsworth and subsequent researchers have inferred to be involved in the attachment system: for example, what Ainsworth saw would be a specific behavior like “clinging”, and what was inferred was clinging as a behavior used in the service of the attachment system.

In addition to observing infant behavior, Ainsworth also interviewed the caregivers (mothers) of the infants she observed. She asked them about their thinking concerning what they were doing as they engaged in behaviors that were seen to be the

parental complement of infant attachment behavior. This aspect of research was given systematic expansion in the work of Main and colleagues through their development of the Adult Attachment Interview. The AAI infers attachment style/quality from an analysis of narrative construction in response to its semi-structured interview.

Infant observation and narrative analysis are the inferential methods currently prominent in attachment research. These two methodologies have been found to have strong convergent validity in various studies evaluating the relationship between parental attachment representations and infant attachment security. (Fonagy, Steele, and Steele, 1991; Fonagy, Steele, Moran, Steele, and Higgitt, 1993; Hesse, 1999)

Main has never published the protocol for coding attachment narratives in her assessment schema: the AAI methodology is not, therefore, readily accessible for research purposes. Partially as a consequence of this, a number of self-report measures of attachment have been created. (Garbarino, J., 1998; Stein, Jacobs, Ferguson, Allen, and Fonagy, 1998; DeHass, Bakermans-Kranenburg, and van IZendoorn, 2001) As the name implies, self-report measures of attachment are pencil and paper questionnaires that ask participants to classify their own attachment behavior by choosing among alternative descriptions provided to them.

The question, however, can be asked, as Stein et al. ask in the title of their article, what do these scales measure? Further, since “none is meant to capture the attachment patterns delineated by Ainsworth, Blehar, Waters and Wall (1978),” (Crowell et al., 1999, p. 435) there is a question whether these self-report measures of “attachment” can accurately claim to be attachment measures at all.

While it is true that an idea cannot be owned or claimed by any individual, within

the sphere of scientific theory and research the criterion of theoretical convergence, or conceptual congruence, exists. By this criterion, it is questionable whether a measure which does not aim “to capture the attachment patterns delineated by Ainsworth” can claim to be an attachment measure. As attachment style, or quality, is a concept that was initially systematized by Ainsworth, if a measure does not use Ainsworth’s conceptualization, then it cannot theoretically be an attachment measure. It may be measuring something of interest, but what it measures is not “attachment” in the sense that term was created by Bowlby and Ainsworth.

Because of these concerns about theoretical convergence, the present study will not employ self-report measures of attachment. What remains are the inferential modes of attachment classification; behavioral observation, and narrative analysis of attachment representation. Behavioral observation is not practical beyond toddler-hood, as behaviors that may be discretely in the service of attachment early in life become more complex and varied over the course of subsequent development. (Hyde, 2003) For that reason, narrative analysis will be the chosen methodology for this study. As Main’s AAI methodology is a research-oriented interview not appropriate for the participants in the present study, an alternative narrative analytic methodology (the Brief Attachment Based Interview, or BABI [Holmes, 2001]) in clinical interview form using structural and process criteria similar to those of the AAI will be used.

### *Attachment and Mental Representation*

Only in infancy, as the patterned relational interactions with attachment figures are being imprinted into the developing brain, is the interpersonal environment dominant

in shaping attachment behavior. From this point onward, repeated patterns of attachment experience are operationalized as psychic constructs that govern the individual's expectations of relational interaction; these constructs Bowlby called "internal working models of attachment" (IWM). (Bowlby 1969/1982) The IWM is the mental representation of attachment, the mechanism theorized as responsible for the multi-generational transmission of attachment in family systems. IWMs "serve to regulate, interpret, and predict both the attachment figure's and the self's attachment-related behavior, thoughts, and feelings." (Bretherton and Munholland, 1999, p. 89)

The narrative-analytic protocol of Main's AAI is a method for mapping and classifying the quality of attachment indicated by one's IWM. This is not a static achievement, but a dynamic maturational process in which the IWM is revised and modified in light of changing experience and changing personal/interpersonal competencies. The ability to so revise attachment representation is the hallmark of attachment "health" or "security", and can be seen as the psychic, mental complement to the secure infant's capacity for exploratory play.

The two varieties of insecure attachment and disorganized attachment styles are each characterized by deficits in some aspect necessary for continued revision of the IWM. Avoidant/Dismissive Attachment devalues and minimizes the role of relationship and emotion in human experience; Ambivalent/Preoccupied Attachment remains locked in a struggle to regulate the affect of past attachment experiences at the cost of the here-and-now; Disorganized/Unresolved Attachment cannot arrive at a coherent schema for guiding relational behavior or making sense of relational exchanges. (Main, 2000; Hesse and Main, 2000; Solomon and George, 1999)

### *Attachment and Mental Illness*

There are two strategies for use in exploring the relationship between attachment security and psychopathology: longitudinal studies and concurrent studies. (Goldberg, 1997) The present study is of the concurrent variety.

To date, the most ambitious longitudinal study of attachment and development is that of Sroufe et al., called the Minnesota Study. (Sroufe, Egeland, Carlson, and Collins, 2005; Sroufe, 2005) A thorough discussion of the still ongoing study's findings is beyond the scope of this brief review; however, a selection of the more relevant data is highlighted below.

A history of secure infant attachment did not preclude the development of later childhood behavior problems that "ultimately qualified for some form of psychiatric diagnosis by late adolescence." (Sroufe, 2005, p. 360) However, statistically significantly fewer securely attached infants had problems at any age than those insecurely attached, and special risk of pathology was present for those with histories of Disorganized attachment.

Study participants with histories of secure attachment had significantly fewer behavior problems in middle childhood when confronted with contexts of familial stress than those in the Insecure and Disorganized classifications. Most study participants with histories of insecure attachment did not have serious behavior problems or psychiatric disturbance. Although the prevalence was higher in these groups than in the securely attached groups, insecure attachment was judged by Sroufe et al. to be only a moderate risk factor for the development of behavioral disturbance or diagnosable psychiatric disorder.

Among insecure varieties of attachment, only Disorganized attachment was a predictor of later psychopathology, with .40 correlation between Disorganized attachment and “number and severity of psychiatric symptoms at age 17 ½.” (Sroufe, 2005, p. 168) Some specific relations between typology of insecure attachment and later problems were noted: Avoidant attachment was correlated with conduct problems; Ambivalent (referred to in Sroufe’s study as “resistant”) attachment was strongly associated with anxiety disorders; Disorganized attachment histories were predictive of later dissociative disorders, and, to a lesser degree, conduct disorder (theoretically because of the dissociative defense’s subsequent negative impact on capacities for impulse control). “Serious self-injurious behavior” (for example, cutting and other forms of self-mutilation) was strongly related to Disorganized attachment, especially in the familial context of maltreatment, most especially sexual abuse.

As the Minnesota Study indicates, research has produced mixed results in the attempt to link attachment security to later psychopathology, with the strongest links always existing between Disorganized infants and subsequent psychiatric or behavior problems. (Bradley, 2000; Goldberg, 1997; Solomon and George, 1999) However, some varieties of emotional difficulty (that is, the so-called internalizing disorders) are hard to discern in early childhood populations, and this may account for the unclear association between Avoidant Attachment and childhood mental/behavioral problems.

Research has suggested a relationship between attachment security and such diverse areas of psychopathology as sexual acting out (Crittenden, 1997); adolescent depression (Shaw and Dallos, 2005); childhood behavior problems (Goldberg, 1997); substance abuse (Schindler, Thomasius, Sack, Gemeinhardt, Kustner, and Eckert, 2005);

disruptive behavior, delinquency and criminality, and borderline personality disorder. (Fonagy, Target, Steele, Steele, Leigh, Levinson, and Kennedy, 1997)

Some of the research into attachment and mental illness uses self-report measures of attachment (DiFilippo and Overholser, 2000; West, Spreng, Rose, and Adam, 1999). No conclusions can be drawn from their findings with respect to the Ainsworth/Main classifications of attachment quality because attachment representations are not accessible to conscious awareness, and therefore, self-report is not a valid or reliable measure of attachment style. (Main, 1993, 1995)

One study (Diamond, Clarkin, Levine, Levy, Foelsch, and Yeomans, 1999) that did use research methods consistent with the Ainsworth/Main conceptualization of attachment quality found an association between Ambivalent/Preoccupied Attachment in adulthood with DSM diagnosis of Borderline Personality Disorder.

A study conducted by Berger, Moore, Land, Bell, and Peck (n.d.) using attachment classifications from the AAI found discrepancies between self-perception and parent/peer reports in both Avoidant/Dismissive and Ambivalent/Preoccupied adolescents. Specifically, Ambivalent/Preoccupied subjects over-reported symptoms compared to parent reports, while Avoidant/Dismissive subjects demonstrated discrepancies between peer reports of behavior and parent reports of symptoms (the direction of the discrepancy was not described).

Although no linear cause-and-effect relationship between particular attachment styles and specific mental disorders can be established, examining the relationship between later psychic function and early attachment remains a fertile area of research.

## Formulation of the Problem

### *General Statement of Purpose*

This study explores the relationship between attachment style and psychopathology among adolescent inpatients admitted to a rural Midwestern acute care psychiatric unit. Specific variables examined are DSM-IV diagnosis and reason for hospitalization (risk of harm to self, risk of harm to other(s)).

### *Statement of the Problem Studied*

The problem studied here is a hypothesized relationship between quality of attachment in adolescents and admission to acute-care psychiatric hospitalization. The objective of the study was to explore whether any identifiable patterns existed in the study sample that suggested a relationship between security of attachment, as assessed by narrative analysis of responses to a brief attachment interview (Holmes' Brief Attachment Based Interview, 2001), DSM-IV-TR diagnosis, and/or presenting problems precipitating hospital admission.

## CHAPTER II

### LITERATURE REVIEW:

#### A THEORY OF FALCONS AND FALCONERS

##### History and Evolution of Attachment Theory

John Bowlby (1907-1990) is the father of attachment theory. In the first volume of his attachment and loss trilogy (1969/1982), he posited the attachment system as an evolutionarily derived, biologically based control system hardwired into the brains of humans and all higher animals that care for their young. His linking of animal behavior with human behavior made Bowlby's theorizing ethological in nature, a unique perspective among psychoanalytic theories of that time. (Bretherton, 1995) Bowlby, a psychoanalyst trained in Object Relations theory, of which he understood attachment theory to be a variation (Bowlby, 1998), saw himself as operating in the tradition of Freud's Project for a Scientific Psychology. Like Freud, he drew inspiration from the work of Charles Darwin; but unlike Freud, Bowlby built his theory of attachment not by reasoning backwards from adult psychopathology, but from his own and others' observation of parent-child interactions in naturalistic and experimental settings. The latter greatly expanded by work of his colleague and eventual collaborator, Mary Salter Ainsworth (Ainsworth, 1963, 1967, 1969a, b, 1979, n.d.), who Bowlby credited with creating the concept of "the secure base."

Although he remained a member of the British Psychoanalytic Society for his

entire life, the storm of controversy raised by his presentation of three seminal papers there (Bowlby, 1958; 1959; 1960) resulted in Bowlby's estrangement from the psychoanalytic community. His theory was viewed as being too behavioral because of its emphasis on identifying the discrete observable indicators that initiate and terminate attachment system activation; as negating the role of intrapsychic processes because of its stress on the importance of mutual influence in the *in vivo* interaction between mother and child. Bowlby challenged the Freudian view of attachment as secondary to need gratification, asserting instead a primary instinct for attachment and proximity; he dismissed the idea of superego development through resolution of the Oedipus complex, believing the mother functions as a symbiotic ego/superego for the child in the early years of development; and Bowlby rejected the Kleinian notion of object ties as the product of infantile fantasy responses to aggressive and sexual drives. (Bretherton, 1995, pp. 46-48)

The theory Bowlby created was one that incorporated principles of evolutionary theory, object relations, ethology, and cybernetic systems into the psychoanalytically radical view of an instinctive drive toward relationship and connection. For Bowlby, dependence was not regression, but an evolved biological given: humans require intimate, interdependent emotional relationships throughout life in order to function optimally. He saw the need for attachment as serving an evolutionary purpose; he saw human emotions as functioning in the service of attachment, by providing relational cues or motivating behaviors that activate the attachment system; he also saw problematic emotional responses—for example, depression, aggression, anxiety—as secondary artifacts arising from frustration of the need for healthy attachment.

The first major empirical research using attachment theory was conducted by Mary Ainsworth, who brought an “enormous experience in instrument development and diagnostics” to Bowlby’s research team. (Bretherton, 1995, pp. 48-49) Ainsworth’s work would eventually expand the theory through both naturalistic observation and, later, experimental testing.

Ironically, Ainsworth’s Uganda studies, the first ethologically-oriented research into mother-infant attachment, were conducted years before the publication of Bowlby’s three controversial papers. Ainsworth eventually published the data from the studies, and the conclusions she drew from them, in two articles. (Ainsworth, 1963, 1967) It was in the Ugandan studies Ainsworth first observed the relationship between maternal sensitivity and security of infant attachment that would be codified in her experimental design, the Strange Situation. (Ainsworth and Wittig, 1969)

In 1963, Ainsworth conducted a second observational study of mothers and infants in Baltimore. This time armed with knowledge of the patterns she had observed in the Uganda study, Ainsworth’s new findings furthered her burgeoning understanding that what she was observing was three different varieties of infant attachment behavior. The patterns she observed in the Uganda and Baltimore studies would later be formalized in the concepts of secure and insecure attachment styles.

Her observations in Baltimore also solidified Ainsworth’s understanding of the attachment behavior of infants being directly tied to the sensitivity of maternal attention, as well as demonstrating a direct relationship between infant security of attachment and willingness to engage in exploratory play.

The second theoretical expansion contributed by Ainsworth was the creation of an

experimental laboratory design, the Strange Situation (SS), to confirm the hypotheses she had developed about the relationship between maternal caregiving and infant attachment security in her naturalistic studies.

The Strange Situation is a 20-minute miniature drama with eight episodes. Mother and infant are introduced to a laboratory playroom, where they are later joined by an unfamiliar woman. While the stranger plays with the baby, the mother leaves briefly and then returns. A second separation ensues during which the baby is completely alone. Finally, the stranger and then the mother return. (Bretherton, 1995, p. 61)

What Ainsworth found particularly interesting as she developed the SS was her observation of unexpected patterns of infant behavior during reunion episodes, which she was able to theoretically link to Bowlby's 1960 paper on separation anxiety. (Bretherton, 1995, p. 61) It was infant behavior at reunion that would eventually be the focal interaction upon which attachment style classification in the SS would rest.

With data culled from her field observations in Uganda and Baltimore, and experimentally replicated in the Strange Situation procedure, Ainsworth was able to develop what remains the gold standard of attachment style classifications for infants and caregivers, the Strange Situation. (Ainsworth, Blehar, Waters, & Wall, 1978)

The next significant developments in attachment research were overseen by Mary Main, who initially focused on the relationship between security of attachment in infants and their capacities for play and problem-solving. (Bretherton, 1995, p. 64) In the late 1970's, however, her attention shifted from observation of non-verbal behavior to the intra-psychic processes governing parental attachment. (Hesse, 1999) As a result, in the early 1980's Main created what stands as the complement to Ainsworth's Strange Situation for classifying adult attachment style, the Adult Attachment Interview.

(George, Kaplan, and Main, 1984) The Adult Attachment Interview (AAI) arose from Main and colleagues' observation that interviews about parental "state of mind with respect to his or her own attachment experiences" (Hesse, 1999, p. 395) suggested a direct relationship to their infants' attachment style as classified using the SS.

Although Bowlby had theorized the maintenance of patterned behavioral responses regulating attachment were governed by intrapsychic processes (referred to as *internal working models of attachment*) (Bowlby, 1969/1982), until Main—and largely because of the success of Ainsworth's observational methodology—attachment research had been confined to observations of behavior, which contributed to the view of many psychodynamically oriented thinkers of the time that attachment theory had inherent a pronounced behavioral slant. Main's development of the AAI marked a change in the field that has been called *the shift to the representational level of attachment*. (Main, 1995; Hesse, 1999)

It is with the representational level of attachment that the present study is concerned; but as it is an inpatient population being studied, a clinical interview is more appropriate for data collection than is the formal AAI procedure. For that reason, this study will use a clinical interview protocol that incorporates principles of AAI analysis, the Brief Attachment Based Interview (BABI), created by Jeremy Holmes (2001).

The work of both Ainsworth and Main was responsible for providing a solid research basis for Bowlby's attachment concepts that has been built upon by today's attachment theoreticians and researchers, such as L. Alan Sroufe. (1995, 2005a,b), Daniel Stern (1985), and Peter Fonagy (2002, 2001, 1997, 1993, 1991)

For over 30 years now, Sroufe has added a significant body of theoretical and

empirical data to the attachment field through his own studies. As Mary Ainsworth was creating the Strange Situation experiment, Sroufe theorized about the function of attachment in organizing the infant's psychic, emotional, and behavioral development. His work offered a substantial conceptual foundation for Ainsworth's experimental design, and elaborated on the intrapsychic elements underlying Bowlby's original theorizing around the function of maternal proximity as a psychic organizer for the infant. (van Ijzendoorn, 2005)

One important contribution Sroufe has provided is the Minnesota Study. (Sroufe et al., 2005.) The findings of the Minnesota Study give empirical validation to Bowlby's assertion that early infant attachment remains influential throughout the lifespan.

It is argued that understanding the role of attachment entails grasping the organizational nature of the attachment construct and embracing a non-linear transactional model. Using such concepts, attachment history was shown in the Minnesota study to be clearly related to the growth of self-reliance, the capacity for emotional regulation, and the emergence and course of social competence . . . specific patterns of attachment had implications for both normal development and pathology. (Sroufe, 2005b, p. 349)

Sroufe (1995) has provided a summary of work spanning 25 years that demonstrates the importance of early attachment in the development of specific emotional states and the ability to regulate such states. Particular contributions of Sroufe's work are the concepts of "dyadic regulation" (the interpersonal process of mutual attunement, misattunement, and interactive repair that provides the unconscious underpinnings of relational transaction) and "reflective function" (the capacity to reflect on our own internal affective experience and from that generalize to an understanding of both similarities and differences in the subjective affect experiences of another). Reflective function is a central capacity required for building a "theory of mind."

Daniel Stern, along with Peter Fonagy, has been instrumental in affecting the reconciliation between contemporary psychoanalytic developmental thinking and the work of John Bowlby. (Stern, 1985; Fonagy, 2001) Stern (1985), details the embeddedness of the child's developing sense of Self and Other in the context of attachment with a sensitive caregiver. The subjective self is inseparable from the interpersonal self; in fact, it is only in the context of relatedness to a significant other (that is, mother, father, primary caregiver) that the infant's sense of subjective self can fully emerge. Central to Stern's view of this developmental progression is the role of "affect attunement" between caregiver and infant in consolidating the infant's subjective sense of self while simultaneously furthering a secure attachment.

Peter Fonagy and his colleagues (Mary Target, Elliot Jurist, Gyorgy Gergely, Miriam and Howard Steele) have focused their work on understanding the role of attachment in influencing the child's development of abilities to regulate affect, think about subjective experience, find a sense of competence and mastery ("self agency"), and the interrelationship of all these factors in structuring capacities for self-organization. (Fonagy et al., 2002)

We present a comprehensive picture of the development of a psychological sense of self, beginning with infancy and ending with adolescence . . . a precise account of the mechanisms through which infants learn to identify and control affect states through interaction with primary caregivers—moving from coregulation to being self-regulating agents . . . important not just as an account of normal development but as a basis for explaining later vulnerability to psychosocial stress and psychopathology. (Fonagy et al., 2002, p.143)

One key concept in this account of the role of attachment in human development is that of “mentalization.” This is similar to Sroufe’s theory of reflective function, but gives special emphasis to using regulated affect in the service of cognition as a tool for environmental adaptation and mastery.

A current fertile area of attachment theory expansion lies in exploring the biological basis of the human attachment system, an important—but undeveloped—dimension of Bowlby’s theory. Although Bowlby speculated about the neurological function (Bowlby, 1969/1982, p. 110) and location (p. 156) of the attachment system, there were no procedures available at that time to test his speculations. With the advent of current brain-imaging technologies that procedural gap has been filled.

No thinker has done more in the creation of a neurobiological model of attachment than Allan Schore. Schore’s primary contribution in this domain has been in his ability to integrate studies that cross disciplinary divides in order to create a neurobiological explanation of attachment and development. (Schore, 1999, 2003a, b) His work has shown the prescience of Bowlby’s own speculations, as well as his conjectures about the optimal developmental-temporal window for the system’s formation. (Bowlby, 1969/1982, p. 180) Grounding attachment theory in the solid empirical bedrock of neurobiology, Schore is acting in concert with Bowlby’s own agenda, which Bowlby saw as answering Freud’s call for a “scientific psychology.” One radical assertion by Schore is that the right cerebral hemisphere makes up “the neurobiological substratum of Freud’s dynamic unconscious.” (Schore, 2001)

The essence of Schore’s application of neurobiological studies to attachment theory is that Bowlby’s hypothesized “internal working models” of attachment are

imprinted in the non-conscious, implicit and procedural memory systems of the right cerebral hemisphere. (Schore 1999, 2003a, b) These brain centers are dominant during the first 18 months of life, only later to be surpassed by the orbital-frontal cortex and development of the capacity for left-hemisphere-dominant capacities of verbal symbolization and declarative memory. The implication of this locational neurobiology of attachment is: activation of right-hemisphere relational schema is primarily affective and behavioral, not a product of conscious deliberation or cognitive thought. Stated differently, Bowlby's hypothesized internal working models are non-conscious—unconscious—in influence.

#### Theoretical and Conceptual Framework of Attachment Theory

Attachment theory as understood in this study is an empirically based transactional model with a neurobiological foundation. In recent years, the study of attachment has expanded to such a degree it is arguably inaccurate to speak of attachment theory as though it remains one unified field. It is more correct to speak of attachment theories, which would give a better sense of the many elaborations and expansions that have taken place to the theory originally proposed by John Bowlby. (Bowlby, 1958, 1960, 1969/1982, 1973/1982, 1980/1982, 1998) The following is a brief review and examination of attachment theory's origin in the work of Bowlby and Ainsworth; the move in attachment research from behavioral observation to narrative representation, exemplified in the work of Mary Main; attachment theory's expansion along developmental lines in the work of Daniel Stern (Stern, 1985) and L. Alan Sroufe (Sroufe, 1995), the psychoanalytic developmentalism of Peter Fonagy and colleagues

(Fonagy, Gergely, Jurist, and Target, 2002), and the neurobiological-affect-regulatory schema proposed by Allan Schore (1999, 2003a,b) as an elaboration of Bowlby's original control-system hypothesis of attachment function. An effort will be made to provide a synthesis and integration of these different but interrelated and often overlapping theoretical lines so that a coherent and comprehensive view of contemporary attachment theory can be offered.

With its emphasis on empirical observation and laboratory experiment, contemporary attachment theory has its foundations in post-positivist British empiricism. Bowlby was meticulous in framing the assertions of attachment theory so that they were scientifically testable. Mary Ainsworth, who began her cross-cultural infant studies with skepticism toward Bowlby's theory, was converted by the correspondence of his theoretical constructs with the observational data she gathered in her research in Uganda, and later Baltimore. (Bretherton, 1995) Current developmental attachment theorists test the correspondence criterion of their hypotheses by experimental design and controlled studies, the most ambitious of which so far has been Sroufe's 30-year longitudinal study. Neurobiological expansions of attachment theory, as suggested by Schore, must correspond to current scientific understandings of both brain biology and infant development.

Attachment theory is a descriptive model of human development in an interpersonal context. It uses naturalistic observation and experimental data as the basis for validation and expansion, and thus strives for a degree of objective replicability unachievable by subjective introspective/empathic report. In fact, a key implication of contemporary attachment thinking is that internal working models of attachment are

unapproachable by purely subjective introspection because fundamental elements of attachment psychology lie outside conscious awareness.

### *The Metapsychology of Attachment Theory*

A comprehensive metapsychology must include theories of development, personality, psychopathology, and treatment. What follows is an examination of attachment theory in each of these domains.

#### *Developmental theory*

Attachment theory is quintessentially a theory of human development, but it is not a comprehensive developmental theory; that is, although describing an important—perhaps primary—aspect of development, attachment theory is limited as an explanatory model. It posits the need for secure attachment to promote healthy development into adulthood. It describes a developmental unfolding of object relations capacities for affect regulation and cognition that are contingent in kind and quality on the sensitive responsiveness of an attuned caregiver. Attachment theory hypothesizes a developmental progression from almost complete dependence on significant others for affect regulation and psychic structure (in infancy) to an eventual autonomous self-regulation and internalized psychic structure (in adulthood).

#### *Personality Theory*

Attachment theory does not profess a theory of personality *per se*, but offers in its stead a conceptualization of a range of early attachment patterns that become internalized

through development into primary attachment styles. These styles each have characterological implications for emotional experience and expression, personality style, temperament, and relational behavior. Each attachment style has characteristic defensive adaptations to stress-inducing experiences, and each of the insecure attachment styles has predispositions to particular kinds of psycho-emotional vulnerability. A key area of research for current attachment theorists is the longitudinal study of each attachment style over the course of development.

### *Theory of Psychopathology*

The concept of “psychopathology” is not easily translatable into the tenets of attachment theory, and can be seen as theoretically inconsistent with that approach. Individual psychic function is viewed in attachment theory as a complex interplay between variables of genetic-biology, temperament, early attachment experiences with caregivers (and implicit in this are the genetic-biological, temperamental, and inter-generational attachment experiences of the caregivers), family system dynamics, and socio-environmental constraints. Healthy attachment will have different cultural expressions in different societies (for example, autonomous personal function has a substantially different meaning in America than in Japan). With its evolutionary perspective, differences in attachment style (along with their inherent deficits, vulnerabilities, and risks) are seen more as non-conscious strategies for adaptation to less-than-optimal attachment environments rather than expressions of pathology. Only the insecure-disorganized style is seen as potentially psychopathological, as it yields no coherent strategy for attachment behavior.

Nevertheless, attachment research has provided data for understanding the role of attachment in such diverse areas of traditionally conceived psychopathology as sexual acting out (Crittenden, 1997); adolescent depression (Shaw and Dallos, 2005); childhood behavior problems (Goldberg, 1997); substance abuse (Schindler, Thomasius, Sack, Gemeinhardt, Kustner, and Eckert, 2005); disruptive behavior, delinquency and criminality, and borderline personality disorder. (Fonagy, Target, Steele, Steele, Leigh, Levinson, and Kennedy, 1997) Alan Schore believes a history of insecure early attachment to be a discriminant variable in the development of PTSD by those exposed to potentially traumagenic experiences. (Schore, 2002)

### *Theory of Treatment*

Although it contains implications for treatment, Bowlby's writing is notable for its lack of explicitness in the area of clinical practice, although clinical applications of attachment theory were the emphasis of his attention in the last ten years of his life. (Bretherton, 1995) One exception to this is the 1998 printing of edited versions of a series of lectures he gave beginning in 1979. (Bowlby, 1998) This work asserts that attachment-based treatment is best done as a kind of preventative or early ameliorative intervention into the attachment system by work with new parents to improve their affective attunement with their children. (pp 18-19) In the chapter entitled "Psychotherapy as Art and Science," after a review of attachment theory, research supporting it, and a discussion of (in his view) flaws in then-current understandings of etiology, Bowlby makes one of his clearest statements about treatment:

To provide, by being ourselves, the conditions in which a patient . . . can discover and recover what Winnicott calls his real self, and I call his

attachment desires and feelings, is not easy. On the one hand, we have really to be trustworthy and we have also genuinely to respect all those yearnings for affection and intimacy that each of us has but which in these patients have become lost. On the other we must not offer more than we can give and we must not move faster than the patient can bear. To achieve this balance requires all the intuition, imagination, and empathy of which we are capable. But it also requires a firm grasp of what the patient's problems are and what we are trying to do. (p. 57)

This statement speaks to general clinical concerns (a focus of heated debate at the time of these lectures, and still active in psychotherapy today) around the issue of gratifying versus withholding gratification from the patient. In this, Bowlby seems to align himself with clinician-theorists such as Winnicott, Fairbairn, Kohut, and contemporary Relational theorists on the side of abdicating a “blank screen” stance for the therapist. Therapists are to attempt a relational repair of the early insecure attachment by being a “secure base” from which the patient can be helped to explore his/her suppressed needs for intimacy and interpersonal connection.

In another section of this book, Bowlby outlines “five therapeutic tasks”. He makes an initial statement that attachment theory “can be used as a framework to guide each one of the three principal forms of analytic psychotherapy in use today—individual therapy, family therapy, and group therapy.” (Bowlby, 1998, p. 138) He then goes on to address only the first of these, individual therapy, in outlining the five tasks of therapy. These are:

1. The provision of a secure relational base, using behaviors that have been identified in the research as supporting secure parent-child attachment;
2. To facilitate exploration of “the various unhappy and painful aspects” of the patient's life past and present, with an emphasis on aiding

identification of the patient's contribution to unsatisfying current relationships;

3. Special attention should be given to the transference-countertransference enactment of attachment in the relationship between the patient and psychotherapist;
4. The patient should be encouraged "to consider how his current perceptions and expectations and the feelings and actions to which they give rise may be the product of" early attachment experiences.
5. The final task is to assist the patient in challenging, once identified, the unconscious models of attachment being enacted, and to explore whether or not they were ever justified. (Bowlby, 1998, 138-139.)

The contemporary attachment theorists Fonagy and Schore have also contributed from their own perspective to the "theory of treatment." Fonagy (Fonagy et al., 2002) discusses the use of play (pp 253-289), "affect mirroring" (pp 291-316), and "mentalized affectivity" (pp 435-467). Schore (2003, b), incorporating implications of his neurobiological framework into a general Self Psychology approach to treatment, appends to his book twenty "Principles of the Psychotherapeutic Treatment of Early-Forming Right Hemispheric Self Pathologies." (pp. 279-281)

Common themes uniting all three clinicians' "theory of treatment" are: (a) the use of the psychotherapy relationship to provide a facilitating environment for patient self-exploration; (b) examination with patients of their "internal working models" of relationship; (c) the patients' unearthing, feeling, and verbalizing buried affect which drives current defensive relational adaptations; (d) use of the here-and-now relationship

between psychotherapist and patient as a “Petri dish” for *in vivo* identification of attachment patterns, and experimentation with alternative transactional behaviors.

### *Summary*

Attachment theory has a solid developmental orientation supported by observational and experimental research. Contemporary expansions of attachment theory are constructing models of attachment function which can be traced to neurobiological foundations. The theory of treatment suggested is consistent with both its developmental model and its view of “pathology”, creating a possible bridge between theory building and clinical application.

### Adolescence: The Changing Nature of Attachment

Adolescence is transition from childhood to adulthood; along with the increase in personal freedoms and responsibilities that accompany this developmental period—marked in the United States by the achievements of driver’s license, high school diploma, and voter registration—there are also subtle, less acknowledged, losses. (Kaplan, 1984)

From a psychoanalytic perspective, a key component of this phase is the withdrawal, or decathexis, of libido from the parents with the goal of eventual libidinal transfer to select special peer relationships, and ultimately to pair bonds. (Scharf and Mayseless, 2007; Kobak, Rosenthal, Zazac, and Madsen, 2007) As this is a transformational process rather than a discrete event, along the way to achieving the new object cathexis (for those who are able to successfully negotiate this transition) will be encountered various intermediate phases of object-less libido, or libido turned inward.

Thus, central aspects of adolescent development with regard to both intrapsychic function and object relations can be seen as analogous to the processes Freud (1917) has described in his discussion of melancholia, which can account for a continuum of emotional reactions ranging from a (more normative) sense of loss, with accompanying assorted behavioral displacements, to (more pathological) depression and delinquent acting out, as well as accounting for the particular narcissism typical of adolescents. (Ochoa, Lopez, and Emler, 2007; Akse, Hale, Engels, Raaijmakers, and Meeus, 2006/2007)

From a more attachment-centric perspective, Scharf and Mayseless (2007) raise interesting questions in regard to attachment theory's ethological foundations: why is it that humans, virtually unique among animal species, maintain a significant attachment to parents past the point of achieving developmental self-sufficiency? More simply, if attachment is an evolutionary capacity linking species survival to the attachment system, what purpose does maintaining a continued attachment to parents serve for humans into adolescence and adulthood? And why the need to transfer that attachment to significant peers beyond the biological imperative of pair-bonding, mating, and reproduction?

An answer to these questions is found in the continued role attachment relationships play in supporting affect regulatory capacities in the human animal (Schorer, 1999, 2002a, b; Fonagy et al., 2002; Sroufe, 1995, 2005), into adulthood and throughout the lifespan. Associated with the mental complexity of humans that has allowed our evolutionary advance is a related complexity in survival needs that include a sense of well-being and mental health; attachment relationships are crucial to the less physical survival needs of humans.

And so, as the adolescent is compelled to a redistribution of libido (through

withdrawing it from the parents, turning it inward, and redirecting it toward peers) the greatest challenges to date of capacities for auto-affect regulation are met. (Allen and Manning, 2007) Once reliant on a dependent asymmetry of co-regulation by the primary caregivers, this process of libidinal transfer requires tremendous abilities for self-regulation until mutually regulatory peer interactions can be established. Failures of early attachments to provide conditions allowing for the structuring of adequate internalized representational models will create significant obstacles here, opening the potential for an emergence of behavioral and psychological pathologies that may not have been present before, or the exacerbation of previously existing conditions.

CHAPTER III:  
METHODOLOGY: A STUDY OF FALCONS

Research Strategy

*Type of Study and Design*

This is an exploratory study using a combined qualitative and quantitative methodology. (Cresswell, 2003; Tashakkori and Teddlie, 1998) The qualitative portion of the study employed narrative analysis of audio recordings of responses to a semi-structured interview conducted with consenting adolescent psychiatric in-patients. The interview used was Holmes' (2001) Brief Attachment Based Interview (BABI). The structural narrative analysis used with the BABI was modeled after that of the AAI (Hesse and Main, 1990). The BABI is used with permission of the author.

Rather than coding written transcripts of the interviews, as is the normal AAI procedure, tape recordings of the interviews were coded, as this was believed to provide a more accurate understanding of narrative quality than written transcripts alone. (Reissman, 1993.) The interview recordings were analyzed using a protocol derived from Main and Hesse's Adult Attachment Interview that emphasizes elements of narrative structure and coherency, conciseness, provision of illustrative detail and examples, but also included vocal qualities (for example, intonation, rapidity, pressure) as classification data, which the AAI does not. This analysis provided a tentative classification of participants' attachment style, the variable of interest in this study.

The quantitative portion of the study involved use of descriptive statistics

(frequency distribution) for the variable of interest (attachment narrative style) and the relative variables of (a) presenting complaints/problems, and (b) DSM diagnosis in order to determine if any identifiable patterns co-relating these exist. (Rubin and Babbie, 2001)

*Scope of Study, Setting, Population and Sampling, Sources and Nature Of Data*

The study is limited to those adolescent inpatients who: (a) gave their consent, and whose parents or legal guardians also gave consent to participate in the interviews; (b) completed the entire interview procedure without withdrawing consent.

The population from which the research sample was drawn was all those admitted to the adolescent unit during the time the research was conducted. Although the population sample is purposive in nature (that is, selection based on the specific research questions under examination), it also has some qualities of convenience sampling in that the study was limited to those youth admitted to the hospital during the time the study was being conducted, and was therefore based on the availability of the sample participants and ease of data collection. (Tashakkori and Teddlie, 1998) The research sample was selected from the general population of adolescent admissions on the basis of random number assignment until the target sample total of 50 interviews was reached, a time period of roughly 8 months. No patients for whom the principal researcher was the primary therapist were selected to minimize the prospects of conflict of interest created by a dual relationship. Participants having a diagnosis of Mental Retardation were excluded from the study, as were those with diagnoses of Autism or Asperger's Disorder, because of the unsuitability of the narrative analytic device for use with this population. Patients exhibiting symptoms or having current or prior diagnosis of any psychotic

disorder were also excluded. As the number of adolescent patients carrying those diagnoses during the time of this study cumulatively totaled less than 3% of the adolescent patient population (Jenkins, 2008), their exclusion did not negatively affect the representative nature of the study sample.

Following selection of the research sample, the variable of interest (attachment style) was obtained by conducting a semi-structured interview, with audio recording of participant responses to interview questions and probes. Relative variables (DSM-IV-TR diagnosis, presenting problems/complaints) were obtained through review of documentation concerning the report of the participants' presenting problems/complaints at the time of admission to the hospital, and review of the hospital treatment team's determination of provisional DSM-IV-TR diagnosis. Fifty-three participants were initially interviewed for the study, but one interviewee subsequently withdrew permission, and two interviews were lost because of technical problems with the recordings; thus, the final research sample totaled 50.

### *Sample Selection*

The study sample was drawn from the general population of teens admitted to a rural Midwestern psychiatric hospital during the course of the study, July 2007 to February 2008. Selection was a three-step process that involved:

1. Random numbers (in a range from 1-5 or 1-10, depending on the number of admissions) were generated weekly by the unit case managers, and the admission corresponding to the assigned random number was reviewed for meeting criteria for inclusion in the study.
2. The treatment team to which the patient was assigned was solicited by the case manager to determine if, in the team's opinion, there were other reasons that contraindicated the patient's involvement in the study. This step was included as an additional safeguard to insure protection of the vulnerable population from which study participants were drawn.
3. The patient's guardian was solicited for consent by the assigned case manager, using a standardized written explanation of the research (see Appendix A[1]), and once guardian consent was given, the primary researcher sought consent from the patient, also using a standardized written consent. (See Appendix A[2])

### *Instrumentation*

A structured clinical interview, the Brief Attachment Based Interview, or BABI (Holmes, 2001) was used to provide the stimulus for narrative construction. (Appendix B[1]) Small modification of the interview text was made to correct for possible misunderstanding of meaning created by some original British English usages (for example "leave" was substituted for "go off," because the latter term as used by the adolescents in the study carries the meaning of having an anger outburst, a confusion of meaning that would potentially influence the participant's response.) This interview was

used with permission of the author, and was chosen because its clinical utility was seen as more appropriate for the clinical population from which the study sample was selected than the AAI.

As can be seen by examination of the interview text (Appendix B[1]), the BABI provides stimulus for narrative construction by posing questions to the interviewee that are designed to activate recall of attachment related experiences, both current and in childhood, or as described by Eric Hesse (1999), the interviewee's "state of mind with respect to his or her own attachment experiences." These states of mind are believed to access intrapsychic attachment processes that Schore (2001) asserts are neurologically stored in the brain's right hemisphere, and comprise Bowlby's "internal working models"—currently more often termed "attachment representations." (Bowlby, 1969/1982; Bretherton and Mulholland, 1999) The states of mind accessed by this methodology are believed to involve both conscious and unconscious material, the latter being most observable in its influence upon narrative structure, including vocal intonation and inflection.

The verbalized narrative constructions (participant answers to interview questions) were recorded using a digital voice recorder (Sony ICD-SX57) then transferred to computer hard drive where a voice editing program (Sony Digital Voice Editor Version 3.0.00, for use with Microsoft Windows XP) was used to play back the recorded interviews for analysis. For the exemplar transcripts presented in the next chapter, additional equipment used was the Sony FS-85USB Digital Voice Recorder Transcribing Kit.

Narrative analysis was conducted using a protocol derived from that of the AAI (George, Kaplan, and Main, 1984; Hesse and Main, 1990) using “Grice’s Maxims” of logical discourse (Grice, 1975) to examine the narrative construct along four dimensions to arrive at a tentative assessment of classification quality using a prepared Narrative Analytic Template (Appendix B[2]) for each recording. Notations were made on each interview template that were used finally in arriving at the overall attachment style assessment.

## Data Management and Analysis

### *Data Management*

Data for the present study consisted of (a) a master list with the names and corresponding code number for each participant; (b) a separate list that contained the code number and initials of the participant, and demographic and variable data (age, gender, race/ethnicity, admitting symptoms, DSM diagnosis, guardian status); the recorded interviews, identified on the recording only by code number and date of the interview; and the Narrative Analytic Template for each interview, including researcher notations made during the analysis. Each data element was stored in a physically separate and secure (locked) place, except when directly under the control of the primary researcher. Following completion of interview analysis, all interviews were downloaded onto a separate portable disk drive, and the hard-drive recordings were erased. The portable drive was secured in yet a fourth, separate, locked place.

### *Data Analysis*

This is an exploratory study using a combined qualitative and quantitative methodology, “mixed” research design. (Cresswell, 2003; Tashakkori and Teddlie, 1998) Because of the mixed design, data analysis was divided into two sections. The first, qualitative, portion involved the analysis of recorded interviews to determine the identified attachment style suggested by each interview. The suggested attachment style became the central variable of interest for the study.

A second, quantitative, research activity involved the statistical analysis of the variable(s) of interest and other relative variables: the two main relative variables of focus for the study, admitting symptoms and DSM diagnostic category, plus other variables of interest including demographics, abuse history, and guardian status.

### *The Narrative Analytic Approach*

The structured interview used, with permission of the author, was Jeremy Holmes’ (2001) Brief Attachment Based Interview (BABI). The narrative analytic strategy used was derived from that of the Adult Attachment Interview (AAI). (Hesse and Main, 1990; George, Kaplan and Main, 1984; Main, 1993) Narrative analysis in this procedure did not focus on the content—that is, what was said—as primary data, referring to content only in examining questions of consistency or contradiction of presentation. Rather, a structural analysis was undertaken, in which the narrative composition was analyzed for elements including brevity, provision of supporting details, conciseness, freedom from contradiction, and reasonableness according to Grice’s Conversational Maxims of quantity, quality, relation, and manner (Grice, 1975) to arrive

at an assessment of overall coherency and linearity of cognitive organization. Different qualities of narrative organization and coherency have been shown to be associated with different qualities of attachment representation, and therefore, correlated with differences in quality of attachment. (Crowell, Fraley, and Shaver, 1999; Hesse, 1999; Gabrino, 1998; Hesse and Main, 1990) [See Appendix D, *Narrative Analytic Template*]

The analysis was then compared to descriptions found variously in the literature (Goldberg, 1995; Hesse, 1999) of narratives assigned to identified attachment styles by the Adult Attachment Interview, to validate assignment of suggested attachment style arrived at through the narrative analysis. Based upon these comparisons, narratives in the study were classified as being suggestive of Secure/Autonomous attachment representations if they were positive for the Gricean elements of Quantity (as informative as necessary; not more informative than necessary), Quality (does not say what is believed to be false; does not say what is lacking adequate supporting evidence), Relation (directly relevant to the question being responded to), and Manner (avoiding obscurity and ambiguity; brevity; orderly and sequenced). Narratives were classified as being suggestive of Avoidant/Dismissive attachment representations if they were found to be negative for Quality (generalizations that lacked evidence, examples that contradicted other data presented in the interview or participant's biographical data) and Quantity (responses were too brief) or Relations (frequent responses of "I don't know" or "I can't remember"; claims of not understanding topics explored that were apparent evasions of introspection and verbal symbolization). Narratives classified as suggestive of Ambivalent/Preoccupied representations were those found to be negative for Manner (vague, ambiguous, convoluted, disorderly, lacking sequential organization), Relevance

(tangential, circumstantial, or irrelevant responses to interview queries), and Quantity (long, rambling, unnecessary provision of detail extraneous to the inquiry). Narratives classified as suggestive of attachment representations that were Unresolved/Disorganized exhibited lapses in reasoning, and/or lapses in monitoring the narrative exchange and discourse, and/or lapses in reality testing, in single or multiple occurrences throughout the interview. Finally, narratives were classified as suggestive of Earned or Acquired Secure/Autonomous attachment representations if the narrative structure met criteria for Secure/Autonomous representation despite the participant having a documented or disclosed history of insecure attachment experiences (for example, abuse, abandonment, multiple placements, parents or caretakers with significant mental health issues). Thus, the Earned/Acquired Secure/Autonomous narrative classification suggests that the participant had “acquired” the ability to reflect on attachment experiences in a manner associated with having had secure early attachment relationships without in fact having had such relationships.

The association of particular narrative qualities relative to Grice’s Maxims with specific states of mind concerning attachment used in the present study is in keeping with descriptions of such narratives provided in the literature, for example, Goldberg (1995).

Rather than coding from written transcripts, as is the usual AAI procedure, audio recordings of the interviews were used as primary data, the assumption being that an analysis inclusive of vocal elements (inflection, pitch, rate, and intonation) provides a more accurate understanding of narrative quality than written transcripts alone.

(Reissman, 1993) In relation to these, a particular area of analysis lay in assessing whether the affect suggested by the vocal elements was congruent with the subject matter

of the narrative. In this way, tone and rate of voice were seen to impact Gricean principles of Quality, Relation, and most especially, Manner.

The interview recordings were analyzed using the above protocol, which emphasized elements of narrative structure and coherency, conciseness, provision of illustrative detail and examples, and vocal intonation. This analysis allowed tentative classification of participants' attachment style, the variable of interest in this study.

It should be noted, although this portion of data collection/analysis is herein described as qualitative, more accurately speaking the narrative analytic protocol being used here was actually a mixed design. Traditionally, qualitative designs are *ideographic* and *emic*, while quantitative designs are *nomothetic* and *etic*. (Denzin, 2001, pp. 40-41) The aim of nomothetic studies is to provide data that can be generalized and classified into abstract categories; etic studies have an external perspective, and assume what is being studied transcends the individual subject(s) of the study. Idiographic studies, by contrast, assume the uniqueness of each study participant and do not see the data as generalizable; emic studies look at the meaning attribution of individual experience through an interactive process. The procedures used in this study to analyze interview narratives, like those of the AAI, combine elements of nomothetic/ideographic and emic/etic research into an integrated methodology that is itself a mixed design.

### *The Statistical Analysis*

The qualitative analysis provided values for the relative variable, attachment style. The attachment style classifications used in this study represent a composite of the classifications used in both Strange Situation infant observation (Secure, Ambivalent, Avoidant, Disorganized) and Adult Attachment Interview narrative analysis (Autonomous, Preoccupied, Dismissive, Unresolved); this strategy was used because study participants—perhaps because of their developmental position standing at the transition from childhood to adulthood—evidenced or described *behaviors* best captured by the childhood classifications, while for others the adult classifications referring to *mental representations or states of mind* were the better fit. (It should be remembered that the SS classifies based on behavioral data, while the AAI classifies based in mental/affective data.) Thus, the attachment style classifications used in the present study were Earned or Acquired Secure/Autonomous (EAS), Ambivalent/Preoccupied (AmbPre), Avoidant/Dismissive (AvDs), and Cannot Classify (CC).

Relative variables, DSM-IV-TR diagnosis and presenting problems/symptoms, were obtained through review of documentation concerning the report of the participants' presenting problems/complaints at the time of admission to the hospital, and review of the hospital treatment team's determination of provisional DSM-IV-TR diagnosis. For the purposes of reducing data values to a manageable number for this study, DSM diagnostic data were compressed into three diagnostic categories inclusive of similar or related psychiatric disorders rather than evaluating particular specific diagnoses. The particular diagnostic categories used in the present study were defined by data present in the study sample (that is, were designed after data collection, not prior to), and follow the

nosology used by the *Diagnostic and Statistical Manual of Mental Disorders, IV-TR*, from which hospital diagnoses were drawn. These categories were Attention/Disruptive/Impulse Disorders (A/D/I); Anxiety/Mood Disorders (Anx/Mood); and Substance Related Disorders.

Attention/Disruptive/Impulse Disorders in the DSM-IV-TR include:

- Attention Deficit/Hyperactivity Disorders (ADHD)
- Conduct Disorder
- Oppositional Defiant Disorder
- Disruptive Behavior Disorder Not Otherwise Specified
- Intermittent Explosive Disorder (IED)
- Kleptomania
- Pyromania
- Pathological Gambling
- Trichotillomania
- Impulse-Control Disorder Not Otherwise Specified.

In this study, the predominant A/D/I diagnoses were ADHD, IED, and Conduct Disorder, and represented 32% of the sample.

Anxiety/Mood Disorders in the DSM-IV-TR include:

- Anxiety Disorders (Panic Disorder, Agoraphobia, Specific Phobia, Social Phobia, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder [PTSD])
- Generalized Anxiety Disorder [GAD]
- Anxiety Disorder Due to General Medical Conditions
- Substance-Induce Anxiety Disorder

- Anxiety Disorder Not Otherwise Specified
- Depressive Disorders (Major Depressive Disorder [MDD], Dysthymic Disorder, Depressive Disorder Not Otherwise Specified)
- Bipolar Disorders
- Cyclothymic Disorder
- Mood Disorder Due to a General Medical Condition
- Substance-Induced Mood Disorder
- Mood Disorder Not Otherwise Specified.

In the present study, the predominant Anxiety/Mood Disorders were MDD, PTSD, and Bipolar Disorder. This category represented 66% of the study sample.

Substance Related Disorders are generally self-explanatory, and involve gradations of severity ranging from abuse to dependence, intoxication to withdrawal. In this study the single case carrying a primary diagnosis in this category exhibited both Cannabis and Alcohol Dependence, and represented only 2% of the total research sample.

Again, to keep data numbers manageable, rather than coding for each specific behavior described for the sample population as an admitting symptom, symptoms were collapsed into three general categories. These categories were dictated by the criteria used at the research site to determine appropriateness for admission to acute-care psychiatric hospitalization; imminent risk of harm to self (S), imminent risk of harm to others (O), or imminent risk of harm to self and others(S/O). The last category (S/O) was created in response to the sample data, in which some participants were found to have been admitted for symptoms that indicated risk of harm to both themselves and others.

Examples of behaviors falling into the S category would include active suicidal ideation/gesture/attempt, self-harm behaviors such as cutting/striking/burning/head-banging, or impulsive behaviors that placed the teen at risk (for example, unpremeditated run away with no ability to acquire food or shelter; compulsive unprotected sex with multiple partners).

Behaviors falling into the O category would include assault or attempted assault of another, threats of a physically aggressive or homicidal nature, active homicidal ideation, sexual assault, or animal cruelty/killing/mutilation.

The mixed S/O category would, then, be comprised of behaviors falling into both the previous categories.

In the study sample, S, O, and S/O symptoms represented 44%, 26%, and 30% respectively. (With regard to the admitting symptom data, it should be noted that one case, representing 2% of the sample, was that of a patient admitted for sexually penetrating an animal, a symptom not clearly defined in any of the categories. This case was included in the O category for the statistical analysis.)

Other relative variables examined were abuse history and guardian-type. These variables were included for analysis because of their presumed importance in influencing attachment style; experiences of parental sensitivity, dependability, reliability, and predictable availability are known to be primary determinants of attachment security, and abuse is known to undermine the quality of parent-child interaction.

Demographic variables (age, gender, race/ethnicity) were included in data collection. These were analyzed for frequency in the research sample, but not for associations with attachment style as there is no theoretical or empirical evidence suggesting an influence on or by the variable of interest.

Statistical operations were performed using the software program SPSS, version 13.0. ; these were simple descriptive statistics involving frequency distributions of the key dependent and relative variables. The only inferential statistics used were cross-tabulation of relationships between the variable of interest and relative variables. Only the association between attachment style and admitting symptoms reached the threshold of statistical significance. Nevertheless, some interesting-if-not-statistically-significant associations were found between the remaining pairs, and these will be discussed below.

## CHAPTER IV

### RESULTS: CAN THE FALCON HEAR THE FALCONER?

#### A Qualitative Description of the Sample I:

##### Who Were These Children?

Letting the kids speak for themselves is the best way to gain a sense of the kind of teen reflected in the study sample. The following are excerpted quotations from the interview recordings, sometimes with brief editorial comments to provide necessary context. Admitting symptoms for each speaker are provided at the beginning of the quote.

- [Admitted for being “out of control,” defiant, self-harm threats.] “I didn’t really get comforted by anybody until I was six: that took a big toll right there.”
- [Admitted for suicidal thoughts and cutting.] “Dad would beat my mom and make me watch.” “I never got taken care of . . .” “My hero was the Little Mermaid . . . because she could control her feelings . . .”
- [Admitted for a suicide attempt by prescription drug overdose.] “If she [mother] was legally able to take a whip and whip me, like the Egyptians, she would have.” “My mom put me in a closet [as a baby] to get me to shut up.”
- [Admitted for severe mood swings and volatile rages.] “It doesn’t bother me that I lost my mom; she was never there for me anyway. My greatest

loss was my brother even though he did those things [sexual abuse] to me.” [When asked for a childhood memory:] “The drunken boyfriends and my mom not caring what happened.” “I’m not really comfortable with anybody . . . I’m actually really comfortable with you [researcher] though—it’s kind of confusing.” “I try to hide my feelings a lot. I try to act like it doesn’t bother me.”

- [Admitted for physically fighting with foster father; burning self with lighter and cigarettes; cutting; choking foster mother and younger brother.] “I didn’t really have anyone to turn to when I was being raised. I was in the foster care system.” [In regard to being abandoned by mother because of her drug addiction:] “I was confused why drugs over me—and I was five years old and thinking that stuff . . .” [When asked for a childhood memory:] “Going from foster home to foster home, never knowing if they were gonna abuse you like the last one did.” “My feelings sway back and forth: one minute I’ll be happy, something will remind me of my past and I’ll have to do something to get back in control.”
- [Admitted for cutting, suicidal thoughts with past history of attempts, bulimia.] “She [mother] was never there. She was always out doing drugs. She’d leave us with people.” “My dad, he’s been a druggie most of my life. He gave me up . . . he was more like a dad when he was getting high.” “I don’t let people get close to me because I’m scared they’re gonna go away or something.”

- [Admitted for aggression and assault, severe mood swings.] “My dad had to go to jail for sexual abuse of my two sisters.” “I fight it a lot [sadness], I try to bottle it up, but I explode.”
- [Admitted for cutting, anorexia, mood swings.] “I used to turn toward my mother; I used to be able to tell her anything.” “There were moments my mom made me feel worthless . . . the things she said made me anorexic and I almost died.” “It gives my mom satisfaction to see me hurt.” “I constantly feel like I’m being criticized by other people.” “I try to keep my space, not to get attached.” [About methods for coping with feelings of loss:] “Cutting, drugs, writing, spacing off into my own world.”
- [Admitted from state residential placement for trying to stab a staff with a homemade “shank.”] “It’s hard to trust. It’s hard to attach to people . . . you never know what’s going to happen.”
- [Admitted for carving on self with a knife.] “My dad tried committing suicide and he was unsuccessful. I hate him for that.” “He beat me with a hanger and a belt.” “I love him but I hate him.” “It [abuse] doesn’t really affect me because I don’t think about it.” “I think it [abuse] affects me a lot; I have PTSD.”
- [Admitted for threatening to kill father and then self after being held down and beaten by parents and siblings.] “I didn’t cry, I didn’t give in, I didn’t give them what they wanted.” [*Them* and *what they wanted* were never specified in the interview.] “I stay away from everybody.” “I don’t get angry . . . I just get unhappy.” “I go inside myself.”

- [Admitted for threats to harm foster mother, foster siblings, self; self-destructive sexual acting out.] “I usually had nobody to turn to.”  
“Sometimes I would feel like I should never have come on earth . . . like I was worthless and invisible.” “When I first went into foster care, I’d never had a Christmas before. I was seven or eight. It was . . . that’s when I had my first Christmas.”
- [Admitted for assaulting younger brothers, pulling a knife on parents.] “I usually just rely on myself to comfort myself.” [When asked for ways of comforting self:] “If I have access to a computer, I turn on the computer. If I have access to video games, I use video games. If I have access to a car, I go ridin’ around.” “I usually don’t get upset.”
- [Admitted for cutting and thoughts of suicide.] “I thought that God was just mad at me.”

## A Qualitative Description of the Sample II:

### What Were Their Narratives?

In an effort to provide a deeper sense of the study’s participants, and to assist the reader in understanding the differences in narrative constructs analyzed in the study, transcribed excerpts representing each of the four analyzed classifications are provided below. The selected transcript excerpts stand as exemplars for the kind of narrative organization associated with each attachment style classification. The same portions of each interview, involving the same set questions and individualized set question probes, will be presented for each excerpt. A discussion highlighting the differential narrative

constructs associated with each attachment classification follows the excerpt presentation.

There are over 50 questions in the complete BABI interview; for the transcript excerpts below, questions 4 through 14, with associated set and individualized probes, are included. It was found over the course of repeated interviews that the preceding BABI questions functioned as “warm up” or “ice breaker” questions for most of the participants; in general across all participants interviewed, “state of mind concerning attachment” was being actively accessed beginning with the first question used in these excerpts. This is believed to be because that question, and the one immediately following, provides direct stimulation of both conscious and unconscious representations of early attachment figures. It was usually beginning with these questions that identifiable structural patterns in narrative organization became observable.

In the excerpts, “I” stands for the interviewer and “P” for the study participant.

*Earned-Acquired Secure/Autonomous Transcript Excerpt*

- I: Now I’m going to ask you to please give me five words to describe your relationship with your mother as a child, and then I’m going to ask you to give me examples from your life that explain why you chose those words. So, please, five words to describe your relationship with your mother.
- P: Bad. Not loving. No relationship at all, I’d have to say.
- I: Can you give me examples that explain that?
- P: Like just an example, period? Because, um, she was never there; she was always gone doing drugs, and she’d always leave our family with different guys. So . . . I didn’t really see her as the mother, I saw her as, like, the enemy . . . [voice tone softens] yeah, that’s why I don’t really care much for my mother.
- I: [After allowing a period of silence to see if participant was finished.] Are you finished? Okay. Now I’m going to ask you to please give my five words to describe your relationship with your father as a child.

- P: Okay. Not really loving. Um, sort of friendship. And that's it.
- I: Okay. Can you give me examples that explain those words?
- P: Um . . . I would have to say because my dad, he's been a druggie most of my life. And he gave me up, so I don't really see him as the fathery type either. So, yeah, [voice softens again, this time almost to a whisper] that's why.
- I: How old were you when he gave you up?
- P: I was like 10 or nine or something like that.
- I: Do you have any contact with him now?
- P: I'm allowed to, but I don't wanna talk to him.
- I: And what about your mom?
- P: I don't know where she is.
- I: So who do you live with?
- P: I live with my foster parents.
- I: Okay. Thank you.  
Um, what was your most frightening situation or moment as a child?
- P: Um . . . when my mom and dad would fight and they would drag me in the middle of it. And my dad busted my lip.
- I: I was going to ask, like, physically fight? So . . . yeah.  
Were you physically or sexually abused as a child?
- P: I was physically, but never sexually.
- I: Who abused you physically?
- P: My mom and dad.
- I: As a child, how did you get comfort when you were frightened?
- P: I'd always go to my sisters.
- I: Older sisters?
- P: Um-hm.

- I: Okay, thank you.  
Now, how do you think the abuse affects your relationships?
- P: Bad.
- I: How do you think it affects your feelings?
- P: Bad.
- I: How do you think your life would be different if the abuse hadn't happened?
- P: I think it would be very different. I think I'd be more loving . . . and more, let people into my life instead of pushing them away.
- I: When you said "bad" for your feelings and your relationships, can you say a little more about that?
- P: Bad because, um, I don't let people get close to me because my family, like my mom and dad, never really cared about me and I thought I was nothing. So . . . I always think I don't let people get close to me because I'm scared they're going to go away or something like that. So that's why.
- I: Thank you. Now, what do you do when you're sick, depressed, worried, or tired?
- P: I keep to myself.
- I: Who do you turn to when you're upset or troubled?
- P: Like now? I turn . . . to, just my friends or my sisters or my foster mom.
- I: Thank you. Now, what's your greatest fear?
- P: [A pause while participant considers.] Going back to my old ways.
- I: What would that mean?
- P: Going back to cutting . . . drugs . . . and . . . just losing my foster home for doing stupid things.
- I: Who do you feel most relaxed and comfortable with now?
- P: My foster family, my mom.
- I: Do you ever feel cut off and detached from people?

- P: Sometimes.
- I: Do you ever feel so frightened of people that you avoid them?
- P: Not really.
- I: Do you ever fear those you are close to will leave you?
- P: Um-hm.
- I: Does this ever cause you to be clingy even though they might find it irritating?
- P: No. I still keep my distance.
- I: So your way of dealing with that fear is to keep your distance?
- P: Um-hm.

*Avoidant/Dismissive Transcript Excerpt*

- I: Now I'm going to ask you to give me five words that describe your relationship with your mother, and then I'm going to ask you to give me examples to explain why you chose each word.
- P: Like, back then?
- I: Um-hm.
- P: Oh . . . uh, I'm not sure. I don't understand. [This is not an issue of intellectual ability; psychological testing conducted at the hospital, including an IQ screening, found this participant to be in the high average range of intelligence.]
- I: Okay. Just five words that describe how you think your relationship was with your mom when you were a child.
- P: [Silence, notes from the interview state participant "appeared lost" when asked to reflect in this way.]
- I: Some people say that this question and the next one, which is the same thing, five words about your dad, um, some people say that those are the toughest questions on the interview. So just do your best; it's not a test. Um, if you can give me the five words that's great, if you can't give me five words that's fine. No pressure about this. Just kind of think about it and tell me the words that come to mind about your relationship with your mom when you were a child.

- P: Um, I can't think of any specific words.
- I: Okay. Well, could you describe the relationship?
- P: Like when we were little? Just with my mom?
- I: Uh-huh. Um-hm.
- P: [Extended silence, approximately 15-20 seconds.] I don't know. I guess, like whenever we got in trouble we'd go to my mom because my dad was always the one that punished us. [Silence as interviewer waits to see if participant is finished.]
- I: Are you done? Okay. Do you think you could give me five words to describe your relationship with your dad?
- P: [Five seconds of silence.] Like, back then?
- I: Um-hm.
- P: Not really, 'cause him and my mom got divorced when I was four . . . and so, we didn't get to see him except, like, on weekends. [Silence.]
- I: Okay. Thank you. You did fine. Like I said, some people think those are the toughest two questions.  
Okay. Again, still as a child, what was your most frightening situation or moment?
- P: Um . . . well, when I was, I think I was six . . . this lady hired two teenagers to break in our house and try to kill my mom. [Voice tonality is unchanged from before, generally uninflected and uncommunicative of emotion.]
- I: Wow. Tell me about that, that's pretty bizarre.
- P: Um, well I woke up in the middle of the night 'cause I heard my dog was barking really loud and I heard my mom yellin'. And I heard a guy yellin', so I thought she was just havin' a fight with my step-dad, so I just laid there for a little bit until she was like just sitting there crying, and so I guess I just got up and went out and she was sittin' there, and she had blood all over her and she didn't have her glasses, she had food all over her and there was food on the floor and then part of our wall or somethin' was like laying on the floor next to her.
- I: What had happened?
- P: She said they injected her with anti-freeze, to try and kill—because she was pregnant with my little brother? To try and kill him and her, and they beat her up

and threw all the stuff in the kitchen at her. So I guess that's why they threw the food. [Voice remains passive and uninflected, totally incongruent with the strangeness of the story being told.]

I: Why did the woman want to hurt her?

P: 'Cause, um, I think it was like my step-dad's ex-wife or something. And I guess she wasn't happy with her.

I: Wow.

P: 'Cause he started to live with us at that time.

I: Wow.

P: 'Cause he was mad, she was mad they had a kid together. [Silence.]

I: Well, thanks.  
Were you physically or sexually abused as a child?

P: [Shakes head but gives no verbal reply.]

I: Okay. These next questions are about now. What do you do when you are depressed, sick, worried or tired now?

P: Usually just sleep.

I: Who do you turn to when you are upset or troubled?

P: Either my friend or my hamster.

I: Okay. What's your greatest fear?

P: I don't know. I guess, like, losing people I love.

I: Who do you feel most relaxed and comfortable with?

P: My friend or my animals, something like that.

I: [Seeing a possible opportunity to get participant to elaborate state of mind around a current relationship.] Is it a particular friend?

P: Hm?

I: Is it a particular friend?

- P: [Nods, but does not respond verbally.]
- I: [After allowing a period of silence to encourage participant verbalization.] Okay. Do you ever feel cut-off and detached from people?
- P: Sometimes.
- I: Particular people or just people in general?
- P: Just, like, large groups of people.
- I: Okay. Do you ever feel so frightened of people that you avoid them?
- P: [Shakes head.]
- I: Can you answer with words?
- P: No.
- I: Thank you. Do you ever fear that those you are close to will leave you?
- P: Sometimes.
- I: Does this ever cause you to cling to them even though they might find it irritating?
- P: Probably. I haven't notice it.

*Ambivalent/Preoccupied Transcript Excerpt*

[Researcher's notes for the following interview: "Soft spoken. Articulate; reflective; intelligent. Good self-assessment of current impact of abuse. Lots of detail and elaboration: answers became stories. Pauses before answering most questions . . . thoughtful? . . . on guard? . . . processing affect? I begin to feel the need to reassure by the fourth question."]

- I: I'm going to ask you to please give me five words that describe your relationship with your mother. And then I will ask you to give me an example that explains why you chose each word. So, five words that describe your relationship with your mother when you were a child.
- P: Uhmmm . . . it was simple. And . . . it was happy. And . . . relaxed. It was comfortable, and meaningful.

- I: Okay. If you could give me examples that explain why you chose each word?
- P: Uhm, “simple” because . . . [five seconds of silence here] when we got into arguments they were over, you know, me not being able to go to a friend’s house maybe. Or me not cleaning my room. Normal . . . normal, quote unquote “child things”, you know, child problems, uhm . . . I said, what else did I say? [Silence, apparently waiting to be reminded by the interviewer, but that does not happen.] Uhm . . . I said . . . “relaxed”, uhm . . . we really didn’t fight very much, it was a calm environment most of the time, uhhh . . . “comfortable”: I was really comfortable telling my mom anything pretty much. She was always there if I needed help. Uhm . . . [whispers to interviewer, like an invitation to enter a conspiracy to not be heard by the recorder] what else? did I say? go on, go on . . . [encouraging interviewer to whisper prompts; interviewer shakes his head] [Resuming regular volume] Uhm, “relaxed” . . . “Meaningful”: uh, she . . . I don’t know, I felt like there was a strong bond between me and my mom, and I used to be, I was, I used to be a good . . . girl. I used to be really good, and I used to get along with the kids, my brothers and sisters, uhm, my mom was proud of me. [Silence.] “Happy”: uhm . . . I think I had a happy childhood, really. My mom was a big part of that, because, she was always at all my soccer games, you know, she always . . . helped me . . . through problems at school . . . and through my relationships with my friends, and . . . uhm, always involved in all the sports that I played, especially soccer . . . you know, she supported the goals I wanted . . . and . . . it was really, it was happy.
- I: Done?
- P: Um-hm.
- I: Okay. Thank you. Now I’m going to ask you to please give me five words to describe your relationships with your father.
- P: As a child?
- I: Um-hm.
- P: [10 seconds of silence] Hmm . . . [12 seconds of silence] Disappointing, at times. Uhm . . . [30 seconds of silence] This is really hard, but [sounding on verge of crying] my father, he wasn’t really around very much, so . . . when he was around [voice strong, no longer hinting tears] I was so excited! To see him, so, I guess “excited.” Uhm . . . [approximately 20 seconds more of silence]
- I: You’re doing fine.
- P: Okay. Uhm . . . [12 seconds of silence] Incomplete . . . Humorous . . . [30 seconds of silence] I don’t know if I know a word for this, but, sometimes I felt . . . uneasy . . . around him.

- I: Can you give me examples that explain those words?
- P: Uhm, “disappointing” because, there was a lot of times in my life where, I wish that he could have been there. But he traveled a lot for his work . . . and he was out of town, and when he would come home from work, he’d get up really early in the morning to go to work and then when he’d come home from work he’d be grumpy and tired and, he’d always go and lay in his bed, and he got migraines a lot, and . . . I guess I just wish there was something more, there. [The drama and changing inflection of the participant’s voice makes this narrative seem like a spoken performance more than an interview conversation.]  
I kind of explained “exciting”. Because he wasn’t around a lot, when he did come around—I have five sisters and three brothers, we would all like, swarm to him, you know, and, fight over who sits next to him on the couch, and . . . It was exciting when he *was* around. Uhm . . . he was, he was really funny, he always knew how to make me laugh, so that’s why I said “humorous.” He . . . he had a good sense of humor. Uhm . . . “uneasy” because . . . when he got angry, you know, it . . . it wasn’t good. Like, he really didn’t . . . we got spankin’s as child, but, I mean there were times when I saw him take the spankings a little too far with my older sis-sister, uhm, my oldest sister, and . . . I don’t know, he gets an angry face and . . . it makes me . . . uneasy . . . uhm . . . “disappointing,” “humorous,” “exciting,” “uneasy” . . . did I say “incomplete”? Yeah, uhm . . . because, “incomplete” because he, I wish there was more, you know, I wish I had more of my father when I was younger . . . I don’t, always, there’s not . . . I mean, there’s lots of happy memories, but not enough.
- I: Thank you. You did very well. Uhm, if people comment on difficult questions, they usually say that those two are two of the toughest. Not everybody thinks that, so I don’t know how you’re going to be, but—
- P: Yeah, that was tough.
- I: You did very well.
- P: Thanks.
- I: Now, still as a child, what was your most frightening situation or moment?
- P: Eww, uh, my dad was doing a lot of work in Seattle, Washington, and . . . mmmmy family went there, uhm . . . Justine was the youngest, she’s ten now . . . there’s two other ones now born, Justine’s the youngest and we were going up to Mt. St. Helen, mmmmy mom and all the kids were in this van that we rented, and . . . my dad was working, uhm, as usual, uh . . . we . . . got . . . we were just getting off the highway . . . and we got T-boned, and . . . our car flipped over . . . uhm, and, I was just falling asleep, we’d just went to McDonalds, and I was just closing my eyes, and then we got hit! And, I don’t, I, it’s really . . . I don’t remember the

car flipping over . . . uhm, but I knew we got in a car accident, and . . . they had to drag everyone out of the car, you know, ‘cause it was upside down . . . and, I remember complaining about my arm hurting, and saying, “I think my arm’s broken! I think my arm’s broken!” and my mom was saying “Where’s Paul? Where’s Paul?” And my little brother, Paul, had gotten thrown out of the van, and he was just walking around, out in the road, and he could have gotten hit by a car, but . . . thank God he . . . he survived and . . . I had a broken collarbone, my brother, John, he slammed his head into the window and had to get stitches . . . and Paul had to get a bunch of stitches and staples in his head and . . . the side of his, uhm, of his abdomen was . . . all scratched up because of sliding on the concrete . . . but he looks the same, and he healed, and I like, those were the three major injuries, everyone else had, uh, you know, whiplash and it was scary ‘cause my dad wasn’t there, and . . . it was just a really . . . traumatic event.

I: Thank you. You were how old?

P: I was in . . . third grade. I don’t know . . .

I: Young.

P: Yeah.

I: Were you physically or sexually abused?

P: Uhm . . . as a child, yes. Uhm . . . when I was . . . eight, uhm . . . the family down the street, they were really close to us, and my mom was best friends with his mother . . . and . . . you know it’s really, it’s really kind of, like, foggy, what

happened, um . . . I don’t know, I walked down the street, and he was the only one home . . . and I don’t even know why I walked down the street, and I went over there . . . but, I remember, being up in his top bunk and he was, like [voice cracks, falters] touching me . . . and, uhm . . . I . . . I didn’t think anything, I didn’t think I was doing anything wrong, you know . . . but I did, I had this sense that, like, this isn’t right, and . . . I don’t know what stopped it . . . I don’t remember exactly . . . but I remember, just running up the street, like, my heart racing so fast . . . and being like, and like, shaking, and being *so scared* like, where’s my mom gonna think I was? Like, what am I gonna tell her? ‘Cause I knew something, that, that wasn’t right, but not really . . . you know, not enough to tell her, and . . . when she asked me where I was, I lied . . .

I: How old was he?

P: He was . . . in high school, I’m not sure exactly how old he was, but . . . yeah.

I: I’m sorry that that happened. Thank you. How did you get comfort when you were frightened?

- P: [30 seconds of silence] I used to . . . go in my room and, get underneath all my covers, and I always made sure my feet were under the covers because, I don't know, I still to this day . . . I can't have my feet uncovered at night . . . and I just remember like, just balling up and making sure I'm like all the way under the covers except my face because I don't like to breathe in the warm air . . . And I still do that.
- I: Thank you. Now, as a teenager, how do you think the abuse affects your relationships?
- P: Uhm . . . I was also abused when I was sixteen, and that was . . . from a totally different guy, uhm . . . I was drunk, and . . . he forced me to do things to him . . . and it was my sister's boyfriend, and still is my sister's boyfriend, and . . . he denies it, and she believes him . . . she doesn't know all what happened, she only thinks that we kissed . . . and I'm scared to tell her, 'cause I don't want to hurt her, you know, like that will hurt her so much, and . . . I don't think she'll believe me, and then, she'll hate. So, I still haven't told her, but he only told her that we, that I kissed him by the sewer or whatever, but . . . uhm, I think it affects my relationships because, I'm always second-guessing if this person cares about me or if they, or how they feel, and I really, it's really difficult for me . . . to trust people, to truly trust them, you know? And I always put up this mask, when meeting new people, and, it's hard to take it down, because I don't know . . . if they . . . are gonna accept me . . . for who I really am.
- I: How do you think the abuse affects your feelings?
- P: [Silence] I don't know, it's made me really numb, to a lot of things, you know, uhm, I hold in *a lot*, and the abuse has made me very angry, towards myself. Uhm [clears throat] It's made me feel . . . really, low, about myself . . . I have extremely low self esteem. A week after . . . this 16 year old abuse, you know, when it happened when I was 16 . . . I started purging . . . and my eating disorder has been present to this day, a year and five months . . .
- I: So you see those two things as connected?
- P: Yeah, I guess so, I think, I think they are, but part of my eating disorder still wants to believe that, you know, it's about weight and it's about food and, you know . . . but that's just . . . a way of, you know, taking the focus off what really happened and taking the focus off how I really feel, and my true feelings.
- I: It's a way of, of feeling in control?
- P: Yeah, I . . . I agree. Uhm . . . my eating disorder is . . . tricky because, I'll go through stages where I . . . want to restrict, and I wanna be anorexic, and, I hardly want to eat . . . and the, it'll switch, and, then I'll start bingeing and eating *a lot* and

I'll feel *really* bad and *really* guilty about eating a lot, then I'll throw up . . . and I go through that cycle and I, you know, throughout that entire time I'm like, [in a manic-sounding rapidity and pressure of speech] "I *really* don't want to be bulimic I *hate* being bulimic I'm never gonna lose weight being bulimic, [a breath, slowing down] I need to go anorexic. And [dramatically snapping her fingers] then I'll switch back. [Silence] Like I feel, I, I don't have control over my thoughts, and my feelings a lot.

I: How would your life be different if the abuse hadn't happened?

P: [Pause] Uhm . . . I think . . . I wouldn't have . . . I wouldn't have been involved with a lot of the guys I did, I were involved in—I, you know . . . I think this is *weird* how I look to, towards, men . . . as . . . like their acceptance of me means *everything*. And like, if, sexually, if, you know—that's what most teenagers, teenage males want, you know . . . if they give me the attention I want, because I seek out *a lot* of attention, and if they give me the attention I want . . . then . . . it makes me feel a little better about myself, you know, they tell me I'm beautiful, they tell me I'm smart, and all good things about myself, and, you know, I fall into their lies [change in voice tone, becoming higher, more wistful] *but I know they're lies* . . . but I . . . I still . . . try and think they're, they're true . . . and . . . I've had . . . multiple sex partners, even after being sexually abused, and that's why I think it's weird . . . you know, but, you know, a therapist has told me once that, when someone is abused sexually they either, like, refrain from any sexual things or they become like really sexually active. And I think that, I've become really sexually active and . . . I feel . . . it just makes me feel worse, in the end, like after the deed is done and over with . . . and they're done and over with with me . . . it just makes me feel worse about myself.

I Thank you for sharing that.

P: [softly] um-hm

I: Is it, is it difficult for you to be in here with me?

P: No.

I: Okay.  
Now, what do you do when you're sick, depressed, worried, or tired?

P: Uhm . . . [10 seconds silence] When I'm worried, I . . . my stress obviously gets a lot more and . . . my nails, I bite my nails *crazy*, they're so small . . . uhm . . . when I'm, I usually . . . I try and isolate myself, you know, but . . . I call myself an attention whore . . . but, you know, I can't just keep to myself all the time, I have to . . . you know, I try and get . . . attention, and . . . like, when I'm depressed sometimes . . . I'll cut myself . . . and you know, it's *never* kept secret, someone *always* finds out, and if it's from me telling someone, or me, you know, showing

- them . . . you know . . . and [voice tone softens, becoming vulnerable, almost seductive] I reach out I guess . . . [change of tone, stronger] and then I do, and I wish I didn't, I wish I wasn't that . . . kind of person where, I could just keep a secret . . . you know . . . I don't know why I'm [drifting into the soft vulnerability again], I'm like that . . .
- I: Who do you turn to when you're upset or troubled?
- P: [18 seconds silence] I'm usually involved in [voice tone is jaded, sounding like someone more than twice her age, which is 17] relationships, frequently . . . uhm, I turn to, my-boyfriend-now, uhm . . . and I used to have, a best friend, uhm . . . he . . . was a senior when I was a freshman in high school and, uh, so he's four years older than me, and I always turned to him. He was, like, he helped me out through so much stuff, but . . . you know, I moved and, we kept in contact and . . . you know, I think he got sick and tired of me calling, you know the majority of the time I called him it was just to complain . . . you know, and . . . my . . . he started talking to another one of my friends . . . but, it's usually friends, or my boyfriends-at-the-time.
- I: What's your greatest fear?
- P: [27 seconds silence] I think that I have a few, but they're all tied together I believe, uhm . . . getting fat, being ugly, not being accepted . . . uh . . . *being alone* [voice rate and tone drop dramatically on this statement, and for the following], *having no-one there . . . yeah . . .*
- I: And you think they're all tied together?
- P: Yeah, 'cause . . . if I'm fat or ugly . . . I think that . . . no one's gonna love me . . . and no one's gonna accept me . . . and I *really* want to be accepted, like . . . 'cause I don't have, I don't accept *myself*, you know I . . . I don't feel good about myself and I look . . . to other people to make me feel good about myself . . . uhm, and if no one will accept me . . . then I'll be alone.
- I: Who do you feel most relaxed and comfortable with?
- P: [10 seconds silence] My sister. My 15 year old sister, Marie.
- I: Do you ever feel cut off and detached from people?
- P: [10 seconds silence] Yeah, uhm . . . a feel like . . . people really . . . don't understand . . . me, they . . . that, you know, I'm *trying* to explain myself to people . . . and it's, they're hearing something different, like . . . or, and sometimes, I'm, I say things to people . . . you know, that I think they took it in a bad way, just like, "This girl just weirds me out", like you know it can just *break* a relationship . . . like, *anything* that you can say to someone . . . can just, end it

all, there, like *that*. Sometimes I just feel like, I'm alone . . . in a lot of the things that I think and do.

I: Do you ever feel so frightened of people that you avoid them?

P: [10 seconds silence] Yeah, uh . . . the, um, my sister's boyfriend? He comes around a lot, you know, 'cause they're still together? And when he's around, uhm, I'll go into a different room or, you know, when I lived with my dad and my stepmom . . . like . . . his, Sheila is *not* a pleasant person . . . and, I, me and my sister would just be up in our rooms, away from my dad, and away from my stepmom . . . 'cause, they can be really pissy, and it's like walking on egg shells . . .

I: Do you ever fear that those you're close to will leave you?

P: [15 seconds silence] Yeah . . . uhm . . . mm, I . . . I feel like, when they do leave me, [again, another dramatic change in voice tone and inflection, becoming vulnerable and seductive] *because people have left me before*. . . [resuming normal tones] it's all my fault, like, you know, it's my . . . I . . . d-did it, you know, I gave them a reason to leave me it's because, I'm . . . boring or . . . you know, or I don't have enough personality, or . . . I'm *dull* and . . . and . . . not pretty enough for that guy or . . . of I make too many mistakes, and I disappoint my family too much, and they're just *sick and tired* of going through the same . . . *shit*, the same problems . . . the same thing, cutting myself since the eighth grade, like, I'm *back in here* . . . for cutting, ultimately . . . and they're just like, so tired, when is it ever gonna stop, when am I *ever* gonna learn . . . ?

I: Does the fear of people leaving you ever cause you to cling to them even though they might find it annoying?

P: Yeeaahh, uhm . . . uh, oh, I kind . . . I don't know, like with me and my boyfriend-right-now, uh, you know . . . I . . . did something . . . to make him really upset in the relationship, and . . . you know, I, before he found out about it I, uh, I, you know, would try and spend more time with him, and . . . you know, make him happier and, you know, because I was guilty . . . and, you know, I, with , like . . . I tried to impress them and be different or *more* than I was . . . and . . . I would, sometimes, call . . . people . . . you know, call them a little bit too much.

*Disorganized/Unresolved Transcript Excerpt*

[Researcher's note: I am clearly pulled out of the researcher role by my counter transference.]

- I: Please give me five words that describe your relationship as a child with your mother. And then I'm going to ask you to give me examples that explain why you chose each word.
- P: This is about childhood?
- I: Uh-huh. As a child, five words that describe your relationship with your mother.
- P: I really don't remember, we really . . . the bad times . . . I don't know how to explain it.
- I: Just the best way you can. I just want to hear your thoughts and attitudes about this.
- P: As a child, it was sometimes good. Like she was my idol, I mean I looked up to her for everything.
- I: Yeah?
- P: I don't, I don't remember, I've blocked all of that out.
- I: How come you blocked all that out?
- P: Uhm, when I was nine my, uh, [clears throat] her husband . . . uh, molested me, and she told me that . . . I was a liar 'cause little girls like to make up stories . . . so from then on it was just . . . me.
- I: Um. So she didn't believe you when you tried to tell her.
- P: [Clears throat again] I know, I know she did, but . . .uhm . . .
- I: She wouldn't admit it?
- P: She was very in denial I thi-- It, it happened to her, too. And I feel like this is the same way that her mother . . . took care of it or thought . . . lets just shove it in a corner, but you can't do that, I think havin' a pink elephant, large elephant in the room . . .
- I: Right . . .

P: [Clears throat again] Everybody walks around it, and tries to avoid it, but you still have this huge elephant in your room.

I: Yeah.

P: So I don't really remember most of my childhood. They think that my grandpa also . . . sexually abuse me.

I: You said you think that, or they think that?

P: They think—my, my, uh, mom's sister. My aunt.

I: But you don't know?

P: I don't remember—I know I used to have bruises on my legs and stuff, and like my inner thighs . . . I remember that.

I: So, is it uncomfortable for you to be in here with me?

P: No. I—I—I've dealt with this since—I've dealt with it for a long time, I can handle it.

I: Okay. Well, thank you.

P: I mean, yeah, I—I've thought about it, okay? Like that door's probably locked—

I: Actually, you can open—it's locked from the outside, nobody can walk in, but you can open it from here.

P: Like the whole time I've been here like I've thought like, on my gosh, like, this whole place is locked up and if somebody, if some guy, a perp or something, it like freak's me out . . .

[Silence.]

I: Well, I, I, I uh, give you my promise that you're safe with me. And the door is locked from the outside but if you turned the handle it would pop right open. Okay? Want to try it?

[Notice here that the researcher's verbal representations have begun to disorganize in concordant counter-transference with the participant; notice also that in this interaction the emphasis has shifted from primarily researcher-data-collection to more therapist-coregulation-and-safe-base-maintenance.]

P: No that's okay.

- I: Okay. Um, thank you. Can you give me five words to describe your relationship with your father?
- P: I, I'm not sure I, well I didn't get to talk to him . . . I, the first time I ever seen him was when I was two, my mom's mother, uhm, wouldn't let . . . him see me. He didn't get to see me like when I was born, 'cause they were never married. But my mom just always spoke about my dad in a negative way, so I always thought he was like this evil person, and then, I got to know him . . . then when I was 14 I moved in with him, and so, I don't know, I know that probably doesn't help you much, but I don't, I'm not sure, I don't . . . remember him, when I was younger.
- I: No, that helps a lot. Um, thank you.  
What was your most frightening situation or moment as a child?
- P: Uh, it would definitely have to be . . .when I was 9.
- I: When you were abused?
- P: Yeah. I didn't know what to do, I didn't know if what he was doing was *okay* . . . I didn't know, at all, and then when my mother didn't believe me . . . that just hurt. I didn't know what to do. I figured if my mother didn't believe me . . .nobody would, so I'm just kind of, just by myself. I tried pushing friends away, I tried to be like really annoying so people wouldn't like me, I felt like if I got close to somebody I'd end up telling them what happened . . . and my mom would be really mad, like I told my grandma and I got in *so* much trouble, for telling my grandma, and, then, my grandma passed away . . . and I just felt like nobody was . . . there, so I just kept it to myself.
- I: How long did it go on?
- P: I don't, the only time *I* remember it was when I was nine, but there were times after that when he'd put his finger in my mouth, and I'd put my finger in his mouth, or just do inappropriate things, or make comments like, like I'd spit or something like when I had, like when I was sick, and he'd be like, "I thought you didn't spit, I thought you swallowed." Or, just, just disgusting things and, my sister—I finally told when I was 14 'cause my sister was right around the age, and I'd always, I wouldn't ever let him . . . be alone with her. I'd always, if they'd left I'd always go with them, uh, at night I had her sleep with *me* . . . I don't know what I thought I'd do, but, I just felt like, I was . . .
- I: Well you were trying to protect her. [Researcher has begun to "interpret up" as in work with patients who are psychotically fragmented, an apparent intuitive response to participant's level of affective dysregulation and increasing psychic disorganization.]
- P: I know but still I don't know, I mean what was I supposed to do, say "no", like I

don't—I, I don't know, I just figured that, if he knew I told my mom, I wasn't scared to tell other people, I just thought that's . . . even though I *was* that doesn't mean he knew that.

I: How did you get comfort? [Getting back on track with the structure of the interview questions, resuming data collection.]

P: What do you mean?

I: With all those feelings, how did you get comfort?

P: Uhm, I started writin' a lot of poetry. That was like—with *people* I didn't, I didn't, anybody, but like with myself . . . I'd just, I'd write things down and I—I had a goal in my head, I was gonna get straight As—I *had* straight As, until, uhm, the middle of my freshman year, that's when I got—when I was able to move in with my dad. I had straight As 'cause my goal was, just to, straight As, go full ride scholarship and get out of there my senior year.

I: So is she still with him?

P: Yes, and they're trying to put me back in the home. 'Cause he wasn't, that happened when I was 9, I didn't tell until I was 14, there wasn't like any *proof* . . . like, my mom knows, 'cause I thought I started my period when I was 9 . . . but it turns out, you know, I was just, hurt. Uhm, I go there on the weekends but I can only be around him, like, supervised—like it has to be a supervised visit like with my mom, my mom has to be there, an adult has to be in the room. But, I don't wanna go back there, I, I blame my mom for all of this. 'Cause, even with my *dad*---like this summer my dad actually like . . . raped me . . . and he was, like, my world.

I: Your dad raped you?

P: This summer.

I: This last summer?

P: This one, June.

I: [Softly] Wow. [Silence.] I'm so sorry.

P: Yeah, me too . . . [24 seconds silence]

I: Sounds like you've been pretty alone. [Researcher moving back into interpretation vs. data collection.]

P: Um, I have friends, [laughs]. I have a lot of friends.

- I: Yeah, but you couldn't talk to them about a lot of the big stuff . . . 'cause you had to keep it secret.
- P: Well, I mean, I have people, I feel, the way I feel about friends and stuff is, if you're more open for them they're more acceptable of like telling *you* their secrets, if you're . . . like if you're, I mean, people are so scared to like, open up 'cause they don't know how you will take it or how you will handle it . . . but I'm the type of person, I'm used to hearing anything, like I'm, that's just who I am, I have so many people that are my friends because they feel . . . they can be themselves around me, there, there's no changing anything, 'cause that's just who I am, I accept people.
- I: [Silence.] How do you think the abuse affects your relationships now?  
[Researcher resumes data collection.]
- P: Um, I feel like I'm following in the same, um, abusive cycle—the actual abusive cycle as my mother, that my mom, was in, very abusive relationship with my father . . . and, if it's not physically, ur, physical abuse, um, definitely emotion.
- I: So you hook up with guys that mistreat you?
- P: [Very softly] Yeah.
- I: How do you think the abuse affects your feelings?
- P: I think I'm very cold hearted. Like I don't *care* if I run over, people. I mean, I do—like, I don't think it's really with girls or anything I think it's more with *guys* . . . 'cause I feel like I've *been* ran over by guys. Like, um, the boyfriend that I'd been with for like two years . . . unh, he did some pretty bad things . . . but like I'd, I'd break up with him, be like, okay I'm getting out of the cycle, 'cause I, I *know* all this stuff in my head, it's just I have to take the action.
- I: Um-hm.
- P: I *know* all of this. I've, I've done *plenty* of research. It's all I do, I hate *not knowing* . . . my options, ur, I hate not knowing that stuff. And, uh . . . after we broke up I dated, like, three of his best friends. And that tore him to pieces, 'cause, he was, like, in love with me.
- I: But he mistreated you. [Interpretation, another movement from research data collection.]
- P: [Almost inaudible] yeah . . . and still does, I'm pretty much still with him. I kinda feel like, mmm, not putting you into a category, but there's a lot of guys, I mean what is the percentage of guys being perps or whatever?

- I: It's actually pretty low . . . but, all you have to do is run across one and it—
- P: --tears up everything.
- I: Yeah. And, unfortunately, you've run across more than one.
- P: Yeah, and . . .
- I: So you have concerns that I'm gonna mistreat you somehow?
- P: No, I just—it just, like, freaks me out a little bit. And like, I mean like, and, I used to not, I'd be like, they're not gonna do it and then like *my dad*, like a person that I lived with, a person that took me to school, a person that *punished* me, some--, like . . . uh, my parent.
- I: Somebody that should have protected you and looked out for you.
- P: Instead of harming me.
- I: Yeah. And so if you can't trust him, who can you trust?
- P: Exactly.
- I: So, let me ask you a, a real curious question that I have now: why did you agree to do this interview?
- P: Uhm, 'cause I feel that, I *love* helping other people, and I don't want people to have to go through what I went through, I feel that if they can find help and *know* that there is help . . . that they don't have to keep it to themselves . . . I like doing that. There was a girl I met the other day, and she was sexually abused, and she was lettin' guys, like I could *see* it, I know I'm in the same situation but I can still *see* it, I'm not, I'm not stuck in my little box, like I know I have options and everything, and it—I talked to her and I was like. “You know,” I was like, “this is probably a cycle.” I was like, “there's people that can help you,” I was like, “my aunt is a DFS caseworker,” like, “you can come in and talk to her about it” and was like, “it's probably, like, happened in your family” and she was like “Yeah it happened to my mom”. Like I guess like, a couple weeks back she woke up with her boss's, or with her husband—with her dad's boss . . . um, so her dad could get a raise. . . and, I was like, “You do not deserve that,” and like I talked to her for like, hours, and the guy that was mistreating her that we talked about in the first place, he came up and he was like “You're not gonna say *bye* to be baby” and like all this stuff and . . . she didn't say one word to him. And she left, and just that feeling that I got from just helping her, it just makes me feel *great* 'cause I, even though all this negativity has been brought in my life I, I can change it, I can help other people not have to go through the same thing.

- I: [Silence.] Thank you.  
[Resuming interview structure] How do you think your life would be different if the abuse hadn't happened?
- P: [Clears throat] Can I do this? [Asking about slipping off her shoes and curling her legs into the chair in which she is sitting.]
- I: Sure.
- [From this point there is a shift in the participant, similar to that observed when a patient finally relaxes into a psychotherapy and begins to use the process for generating new psychic potential. Participant's anxiety level decreases, and she seems to become more capable of *reflection* about her experience vs. *reliving during the retelling*. She also, for the first time in this interview, begins to exhibit awareness of her lapses in discourse monitoring.]
- P: My whole entire life nothing has ever been *stable*, I've never had a stable *home*, there's always been *drama* brought into my life, and I feel that I "feen" [a slang term meaning an addictive high] off of that, I "feen" off of drama, and . . .
- I: So it kinda becomes an addiction.
- P: Yeah, if, uhm, something's not—me and my boyfriend can be perfectly fine, like no fight whatever—that drives me crazy, I, I, I can't stand it, I have to start a fight, I have to—start *something*, I bring up something that we fought about a year ago. And I don't know why. And I think that, my life wouldn't be . . . full . . . of all this drama that *I* bring to it myself, but, it's not really even with girls, it's really just . . . with guys, I think that's because of the abuse . . . um, I mean. yeah, I have had problems with girls but that was just because she was the type of person that didn't like her own life so she had to bring down other people's lives, there are *lots* of people out there who are like that if you just stop and just pay attention instead of just focusing on yourself and what you're about you can definitely tell . . . what people are really about.
- I: Thanks. Now, what do you do when you are sick, depressed, worried, or tired?
- P: Uhm, when I'm sick, [with laughter] I usually go to the doctor. Uhm, [clears throat] if I worry about things, I usually just calm myself down, 'cause, it's *gonna happen*. You can't worry, it just, you can't worry, it's just *life*. Are you talking about like if I'm worried about a guy I like or whatever?
- I: Just in general.
- P: Usually if I'm worried I'll just freak out, I mean not like freak out, but I'll be like "Oh my gosh!" But you just gotta deal with it, it's something that *has to happen*.

If I'm depressed, I just, it's very bad, but I just go to sleep. If I'm asleep I don't have to think about it. I, I remember the first time I did that, it wasn't really 'cause of what happened to me it was 'cause of my boyfriend, he um, he would always be *out* at night and he'd already cheated on me once, it, it scared me. And so like, I'd be worrying about it, and I'd be like, I'm just gonna go to sleep, if I'm asleep I don't have to *think* about it, I don't have to *worry* about it and I'll wake up the next day and . . . start all over. And, uh, I don't know, if I'm tired I just go to sleep, [brief laughter].

I: Okay. Who do you turn to when you're upset or troubled?

P: Uhmm, Devin. My boyfriend.

I: Now, what's your greatest fear?

P: Um, probably being alone. Like absolutely having nobody there, 'cause every single person I've ever counted on in my life has . . . turned away, gave up, or been the reason, like, I've had problems.

I: So it seems to me like you've already been very alone.

P: [Silence] I think I, I don't know, like I—this is something I've thought about before, like, I have tons of friends, I'm always doing something, like if I'm not doing something it just depresses me 'cause I just think about everything. I don't like that, I, I hate being told "no," because I've had restrictions my whole entire life, everything's always been, "no", I mean, I raised my dad's three kids [laughter] it was my job to get them up for school, to get, make them . . . um . . . supper [laughter] like, I did their laundry, I potty trained my brother . . . he was . . . I don't even know what I was talking about . . . .

I: It was about being alone.

P: Oh. I've always—how did that get there? I mean, how did I get to talkin' about that?

I: Well, you talked about . . . I said you'd already, I asked you what you feared—

P: --oh, like I always did that, everything, like I always had stuff to do—

I: --you stayed busy, yeah—

P: I always had, I always played an adult role, I've never actually been a child and that's all I, I want to—I want to get in trouble for being 15 minutes past curfew, like, not really but I'm just—

I: Yeah, normal kinds of things.

P: Yeah, and, and, I hate being told “no” ‘cause that’s what I’ve always been told my whole entire life. And I mean, I’m always, like even when I my parents told me “no” about something so simple like, I wouldn’t just think, in a teenage mind, I’d place myself outside of the box, and be like, “why would I not let my child do this?”, and most of the time I’m like, “I don’t know,” something as simple as going to a middle school dance and having forty teachers there to chaperone it . . . like I, I don’t know . . .

I: You don’t know what normal is, do you?

P: No, that’s why I’m scared, I don’t know if I want to have kids ‘cause I haven’t been raised right and I would have not the slightest idea, most people have an idea of how they want to raise their kids but, I was not even close to being raised right and . . . I don’t want to, I don’t want to be my father and screw up somebody’s life.

I: Uhm. Thank you. Who do you feel most relaxed and comfortable with?

P: Probably my boyfriend Devin.

I: Do you ever feel cut off and detached from people?

P: Because of him?

I: No, just in general.

P: [Silence]What do you mean?

I: Do you ever have times when you feel cut-off from people? Emotionally cut off? Detached, not connected.

P: Yeah, yeah, I don’t even know if this is what you’re talking about, but I’m just gonna—

I: Umhm.

P: Um, like when I was in like in school, like uh, they’d be talkin’ about this . . . new restaurant or something or, um, like a fairy tale . . . like a, like a book, let’s just say Cinderella, and I had no idea what it was. Like I mean I, I know what Cinderella is but I *don’t* remember what they used . . . now they’ll, “You haven’t ever heard that?” and like I was the only one in the class who . . . hadn’t . . . heard it. [Laughter] That’s really not even relevant to what you’re talking about.

I: No, that’s exactly the kind of thing I’m talking about, yeah.

- P: Like *that*, and then like, like sometimes, like people just group themselves together *so* quickly and, if you're not in that group you're just totally out of it. And I don't really have a group, I, I'm kind of *all over*, I'm—I, I have a *lot* of friends, but . . . sometimes I just feel like I don't have *any* . . . [silence] . . . [something inaudible]
- I: [Feeling the need to reassure] You answered that question very well. Do you ever feel so frightened of people that you avoid them?
- P: [Silence] Um . . . not really, 'cause of, um, like I said I'm used to drama, and if they do frighten me that will just stir up more *stuff*.
- I: So it's almost more exciting for you?
- P: I guess. Unless you're talking about, like . . . pedophiles or something like *that*.
- I: People that you have specific reasons to be afraid of right? Yeah.
- P: My dad, I mean I seen him the other day and he didn't do anything but *look* at me and I started bawling, I *did not know what to do*, I just, I freaked out. He um, I uh, they keep changing the court date, I mean the preliminary hearing it's supposed to be, like, uh, September 10<sup>th</sup> then they moved it to October 30<sup>th</sup> and now it's December 12<sup>th</sup>, I *hate* our judicial system, I *hate it*.
- I: It just draws it out, and keeps it hanging over your head, doesn't it?
- P: I know because it's still *there* and like, he's still out, I mean . . . excuse me I don't know if, I don't know if he was so drunk and . . . I mean he was on drugs, and . . . then prescription drugs and oh he had marijuana in him and he give it to me and I thought it was a cigarette, it was like a one-hitter [unintelligible] and, like he was on all this medication for his back, like Vicodin and Somma, like this high notch crap, and then plus like, I don't even know *how much* alcohol he consumed that night . . . but it was *a lot*, I don't know if it was, it was just because of *that* and because I—I looked it up, I said I look a lot of things up, um, men that are—he was getting a divorce, they were in a very bad positions, um, she cheated on him, he cheated on her, it was just a big mess—a lot of guys that are getting out of a relationship like that tend to turn to . . . their daughters, and I think—actually in all honesty I think, I feel like my stepmom was jealous of me . . . there's a, there's a thing called “Cinderella Syndrome,” have you heard of that?
- I: Umhm.
- P: Yes? Um, and there's another one, I can't, I can't recall what it was, but um . . . I felt like, uh, she, like if my dad asked me to go somewhere with him? She'd just get all rude and defensive about it and it wasn't a big deal, like he'd ask me to go to Wal-Mart or somethin' but . . . uh, I feel like our relationship wasn't like a

- parent relationship it was like a boyfriend-girlfriend relationship, and I, I didn't see that until *now* because I've never had a father, obviously, and I . . . never . . . my mom hardly let me do anything so I didn't get to see . . . other families, like how they work and stuff, like . . . do you get what I'm saying?
- I: I do.
- P: Um, yeah, and . . . so I didn't know that that wasn't right, I mean my dad would hang out with my friends and . . . he'd kinda be like the cool, cool dad I'd guess you'd call it, I mean he'd let, he'd let me have friends over and we'd drink, my boyfriend would stay the night—not in the same rooms or anything like that, he had to sleep in a different room . . . um, he pretty much spent all last summer with us . . . he went on vacation with us, um, my dad was really big into stereos which is a big thing in my little small town . . . um, so that got a lot of people like hangin' out with my dad and stuff, and my dad told me if I wanted to try pot for the first time I had to be with *him* . . . and, I refused it 'cause I was, wasn't, highly intoxicated at that time, and then later on I took it . . . [silence, then softly] yeah . . . So I just keep blundering on and I forget what I'm, what you've even *asked me*.
- I: It's okay, you're doing well. [Silence] Thank you. [Silence] Do you ever fear that those you're close to will leave you?
- P: I . . . um, Devin, I was terrified, I didn't want to fall in love with him 'cause I was so scared that . . . he wouldn't want me, he wouldn't accept me . . . 'cause I felt like I've never been accepted . . . I mean like I wasn't *good enough* . . . and if I was good enough, if I was *what* my mom wanted me to be she would, she would have believed me, she wouldn't 've . . . *chose* her husband over her daughter. Like, if, if I was . . . *right* or whatever and my stepdad wouldn't 've done that . . . I mean if my own father wouldn't 've done that . . . I don't like getting *close* to people 'cause I don't like getting hurt . . . and then, sometimes I can't *help* it and I say "I didn't watch my step too well, and I fell" . . . I didn't, I tried pushing him away forever, I would be *so* mean to him 'cause I figured he'd just give up and leave like everybody else has . . . but, he's still there and I don't, I don't know why.

### Differential Comparison of Narrative Transcripts

On review of the preceding transcript excerpts, a few points are immediately apparent. One is the comparative difference in manifest content quantity: both the Earned/Acquired Secure (EAS) and the Avoidant/Dismissive (AvDs) narratives were significantly briefer than either the Ambivalent/Preoccupied (AmbPre) or the

Disorganized/Unresolved (DU). This involves the Gricean element of Quantity, in which a logically ordered and coherent narrative is seen to be brief while simultaneously providing enough illustrative detail to support assertions without becoming lost in extraneous detail (this later aspect influences the other Gricean elements of Quality, Manner, and Relation.)

A key distinction that can be drawn between the shorter narrative transcripts here (EAS and AvDs) is that the former provides enough information spontaneously to support the statements made by the participant (positive for Quality), while the participant classified as AvDs in narrative structure does not, and in fact offers no supporting detail without being facilitated by the interviewer via furthering questions (thus, negative for Quality). Another discrepancy observable in this transcript excerpt, and typical of AvDs narratives in general, is the frequent claim of “not knowing” or “not remembering” or “not understanding,” which, in this context, appears to function more as a block or evasion of introspective reflection rather than giving evidence of legitimate amnesia, forgetting, or problems in cognitive processing.

Turning to the longer transcript excerpts, the AmbPre and DU narratives, some introductory comments are necessary to avoid confusion here; these have to do with the complexities of DU classification that were *not* addressed in the present study.

It is standard practice within the AAI system from which the present study’s methodology was derived to provide a secondary classification for all narratives that in this study are classified as DU by force-fitting them into one of the other classifications. This is possible because, rather than being an over-arching quality of narrative structure that permeates all interview responses, as are the other classifications (with the arguable

exception of the Cannot Classify), Disorganized/Unresolved status is assigned on the basis of topic-specific disorganization/disorientation/un-resolution demonstrated episodically in the interview. Thus, a participant who becomes disorganized in narrative structure, or disoriented in thought processes (as demonstrated, for example, by lapses in reality testing or discourse monitoring) in only one instance during the interview—say, when discussing an early parental loss—would still qualify for a DU classification. So, aside from those instances of DU narrative quality, a participant will exhibit basic foundational narrative qualities overall that will be assignable to one of the other classifications.

A study by van Ijzendoorn and Bakermans-Kranenburg (in Adams, Keller, and West, 1995) found “[t]here is a strong interrelationship between unresolved/disorganized [DU in the present study] classification and forced second classification of preoccupied [AmbPre in present study] . . . Nearly half (48%) of the 65 subjects classified as Ud [DU in present study] were assigned a secondary classification of preoccupied (Amb/Pre in present study).” This finding raises two points salient for this discussion: (1) forced-fit secondary classifications of DU narratives was not done in the present study because of the small sample size; (2) the similarities between the Amb/Pre and the DU narratives observable in the transcripts documented here may be attributable either to the secondary Amb/Pre nature of this participant’s narrative structures, or to the overlap between Amb/Pre narrative structures and DU structures found in the van Ijzendoorn/Bakermans-Kranenburg study.

Both the Amb/Pre and DU classifications in these transcripts yield narratives that are found negative in the Gricean elements of Quantity (more informative than necessary;

frequently containing superfluous detail; providing supportive examples in the form of stories that verged on verbal enactment), Quality (by presenting either mutually exclusive or contradictory or polarized data as equally representative of the participant's state of mind; by being convoluted, circumstantial, or tangential in associations provided; by being more associative than linear in narrative construction), Relevance (by becoming tangential and getting lost in story-telling and details so that the final narrative product was irrelevant to the original inquiry), and Manner (by being non-linear, non-sequential, dis-ordered, and often ambiguous in manifest narrative content.)

To these narrative qualities the DU structure adds an additional element by exhibiting lapses in conversational or narrative monitoring, and/or lapses in reality testing (for example, slipping into the present tense when talking about a past event, indicative of becoming disoriented with regard to temporal context). Thus, although each participant in the excerpted transcripts provided here would launch into narrative flights that were more story than question response, become mired in unnecessary detail, exhibited signs of affective flooding when describing past trauma, or used such dramatic gestures, facial expressions, and vocal inflections that their responses became performative more than narrative, the participant whose narrative was classified as AmbPre would bring the response back around so that it remained oriented to the original query while the DU participant often lost track of the stimulus question, and only occasionally throughout the interview demonstrated awareness of having done so.

A final notable aspect of interviewing AmbPre and DU participants lies in more scientifically fragile territory: that is the observation by this researcher that the affective flooding and cognitive disorganization of these participants would often be associated

with a strong pull for the researcher to move beyond the intersubjective distance provided by the “researcher-data-collector” role. Said differently, within such interviews a relational field would arise in which the interviewer experienced a counter-transference response that stimulated the adoption of a more co-affect-regulatory or “psychic containment” posture relative to the participant. Although this beggars the empirically oriented elements of the present study’s methodology, an attempt was made in the DU transcript to document the phenomenology of such interviewer response as it occurred with one participant.

#### A Qualitative Description of Researcher Responses to the Interviews:

##### The Intersubjective Dynamics of a Clinician-Researcher

Early in the interview process, the researcher was confronted with the non-conscious psychic structuring processes he routinely engages in when working clinically with this adolescent population; this confrontation occurred when he was required to refrain from such interventions in the process of doing the research interviews. As reported above, the more preoccupied and disorganized the narrative, the stronger the pull experienced by the researcher to violate the pure data collection purposes of the interview procedures in favor of intervening in a way that helped the participants regulate their affect and provide structure to their narratives. Therefore, it is likely in the initial interviews that a faulty assessment of narrative organization was arrived at by the researcher because of his engaging in a way that provided external organization to an otherwise disorganized narrative.

Additionally, the strong counter-transferential affects aroused within the researcher when empathically attuning to the traumatic affects of his participants became a repeated source of distress both during the live interviews and the coding of recorded interviews. These researcher affects were experienced as aversive, and prompted unconscious avoidant reactions that would have threatened completion of the research had they not been brought to conscious awareness and regulated by a more considered pacing of the interviews and of the coding sessions.

Finally, it is notable that in three separate interviews the researcher became concerned, on the basis on his counter-transference reactions and the participants' affective dysregulation associated with their narrative disorganization, that the participants' had become so fragmented during the interview that crisis debriefing would be necessary before they could be safely returned to the unit. In each instance, as this worry was explored with the participant during post-interview processing, the individual in question evidenced an apparently paradoxical positive response to having done the interview. Speculation as to the possible clinical implications of these occurrences will be offered later in this document.

#### A Quantitative Description of the Sample

The sample in this study was not necessarily representative of the general American adolescent population, nor of the general population of adolescents admitted nationally to acute-care psychiatric settings; therefore, the reader is cautioned against any attempt to generalize these findings beyond the parameters of the specific population from which this sample was drawn.

Study participants were of mixed socio-economic status, but clustering of the sample population toward the low-middle to poverty end of the socioeconomic spectrum was found. Social class of participants was largely working-class or poor, with little representation provided for teens of professional families, and adolescents of wealthy parents were entirely absent from this study. Likewise, the cultural context of most study participants was rural- or small town-Midwestern, with minimal representation of participants from large urban populations or affluent suburbs. All these factors reflect characteristics of the normative patient population in the hospital chosen as the setting for the present study, and thus were consequent to the use of this convenience sample.

No attempt was made to control for age, ethnicity, or gender. Potential study participants ranged between 13 and 17, and participants representing both ends of the age spectrum were included in the sample. Each potential year of age (13, 14, 15, 16, 17) was represented, although the majority of participants were in the 15-16 range, making the median age of the sample 15, and the mean age 15.24—this characteristic is also in keeping with the normative age distribution of all adolescents admitted to the research site. Among racial and ethnic groups in the sample, Caucasian whites comprised the overwhelming majority (47 of 50, or 94%); this, as with socio-economic status, is a characteristic typical of the normative patient population found at the research site. Females and males were represented almost equally (26/24, or 52%/48% respectively) in the study sample.

With these preliminary demographics in mind, attention can now turn to the findings of this study.

*Attachment Style Frequencies (Figure 3)*

There were no Secure/Autonomous attachment classifications found among the study participants. To qualify for this designation, the narrative structure must be analyzed as meeting the criteria for Secure/Autonomous organization and the attachment history must meet criteria for security of attachment; no participants in the study had experienced the reliable, dependable, predictable, consistent, and attuned primary attachment relationships requisite for this classification. Goldberg's (1995) data estimates the non-clinical population prevalence of securely attached infants and toddlers to range between 55% and 65%, and Secure/Autonomous adults between 45% and 55%. Sroufe et al. (2005) found in their 30-year longitudinal study that security of attachment did not prevent later development of diagnosable mental health problems. These two sources singularly and combined suggest that the complete absence of such narrative structures among the present research sample is significant.

Figure 3

**Frequencies of Attachment Styles**

Attachment Style					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Ambivalent/Preoccupied	7	14.0	14.0	14.0
	Acquired or Earned Secure/Autonomous	3	6.0	6.0	20.0
	Avoidant/Dismissive	17	34.0	34.0	54.0
	Cannot Classify	3	6.0	6.0	60.0
	Disorganized/Unresolved	20	40.0	40.0	100.0
	<b>Total</b>	50	100.0	100.0	

The largest proportion of narratives analyzed (20, or 40%) fell into the Disorganized/Unresolved attachment style. Second to this was the Avoidant/Dismissive, with 17 or 34%, of analyzed narratives meeting criteria for this attachment style. Ambivalent/Preoccupied narratives were found in seven (14%) of the sample interviews. Finally, narratives suggestive of Earned/Acquired Secure attachment style, and those not clearly meeting criteria for assignment to one of the four identified attachment styles (Cannot Classify) each were represented by three (6%) of the analyzed interviews; these were omitted from the statistical analysis so that they would not confound the data with regard to dilution of statistical significance.

As can be seen from this brief description, the insecure attachment styles were heavily predominant among the analyzed interviews, cumulatively comprising 44 out of 50, or 88% of the sample.

Golberg (1995) reports that findings for non-clinical, normative samples range between 15-20% for the Unresolved/Disorganized classification, 20-35% for the Dismissing classification, 10-15% for the Preoccupied. This study's findings, therefore, exceed normative samples in prevalence of the Disorganized/Unresolved category by 20-35%. Secure/Autonomous classifications were entirely absent from the present sample, and thus was 45-55% under the prevalence of that classification found in normative samples. The Ambivalent/Preoccupied classification was squarely within the normative range reported by Goldberg, and the Avoidant/Dismissive classification was at the outer limit of the predicted range for a normal population sample. No comparative data was available regarding the Acquire/Earned Secure classification.

*Primary DSM Diagnostic Category Frequencies (Figure 4.1) and  
Associations with Attachment Style (Figure 4.2)*

Again in this area, as in the area of attachment style, one category was clearly predominant among the variables analyzed: 33 of the 50 participants, or 66% of the sample, had a primary DSM diagnostic category of Anxiety/Mood Disorder. This diagnostic category was also predominant across attachment style classifications: 12 of 20 narratives suggestive of Disorganized/Unresolved attachment style; 7 of 10 Avoidant/Dismissive; 5 of 7 Ambivalent/Preoccupied; and all (3 each) of both the Cannot Classify and Earned/Acquired Secure narratives were in this diagnostic category. Next in prevalence was the diagnostic category of Attention/Disruptive/Impulse Disorders, with 16, or 32%, of participants placed here. This diagnostic category was scattered among the insecure attachment styles, with 7 of 20 Disorganized/Unresolved, 7 of 10 Avoidant/Dismissive, and 2 of 7 Ambivalent/Preoccupied having a diagnosis in this category. What was found here was notably higher frequencies of study participants with narratives suggestive of Avoidant/Dismissive and Disorganized/Unresolved attachment carrying DSM diagnoses of attention/disruptive/impulse disorders classification (each style comprising seven, or 43.75%, of the 16 participants in this diagnostic category, or 87.5% cumulatively.)

Figure 4.1

### Frequencies of DSM Diagnostic Categories

#### Primary DSM Axis I Diagnosis

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid <b>Attention/Disruptive/Impulse Disorders</b>	16	32.0	32.0	32.0
<b>Anxiety/Mood Disorders</b>	33	66.0	66.0	98.0
<b>Substance Related Disorders</b>	1	2.0	2.0	100.0
<b>Total</b>	50	100.0	100.0	

Figure 4.2

### Associations between Attachment Style and Primary DSM Axis I Diagnosis

		Primary DSM Axis I Diagnosis			
		Attention/Disruptive/Impulse Disorders	Anxiety/Mood Disorders	Substance Related Disorders	Total
<b>Attachment Style</b>	<b>Ambivalent/Preoccupied</b>	2	5	0	7
	<b>Avoidant/Dismissive</b>	7	10	0	17
	<b>Disorganized/Unresolved</b>	7	12	1	20
<b>Total</b>		16	27	1	44

#### Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.575(a)	4	.813
Likelihood Ratio	1.951	4	.745
Linear-by-Linear Association	.029	1	.864
N of Valid Cases	44		

a. 5 cells (55.6%) have expected count less than 5. The minimum expected count is .16.

Only one case (2% of the sample) had a primary diagnosis falling outside of the Anxiety/Mood or Attention/Disruptive/Impulse Disorder categories; that was a Substance

Related Disorder, which was given to a participant whose narrative was suggestive of Disorganized/Unresolved attachment style.

*Admitting Symptom Type Frequencies ( Figure 5.1) and  
Associations with Attachment Style ( Figure 5.2)*

To be admitted into the acute care psychiatric setting from which the sample was drawn, a teen had to be judged as meeting one of three criteria: imminent risk of harm to self, imminent risk of harm to others, or active psychosis. Active psychotics were eliminated from the study sample; some participants were reported as being a risk to both self and others at time of admission. Of these variable values, risk of harm to self was the leading cause for admission (22 participants, or 44% of the sample); risk of harm to both self and others was second (15 or 30% of participants); risk of harm to others was the lowest ranked admitting symptom among all study participants (12, or 24%). All of the sample patients admitted for being of imminent risk to others had narratives suggestive of either Avoidant/Dismissive (eight of the 13 admitted for risk of harm to others,) or Disorganized/Unresolved (5 of 13 attachment).

However, neither the “Avoidant/Dismissives” (totaling 17, or roughly 38%, of the 44 insecure-classified participants in this analysis) nor the “Disorganized/Unresolveds” (20, or approximately 45%) exhibited only admitting symptoms in this category.

The most frequent reason for hospitalization in the Disorganized/Unresolved group was being a risk to both self and others (9/20) and this classification was easily the most frequently represented in the risk to self and other category (9, compared to 1 Ambivalent/Preoccupied and 3 Avoidant/Dismissive).

Figure 5.1

### Frequencies of Admitting Symptoms

Admitting Symptoms					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Risk of Harm to Others	13	26.0	26.0	26.0
	Risk of Harm to Self	22	44.0	44.0	70.0
	Risk of Harm to Self and Others	15	30.0	30.0	100.0
	<b>Total</b>	50	100.0	100.0	

Figure 5.2

### Associations between Attachment Style and Admitting Symptoms

		Admitting Symptoms			Total
		Risk of Harm to Others	Risk of Harm to Self	Risk of Harm to Self and Others	
Attachment Style	Ambivalent/Preoccupied	0	6	1	7
	Avoidant/Dismissive	8	6	3	17
	Disorganized/Unresolved	5	6	9	20
Total		13	18	13	44

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.104(a)	4	.025
Likelihood Ratio	12.187	4	.016
Linear-by-Linear Association	.643	1	.423
N of Valid Cases	44		

a. 3 cells (33.3%) have expected count less than 5. The minimum expected count is 2.07.

A total of 18 study participants (of the 44 insecure narratives used in this analysis) were admitted for posing an imminent risk to self; of those 18, there was an equal distribution of participants (six each) among Avoidant/Dismissives, Disorganized/Unresolveds, and Ambivalent/Preoccupieds. This is not to suggest that each attachment style here was equally likely to pose a risk to self, because the proportional distribution within attachment styles showed wide variance: six Avoidant/Dismissive participants admitted for risk to self represented roughly 35% of all Avoidant/Dismissives in this analysis, six Disorganized/Unresolveds comprised 30% of that classification, while six Ambivalent/Preoccupieds represented approximately 85% of that classification. Thus, taken as a group, narratives suggestive of Ambivalent/Preoccupied attachment status had a proportionately stronger association with hospitalization solely for posing a risk to self, just as Avoidant/Dismissives had stronger associations with risk of harm to others.

The only statistically significant association of this study was with relation to attachment style and admitting symptoms: all study participants admitted for risk of harm to others were in either the Avoidant/Dismissive (8 of 13, or roughly 61.5%) or Disorganized/Unresolved classifications (5 of 13, or roughly 38.5%), with no

Ambivalent/Preoccupied attachment narratives associated with this symptom presentation. Using SPSS to analyze a sample comprised of the 44 insecure attachment narratives in association with the three categories of admitting symptoms, a Pearson Chi-Square value of 11.104 was obtained, with 4 degrees of freedom, and a probability of .025. Discussion of the relevance of this finding is presented in the final chapter.

Also worth noting, the ambiguous symptom category “risk of harm to self and other” yielded interesting results. Although each attachment style was represented here, there was obvious variance among the styles in their proportional association with this symptom category (13 total: one Ambivalent/Preoccupied; three Avoidant/Dismissive; nine Disorganized/Unresolved), both in distribution among all participants exhibiting these admitting symptoms and in the distribution within particular attachment styles. In this area, Disorganized/Unresolved narratives were the most represented (9 of 13, or approximately 69%), and this symptom constellation was the most prevalent reason for hospitalization in the Disorganized/Unresolved classification (9 of 20, or 45%).

*Abuse History Frequencies (Figure 6.1) and  
Associations with Attachment Style (Figure 6.2)*

Information about the abuse history of participants came from either (or both) of two sources: the self-report of study participants (a question in the BABI asks directly about physical/sexual abuse), or through documentation at intake via the report of admitting guardians. In a few cases, participants did not report abuse that was documented at intake; in these instances, the intake documentation was given precedence in deciding whether to record an abuse history for that individual. In other cases,

individuals described abusive interactions with caregivers or their surrogates (for example, a mother's boyfriend) but did not characterize these as abuse when directly asked about this during the interview; in these instances, the description of abusive interaction was given precedence in the decision-making process around assignment of abuse history. In yet other examples, a study participant would describe or disclose abuse that was not documented at intake (in these cases, the information was forwarded to the individual's primary therapist for follow-up investigation in order to determine whether a mandated abuse report was required—that is, whether this was a new disclosure of previously unreported abuse); in these instances, the participant's report was given precedence in abuse history assignment.

Figure 6.1

### Frequencies of Abuse by Type in Study Sample

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid <b>None</b>	8	16.0	16.0	16.0
<b>Emotional/Relational Abuse</b>	14	28.0	28.0	44.0
<b>Physical abuse</b>	14	28.0	28.0	72.0
<b>Physical&amp; Sexual abuse</b>	5	10.0	10.0	82.0
<b>Sexual abuse</b>	9	18.0	18.0	100.0
<b>Total</b>	50	100.0	100.0	

Figure 6.2

### Associations Between Attachment Style and Abuse History

		Subject Abuse History					Total
		None	Emotional/Relational Abuse	Physical Abuse	Physical/Sexual Abuse	Sexual Abuse	
Attachment Style	Ambivalent/Preoccupied	1	2	2	0	2	7
	Avoidant/Dismissive	4	6	5	1	1	17
	Disorganized/Unresolved	2	5	5	2	6	20
Total		7	13	12	3	9	44

#### Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.151(a)	8	.741
Likelihood Ratio	6.135	8	.632
Linear-by-Linear Association	1.076	1	.300
N of Valid Cases	44		

a. 12 cells (80.0%) have expected count less than 5. The minimum expected count is .48.

For the purposes of this study, the variable of abuse history was subdivided into the values of “no abuse,” “physical abuse,” “sexual abuse,” “physical and sexual abuse,” and “emotional/relational abuse.” In this sample, physical abuse and emotional/relational abuse was the most common, each being found in 14, or 28%, of the participants. Sexual abuse was the next most common finding, with nine participants (18%) in this category.

No described or documented abuse was found in eight (16%) of participants. Both sexual and physical abuse was present in five, or 10 %, of participants. Of note in this breakdown, participants with narratives suggestive of Disorganized/Unresolved attachment style ranked highest in all abuse values, with the exception of “no abuse” (where they were exceeded by the Avoidant/Dismissive group), and “physical abuse” (where they were tied with the Avoidant/Dismissive group).

In the present study, the insecure narrative classification most strongly associated with sexual abuse and the combination of both physical and sexual abuse was Disorganized/Unresolved. Sexually abuse Disorganized/Unresolved narratives = 6/20, versus 1/17 Avoidant/Dismissive and 2/7 Ambivalent/Preoccupied. Combined sexual and physical abuse in Disorganized/Unresolved narratives = 2/20, compared to 0/7 Ambivalent/Preoccupied and 1/17 Avoidant/Dismissive.

*Legal Guardian Status Frequencies (Figure 7.1) and  
Associations with Attachment Style (Figure 7.2)*

Guardian status is clearly a potentially important variable in any attachment study, given the direct relationship between attachment style and experiences of adult caregiving. In this study, the variable of “guardian status” was further divided into three values dictated by the findings of the data: “adoptive parents,” “birth parent(s)” (meaning that the participant was living with at least one birth parent at the time of the interview and their admission to the hospital, with the single occurring case of guardianship by biological grandparents included in this category), and “state agency”.

Figure 7.1

**Guardian Status of Study Sample**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<b>Adoptive parent(s)</b>	4	8.0	8.0	8.0
	<b>Birth parent(s)</b>	30	69.0	60.0	68.0
	<b>State agency</b>	16	32.0	32.0	100.0
	<b>Total</b>	50	100.0	100.0	

Figure 7.2

**Associations Between Attachment Style and Guardian Status**

		Subject Legal Guardian			Total
		Adoptive parent(s)	Birth parent(s)/ Grandparents	State agency	
<b>Attachment Style</b>	<b>Ambivalent/Preoccupied</b>	1	5	1	7
	<b>Avoidant/Dismissive</b>	1	12	4	17
	<b>Disorganized/Unresolved</b>	2	10	8	20
<b>Total</b>		4	27	13	44

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.690(a)	4	.611
Likelihood Ratio	2.771	4	.597
Linear-by-Linear Association	1.743	1	.187
N of Valid Cases	44		

a. 5 cells (55.6%) have expected count less than 5. The minimum expected count is .64

All the variable values are self-explanatory, but caution must be used in examining the category of “birth parent(s).” A few of the participants, although under the

technical guardianship of at least one birth parent (single-birth-parent guardianship being by far the largest sub-grouping in this data value), were not living with them at the time of admission; or, in other instances, had been removed from their care by the state at some earlier point(s) in childhood, and were once again with them following reunification. The basic caveat, then, is that identification of an interview participant as having the guardian status of “birth parent(s)” should not be interpreted as denoting an uninterrupted caregiving relationship with both birth parents, as this was not the case with any of the participants interviewed.

In this sample, “birth parent(s)” was the guardian status for most (30, or 60%) participants, followed by “state agency” (16, or 32%), and “adoptive parents” (4, or 8%). In examining the association between guardian status and attachment style, Ambivalent/Preoccupied narratives were found in five instances of birth parent guardianship, and one instance each in the adoptive parent and state agency guardianships; 12 of the Avoidant/Dismissive narratives were found with birth parent guardians, four with state agency guardianship, and one with adoptive parents; Disorganized/Unresolved narratives were present in 10 birth parent guardianships, eight state agency guardianships, and two adoptive parent guardianships. It is interesting, although not reaching the level of statistical significance, that of the 3 narratives suggestive of Acquired or Earned Secure attachment style, two of those were under the guardianship of state agencies, only one was (reunited) with a birth parent, and all had participated in extensive psychotherapy.

## Practice Issues for the Social Worker

Attachment theory has been established as an empirically supported psychoanalytic developmental theory (Fonagy, 2001; Fonagy et al., 2002; Sroufe, 1995, 2005; Sroufe, Egeland, Carlson, & Collins, 2005; Stern, 1985) that now functions as a central paradigm for understanding infant development, and explains how interactions with primary caregivers (usually parents) shape later functioning. Contemporary attachment research has demonstrated the impact of early attachment on developmental neurobiology (Schoore, 1999, 2001, 2002, 2003a, b) and shown an influence of attachment experiences on later psychopathology (Crittenden, 1997; Fonagy, Target, Steele, Steele, Leigh, Levinson, and Kennedy, 1997; Goldberg, 1997; Schindler, Thomasius, Sack, Gemeinhardt, Kustner, and Eckert, 2005; Shaw and Dallos, 2005; Sroufe, Egeland, Carlson, and Collins, 2005)

Little data exists on the relationship between security of attachment and acute psychopathology precipitating psychiatric hospitalization. Particularly absent is information about inpatients in the adolescent phase of development. As social workers provide an array of services (case management, psychotherapy, support and advocacy) for clients in the mental health system, findings of the present study should be particularly useful in shaping the relational dimension of that work—that is, the way in which clinical relationship is used to further the goals of treatment. With respect to the more specific social work practice dimension of psychotherapy, this research has implications for guiding the clinician in assessment of target symptoms and their relationship to underlying developmental psychodynamics (affect regulatory capacities, issues of inhibition/disinhibition, reflective function, reciprocity and mutuality) as they

may emerge in the psychotherapy. For a more in-depth discussion of this issue, see “Clinical Social Work from an Attachment Perspective” in Chapter V.

### The Effect of Time on the Variable

John Bowlby’s view of development “was a non-linear, transactional model akin to various systems perspectives . . . most succinctly summarized by a quotation from the second volume [Bowlby, 1973/1982], where he says that the developmental pathway chosen ‘turns at each and every stage of the journey on an interaction between the organism as it has developed up to that moment and the environment in which it then finds itself.’” (Sroufe, 2005a, p. 350, quoting Bowlby, 1973, p. 412) Bowlby saw the influence of environmental factors (including interactions with others) as so important in shaping formation of internal working models of attachment that he created a term to specify the highly particular role of environment on development of the attachment system, “the environment of evolutionary adaptation.” (Bowlby, 1969/1982) One way of viewing Bowlby’s theory and all subsequent research using his model, then, is to see in it the attempt to trace the various ways in which environmental influence becomes internalized as psychic representation, which then goes on to influence the environment in constant recursive exchange.

With such a transactional, evolutionary perspective on developmental processes inherent, it is unreasonable to assume that either internal working models (attachment representations) or the behaviors they govern will be static and unchanging over time. So it is that Jacobvitz and Hazen (1999) found in their follow-up early childhood observations of children classified as disorganized and disoriented in infancy, that the

chaotic, bizarre, “crazy” behaviors previously associated with that attachment designation had typically resolved themselves into either of two interactional styles now characterized as “controlling.” Likewise, Pearson et al. (1994), found that some adults (those classified as “earned secure”), who as children experienced environments associated with insecure or disorganized varieties of attachment, demonstrated as good sensitivity and responsiveness to their children as those adults having experienced more positive childhood environments.

Both these studies illustrate the point that attachment is a dynamic process, one motivational system among others that function as defining variables in personality development. The fact that attachment experiences and, ultimately, attachment representations can be modified over time is reassuring to those of us who are averse to fatalistic, determinist models of human existence.

Yet two facts salient to understanding the effect of time on attachment representation as a developmental variable emerge from Sroufe et al.’s longitudinal attachment research in the Minnesota Study. As articulated by Gerhard Seuss and June Sroufe, these are (a) “the emergent person becomes increasingly a homeorhetic force in development” (Seuss and Sroufe, 2005, p. 386), and (b) “experience, representation, and ongoing adaptation are a non-dissociable triad.” (p. 387) That is because experience, representation, and ongoing development *are* inter-related and interdependent mutually influencing factors, their interaction over time—failing the intervention or intrusion of some powerful relative variable (for example, psychotherapy or war trauma)—tends to become ever more recursive and reinforcing so that, for example, avoidant attachment representations give rise to interactive behaviors (adaptations) that work as cues drawing

reciprocal complementary interactions (experience) from the environment. More simply put, the ways of organizing internal experience typical of each kind of attachment representation that make for more or less coherent and patterned responses to the environment tend toward homeostasis over time.

## CHAPTER V

### DISCUSSION AND CONCLUSIONS: WHEN THINGS FALL APART

#### Discussion

##### *The Socio-Economics of Attachment*

Although socio-economic factors have never been seen as primary determinants of attachment quality, notable differences have been found in stability of attachment style over time, and among specific subtypes of insecure attachment, in different SES samples. Studies have found attachment styles demonstrating significant stability over time (as measured in infancy and young adulthood) in a middle-class research sample. Alternately, another study done by Weinfield, Sroufe, and Egeland (1998) using a poverty sample found no significant relation between infant attachment style and young adult (19 year olds) attachment style. Similarly, a study by Lyons-Ruth, Repacholi, McLeod, and Silva (1991) found that among infants classified as Disorganized, notable differences in frequency among secondary classification subtypes (that is, Disorganized-Secure, Disorganized-Avoidant, Disorganized-Ambivalent) were associated with different SES status; specifically, Disorganized-Secure classifications were more often found in middle-class samples while Disorganized-Avoidant and–Ambivalent classifications were both more common in low SES participants, suggesting that although higher SES does not immunize against experiences of disorganizing traumata, those

experiences are more likely to be cushioned by underlying secure attachment representations. This does not seem to hold for the low SES sample; disorganizing experiences seem to occur over a foundation of insecure attachment representations.

What is consistent among these studies is the association of negative life experiences with instability and insecurity of attachment classification. Rather than suggesting that SES is a causative factor in attachment style, these studies suggest that poverty-level and low SES populations are at greater cumulative risk for encountering negative life experiences; it is this fact, and not socio-economics per se, that influences quality of attachment and attachment style.

That being said, the research sample's weighting toward working-class or poverty-level rural SES may be one factor influencing the disproportionate number of narratives suggestive of Disorganized/Unresolved attachment found in this study.

#### *Adolescence, Attachment, and Affect Regulation: Opportunity and Vulnerability*

If a central challenge of adolescent development from an attachment perspective is the withdrawal of primary emotional investment from parental attachments and its re-investment in peers (Kobak et al., 2007; Scharf and Mayseless, 2007), then the individual teen's capacities for auto-affect regulation become of central importance in facilitating normative development. Where sensitive parental attunements to affect-regulatory idiosyncrasies of their children may accommodate for deficits so that the potential for affective homeostasis is maximized, it is unlikely that adolescent peers will be capable of such compensatory attunement. Therefore, as reliance on parental co-regulation is minimized, the teen must become increasingly self-reliant in managing affect. Deficits

in affect regulatory capacities that developed in response to, and were compensated for by, parent attunement styles will now become highlighted because of the absence of a complementary co-regulatory “fit” in peer attunements. Just as problem behaviors in younger children may be masked by the sheltering influence of the primary family system until the child reaches school age and is thrust beyond the familial environment, problems in developing auto-affect-regulation capacities that may be moderated by co-regulatory compensation of parental attunements will become increasingly problematic as the teen de-invests in the parent-child relationship and seeks attachment affiliation with peers—a process that reaches its developmental crescendo during adolescence.

As attachment systems, like all systems, tend toward homeostatic equilibrium (von Bertalanffy, 1969), it is a logical consequence of this attachment-oriented view of adolescence that the attachment quality of relationship systems established at this developmental phase will tend to be self-replicating. That is, teens with particular attachment styles will be drawn to, and will draw unto themselves, relationships of a reciprocal nature through the mediating mechanism of behavioral cueing, in which relational behaviors that developed as adaptations to the early attachment environment later become elicitors of supporting relational behaviors in others with complementary attachment representations. Thus, Secure-Autonomous teens will predictably seek out, and be sought by, peers with similar attachment orientations; the auto- and co-affect regulatory resiliencies of these peer groupings would be predicted to become mutually reinforcing while their vulnerabilities would be mediated. The basic unconscious expectation for relational fulfillment believed to exist in Secure-Autonomous teens would allow for the anxiety provoked by exposure to new varieties of secure attunement to be

tolerated, so that new possibilities for relating can emerge. In the case of teens with Insecure and Disorganized attachments, the mutually reinforcing nature of their peer affiliations would expectably have a paradoxical consequence, with resiliencies that may exist in the context of the peer-group relationships actually operating as vulnerabilities in interaction with the wider population. This would set the stage for an adolescent emergence of mental health and behavioral impairment, possibly resulting in a range of self-and-other-destructive acting out eventuating psychiatric hospitalization.

#### *Attachment Style and Psychiatric Hospitalization*

As previously noted, Sroufe et al.'s Minnesota Study found the disorganized style of attachment to be most associated with development of later psychopathology. (Sroufe, 2005a) In that light, the findings of the present study that Disorganized/Unresolved narrative quality was the largest classification found in the research sample is entirely consistent. That all insecure varieties of attachment, as suggested by the narrative analytic protocol used here, were higher in frequency than secure attachment narratives is similarly consistent both intuitively and empirically: security of attachment is well documented as a resiliency factor mediating against the development of psychopathology, therefore one would expect a higher representation of insecure attachment narratives among a sample drawn from individuals hospitalized for acute psychiatric disturbance.

It is, however, significant that *no* study participants were found to have both Secure/Autonomous narrative structures and Secure/Autonomous attachment histories, qualifying for a classification of Secure/Autonomous attachment. The significance of

this absence is that, as reported in the Minnesota Study (Sroufe et al., 2005), although secure attachment is seen as providing a *resiliency* against later psychopathology, it is not an *immunizing* factor. Therefore, one would expect to find some representation, however minimal, of Secure/Autonomous narratives in the present study.

Of note here also was the small number of participant narratives suggestive of secure attachment despite reported or documented histories describing clearly insecure early attachment experiences; in keeping with past practice, these participants were assigned classifications of “earned or acquired secure.” (The factors likely mediating the impact of past insecure attachment experiences on current secure attachment narrative structure will be discussed later this chapter.)

Also of note were the study participants whose narrative organization yielded an assignment to one of the insecure classifications, but who had no identified abuse histories. This again demonstrates the complexity of the relationships among variables linking attachment and psychopathology or mental health; for participants of the present study, the absence of abuse did not insure against insecure attachment or hospitalization, while insecure attachment experiences in childhood did not dictate later insecurity of attachment narrative organization. Of course the role of neglect in the past histories of these patients, likely an influencing factor in attachment security if present, cannot be assessed because only confirmed abuse was documented in their hospital histories.

#### *Attachment and DSM Diagnoses*

The majority diagnostic category for this sample was Anxiety/Mood Disorder; that finding, when coupled with the high frequency of insecure attachment narratives

found in the sample, suggests a strong association in the present study between security of attachment and capacities for managing emotions. This finding is consistent with the literature to date, beginning with Bowlby's theorizing in the third volume of his trilogy (Bowlby, 1980/1982) and extending to contemporary researchers (Fonagy et al., 2001; Schore, 2001, 2003a, b; Sroufe, 1995) hypothesizing a direct impact of the attachment system on mediating subjective feelings of distress and capacities for affect regulation.

Those authors and others (Dozier, Stovall, and Albus, 1999; Jacobson and Miller, 1999) have found a strong association between the presence of major depression (in both parents and their offspring) and attachment quality. The association of psychological trauma with attachment insecurity is likewise well established. In this regard, it is notable that specific DSM disorders of MDD and PTSD were the two most prevalent Anxiety/Mood Disorder sub-types in the study sample.

Although not reaching the level of statistical significance, the higher representation of both Avoidant/Dismissive and Disorganized/Unresolved attachment narratives associated with the diagnostic category of attention/disruptive/impulse disorders is also consistent with most other research findings to date, the specifics of which will be discussed in the following section.

All of these findings lend support to the idea—implicit in Bowlby's theorizing, Ainsworth's field observations, Ainsworth and Main's laboratory work, and made explicit by contemporary attachment researchers—that attachment plays a direct role in influencing the individual's affect state and emotional experience. Current thinking strongly links attachment with the development of capacities to regulate affect and cognition. This study's data can clearly be interpreted in that light.

*Internalizing or Externalizing Psychopathology and Its Relation to Attachment Quality*

Studies have yielded mixed findings when examining the question of whether a particular attachment style is more prone to either an internalizing or externalizing psychopathology. (van Ijzendoorn and Bakermans-Kranenburg, 1997) However, a number of studies in this, and in closely associated areas (social competence; behavior and conduct problems; aggression, anger, and hostility) have shown findings that can easily be interpreted as consistent with findings of the present study.

The present study found higher frequencies of participants with narratives suggestive of Avoidant/Dismissive and Disorganized/Unresolved attachment carrying DSM diagnoses associated with externalizing psychopathology, the attention/disruptive/impulse disorders classification. With regard to symptoms precipitating hospitalization, all study participants admitted for risk of harm to others were in either the Avoidant/Dismissive or Disorganized/Unresolved classification. These findings seem to suggest that, at least for the present study participants, these two varieties of attachment classification carried an increased vulnerability to acting out, or externalizing psychopathology.

What has been ambiguous in past research was not whether insecure attachment styles were more strongly associated with externalizing problems than secure attachment (virtually all studies consistently demonstrate linkages between insecure attachment and externalizing psychopathology), but which of the insecure varieties of attachment were more predisposed to these conditions. Still, the strongest body of evidence drawn from direct studies of this question, as well as across studies of related areas (as identified

above), has shown the strongest associations between Avoidant/Dismissive and Disorganized/Unresolved attachment styles with externalizing psychopathology (impulse disorders, conduct disorders, disruptive behavior disorders) and social/interactional variables of hostility, anger, aggression, and behavior problems. (Allen and Land, 1999; Greenberg, 1999; Berlin and Cassidy, 1999)

Looking at this issue through the lens provided by examination of symptoms leading to hospitalization in the present study sample, if one accepts that being of imminent risk of harm to self evidences internalizing psychopathological processes while posing and imminent risk to others indicates externalizing processes, the present findings have some consistencies with previous related research: all of the sample patients admitted solely for being of imminent risk to others had narratives suggestive of either Avoidant/Dismissive or Disorganized/Unresolved attachment, thus supporting the notion that these attachment styles are more prone to externalization. On the other hand, this study also mirrors the ambiguity of past related research in that neither the “Avoidant/Dismissives” nor the “Disorganized/Unresolveds” exhibited *only* admitting symptoms in this category.

As mentioned previously, taken as group, narratives suggestive of Ambivalent/Preoccupied attachment status had a proportionately stronger association with hospitalization solely for posing a risk to self than did the other insecure attachment classifications. This suggests that, in the present study, Ambivalent/Preoccupied attachment representations carried with them a greater vulnerability to internalizing psychopathology, or aggression turned toward the self.

The ambiguous admitting symptom category of “risk of harm to self and others” could be seen as a bridge between predominant externalization/internalization strategies, or as a composite of both types of pathology. In this category, Disorganized/Unresolved narratives were the most represented, and this symptom constellation was the most frequent reason for hospitalization in that attachment classification. Although inconclusive, this data can be seen to suggest that the behavioral processes demonstrated by disorganized infants, in whom no coherent strategy for regulating attachment impulses can be found, may show some continuity with the Disorganized/Unresolved adolescents in this study who could not seem to find a coherent strategy for self-regulation by employing organized (principally externalizing or principally internalizing) psychopathological processes. Put more colloquially, and with some risk of oversimplification: while Avoidant/Dismissives self-regulated largely through aiming aggression outward, and Ambivalent/Preoccupieds self-regulated almost exclusively through aiming aggression inward, Disorganized/Unresolveds could not decide where to aim their aggression.

#### Limitations of the Study

No cross-validation studies have been done comparing attachment-style classification obtained through use of the present narrative analytic protocol with those arrived at by using the AAI; although face validity exists between these two methodologies, there has been no quantifiable validity established between the AAI and BABI, or between the narrative analytic protocol used in this study and that of the AAI.

The research sample in this study was not controlled for gender, race/ethnicity, or

age distribution of the adolescent participants (although comparative analysis of these variables does suggest the sample to be a good representation of the total inpatient adolescent population in the hospital that was the research site). Therefore, the research findings are not proposed to be representative of adolescents in general or adolescent psychiatric inpatients more specifically, at either the national or local levels. Rather, these findings provide data relevant only to the understanding of these particular research participants in this specific Midwestern, rural psychiatric acute care setting. No attempt should be made to generalize these findings beyond this sample.

Participants having DSM-IV-TR diagnoses of Mental Retardation, Asperger's Disorder, Autism, or any psychosis were excluded from this study, and thus, the findings offer no data applicable to understanding these patient populations.

Only the author conducted the narrative analysis to arrive at a tentative attachment style assessment, therefore no opportunity to establish inter-rater reliability for attachment style assignment was available.

A final limitation of this study is that, although sub-classification within each attachment style is possible, this was not done for the purposes of the present study because of the sample size and the decision to use statistical analysis as part of the study. Neither was the standard practice of "forced fit" of Disorganized/Unresolved narratives into a secondary attachment classification used in this study's methodology for the same reasons.

### Implications for Social Work Practice

As noted earlier, the profession of social work spans several practice domains

ranging from social policy development and advocacy (the macro level), implementation of those policies through job functions in various government agencies and bureaucracies (the meso level), and provision of direct services to individuals and families (considered the micro level of social work practice). With regard to the macro and meso levels of practice, this study does little but provide one more research validation for the major principles of attachment theory already articulated in previous research: that is, the need for social planning and policy that provides meaningful support to the establishment/maintenance of secure attachment systems (immediate and extended families or their surrogates).

What the present study does shed additional illumination on is of particular interest to members of the social work profession who practice in the micro domain of psychotherapy. These findings are especially relevant for clinicians working in mental health clinics and hospitals. The major implications of this study, therefore, are seen as most germane to social work clinicians.

#### Clinical Social Work from an Attachment Perspective

One implication of Bowlby's views regarding the role of the attachment behavioral system is that attachment relationships carry within them the ability to soothe emotional distress. A pattern of dependable, predictable, sensitive attachment experiences will, over time, build an unconscious expectation of what may be called "satisfaction through relating", and ultimately strengthen individual abilities to self-soothe in situations where there is a temporary absence of relational avenues. The adolescent participants in this study were sorely deficient in such capacities and abilities,

evidencing neither the consistent expectation of satisfying relationships, nor the acquired capacity to regulate their own distress. (This was best illustrated in the first two questions of the BABI which ask, “As a child, to whom did you turn when upset sick or tired?”, and, “Who did you feel understood you best as a child?” “No-one,” was a heartbreaking, but not uncommon reply.)

What, then, do these children need, and what can clinical social workers do to provide it?

An increasing body of literature (Schoore, 1999, 2003a,b; Sroufe, 1995; Fonagy et al., 2002) has highlighted the role of early attachment in shaping intrapsychic and interpersonal capacities for emotional processing, as well as influencing the very neurobiological underpinnings of such capacities. The findings of this study indicate significant problems, at least for some adolescents with narratives structures suggestive of insecure or unresolved attachment, in the related areas of affect regulation (as evidenced by the predominance of anxiety and mood disorders) and impulse inhibition (as evidenced by the frequency of sample participants having DSM diagnoses falling into that category). This suggests that an attachment-oriented re-visioning of psychotherapy would focus on the processes of affective co-regulation that occur within the therapy.

Support for this can be found in the evidence provided by the intersubjective phenomena encountered by the researcher and the participants during the interview process. As earlier discussed, strong affects were evoked within the participants by the stimulus of the interview questions, and reciprocal strong counter-transference reactions were provoked within the researcher. Exploration of the theoretical/clinical meaning to be mined from this data is beyond the scope of the present study. However, two

conclusions are immediately suggested:

1. The present research provides empirical evidence in support of a body of already extant clinical theory (for example, that of Donald Winnicott and Heinz Kohut) asserting the essential relevance of early primary relational experiences in shaping psychic organization and character structure.
2. Data available in this study lends strong support to the idea that *talking can be healing*; that is, that “talk therapy” in the context of an attuned empathic listener can offer an experience allowing for at least temporary relief of affective dysregulation and provision of co-regulatory psychic structure that can be internalized with repetition over time.

## Conclusions

### *When the Center Does Not Hold: Disorganization and Dysregulation*

The significantly higher prevalence of Disorganized/Unresolved narratives in this study gives evidence of the cost exacted by having no solid representational center to rely on. Narrative disorganization reflects incoherency of thought; incoherent cognitions provide no intrapsychic structure to buttress against affective flooding. As the ability to construct coherent and organized narrative reflects left hemispheric frontal cortex neurological processing (Schoore, 1999, 2003b), the ability to symbolize internal affective experience in language is indicative of the ability to think about our experience. This is what has been called “reflective function”, as contrasted with the quasi-instinctive right-hemispheric mid-brain function of reflexive affect-behavior chains. To reflect on, rather than reflexively react to, affective experience is the developmental achievement of the

mature human. It is an achievement unrealized for the sub-sample of Disorganized/Unresolved narratives in this study.

*Disorganized/Unresolved Attachment Representations:*

*Vulnerability to Psychic Breakdown*

Narratives analyzed as suggestive of Disorganized/Unresolved attachment representation were the largest classification in this study. As has already been stated, Goldberg's (1995) data estimates the prevalence of disorganized infants and unresolved adults both at 15-20% in the normal population; the representation in the research sample of this classification was twice that of the outer estimates in a non-clinical sample. So, whereas both the Ambivalent/Preoccupied and the Avoidant/Dismissive narratives found in this study were within estimates for a normal representation in a non-clinical sample, this was clearly not the case for the Disorganized/Unresolved classification.

These individuals were the most likely of the insecure attachment classifications in the present study to have been sexually abused or to have been both physically and sexually abused. The most frequent reason for hospitalization in this group was being a risk to both self and others and this classification was easily the most frequently represented in the risk to self and other category, which likely reflects their inability to reach a stable organization around either predominantly externalizing or predominately internalizing psychopathological processes.

Follow-up studies of infants classified as disorganized in their attachment behavior as they entered early childhood (school age), have found that the bizarre posturing or behavioral paralysis previously demonstrated had been replaced by

apparently more organized behavioral strategies meant to coerce or seduce attention from caregivers and peers. (Jacobvitz and Hazen, 1999) However, although their outward behavior had taken on a more organized appearance, their intrapsychic representations of attachment remained subject to disorganization and affective flooding. Whereas avoidant individuals suppress affect with cognition, and ambivalent individuals are affectively well developed but deficit in cognitive mastery, disorganized individuals have deficits in both affective integration and cognitive processing. (Crittenden, 1995.) Consequently, the Disorganized/Unresolved narrative structures found so frequently among participants of this study suggest that an underlying inability to both regulate affect and maintain linear and coherent thought processes functions to create a significant vulnerability for developing psychopathology during adolescence.

*Avoidant/Dismissives: The Cost of Schizoid Withdrawal*

Study participants whose narrative analysis suggested avoidant-dismissive attachment status were the second most predominant classification in the study (34%). This compares with Goldberg's (1995) prevalence estimates for avoidant infants at 20-25% and dismissive adults at 20-35% in the normal population. Thus, the prevalence of narratives suggestive of this attachment style in the present study is still within expected ranges—although approaching the outer boundary—for a normal population frequency.

Although more likely than any of the other insecure attachment organizations to have been admitted for being a risk to others, Avoidant/Dismissives were also represented in both the “risk of harm to self” and “risk to self and others” categories. Crittenden (1995) has pointed to the Avoidant/Dismissive individual's increased

difficulties in adjusting to the adolescent phase of development because of the increasing importance of being able to establish intimate relationships at this life-stage. She also has highlighted the imbalance in these youth toward cognition and away from affect, leading to defensive denial of emotion, and idealization of attachment figures that is incongruent with their actual lived experience. This situation creates a profound split between emotion and cognition, and over-burdens cognitive processing in absence of affective integration, with the result that situations provoking intense emotionality will consistently threaten to overwhelm coherent thought processes. This could account for the comparative over-representation of Avoidant/Dismissive narratives associated with violent externalizing pathology, as well as explaining the occasional internalizing symptoms; when coherent thought is overwhelmed, then one is left with reliance only on more unconscious defensive behavioral mechanisms.

*Ambivalent/Preoccupied Attachment: Less Risk of Acute Psychopathology?*

On the basis of the present study findings, it would seem that having an Ambivalent/Preoccupied attachment status posed less of a risk of acute care psychiatric hospitalization than did either Disorganized/Unresolved or Avoidant/Dismissive status. Recall Goldberg's (1995) data indicating the prevalence of ambivalent infants and preoccupied adults both at 10-15% in a normative population sample; the frequency of Ambivalent/Preoccupied narratives in the present study is, therefore, within the normal distribution that would be expected in a non-clinical sample. Thus, although the present study sample was within predicted ranges for prevalence of this attachment classification in the normal populace, it is less than might be expected for a clinical population.

It could be that Ambivalent/Preoccupied attachment organization, although ultimately unsuccessful in providing a template for satisfying, mutually regulatory and sustained interpersonal relationships, yet provides “good enough” internal representations that those individuals with this attachment status are able to mediate their psychological distress without becoming so symptomatic as to require hospitalization. Unlike Avoidant/Dismissives, who turn away from relationships in times of psychic distress, and Disorganized/Unresolveds, who cannot structure coherent internal representations to provide organized approaches to relational needs, the Ambivalent/Preoccupieds have not given up hope, have not turned away from relationship, and have been episodically successful in eliciting regulatory relational attending. Perhaps this allows the Ambivalent/Preoccupieds a modicum of affective integration and mastery that neither Avoidant/Dismissives nor Disorganized/Unresolveds have available.

An alternative possibility for explaining the comparative under-representation of Ambivalent/Preoccupied narrative organizations in this clinical sample is that, given the absence of tendencies for this attachment style to manifest psychic distress by acting out toward others in aggressive ways, perhaps these individuals are more successful at “staying below the radar”, and thus avoid the attention of others that might precipitate involuntary (as was the case with virtually all the study participants) psychiatric hospitalization.

*The Fascinating Outliers: What Do They Tell Us?*

Particularly interesting in this study were a small number of participants who could not be classified to an attachment style on the basis of their narrative analysis, and

a separate, equally small number whose narrative structure suggested a current secure attachment organization although their past histories (either by report, or documentation, or both) described clearly insecure or potentially disorganizing early attachment relationships. In the case of the former, narrative structures evidenced characteristics of different insecure attachment representations without falling clearly into one classification. (Perhaps these are the *truly* disorganized narratives?) In the latter case, all three of the participants, despite having documented or described histories of attachments that were clearly *not* secure-making (for example, in the most extreme instance the participant estimated that (s)he had been in over 100 out of home placements), the narrative structure as analyzed with the protocol used in this study suggested Secure/Autonomous attachment representations—a situation that traditionally has been addressed by assignment to the classification of “earned secure” (in the nomenclature of the current study, “earned or acquired secure”), reflecting the fact that these individuals had somehow achieved secure attachment representations in spite of their insecure pasts.

What is notable about the “earned/acquired secure” classified participants in this study is that, universally, they each had significant histories of long term psychotherapy or counseling. This suggests that the significant relationship constituted by the therapy alliance can allow for repair of attachment representation. However, the willingness to engage in ongoing psychotherapy/counseling may represent a non-quantifiable individual variable that plays a significant role in the remediation of past insecure attachments; that is, willingness to engage in therapy may be indicative of an unconscious hopefulness about relationship specific to the individual that is lacking in other cases of similar insecure attachment history.

Also notable with reference to this group, again universally among the participants, although each was able to maintain a coherent, organized, reflective narrative capacity in the controlled setting of the research interview (which likely carried associations to past therapy experiences), each participant described instances of behavioral dysregulation strongly suggestive of becoming disorganized in the face of intense emotional experience reminiscent of past trauma. In other words, the participants described current instances of behavior that, if observed in the interview setting, would likely have resulted in assignment to the Disorganized/Unresolved classification. This may mean that what psychotherapy offers the insecurely organized individual is the ability to reflect on and symbolize in verbal narrative past traumagenic attachment relationships while in the safe holding environment of a therapy session, but does not immunize an individual against affective flooding and behavioral dyscontrol when in a less controlled setting and exposed to stimuli reminiscent of prior trauma.

#### Areas of Further Research

One interesting offshoot of the present study would involve using a larger study sample that would allow for sub-classification of Disorganized-Unresolved narratives. The interest here would be in seeing what patterns might emerge regarding particular behavioral symptoms and diagnostic categories relative to each subtype of disorganization.

Many of this study's participants reported parental mental health diagnoses. Although not tracked specifically in the present study, an area of continuing research interest would be conducting a more detailed data collection in this regard to determine

whether any interesting patterns emerge correlating parental psychopathology with particular narrative quality, behavioral symptoms, and/or diagnostic categories in the adolescent children.

As the relationship of narrative classification with affect regulatory capacities came to be emphasized in this study, more detailed analysis in this area of inquiry would be both theoretically intriguing and potentially clinically useful.

1. Psychometric assessment could be conducted to identify possible patterns in affect regulation capacities among and between different narrative organizations.
2. Psychometrics could be used as pre- and post-test measures to determine the efficacy of various psychotherapy modalities and durations of treatment in modifying capacities for affect regulation in a clinical sample. Do participants with different narrative organizations respond differently to various types of psychotherapy? To different lengths of treatment? What modalities work best with which narrative organizations? Do particular therapies differ in their ability to improve affect regulatory capacities in patients? How is that change measured through psychological testing? Does psychometrics yield different “profiles” for different narrative organizations?

These are among the areas of further research suggested by the present study.

## Falcons, Falling:

### Reflections of a Surrogate Falconer

The gyre flown by our adolescent falcons continues to widen . . . they still cannot hear the falconer. Or, hearing, find in the voice no beacon to home on but something confusing, frightening, a source of panic and disorientation. Some hurtle to the ground; some collide in the air; some others, a few, fly free for a while longer before finding themselves lost in the next storm. These falcons need their falconers.

For a brief moment in the context of their young lives, the author had the immense privilege and responsibility of becoming a temporary surrogate for the missing falconers. In that moment, he was gifted with the opportunity of offering to them something one suspects was rarely or never reliably available to them before; the experience of being able to tell their stories in the presence of a caring and non-intrusive Other; the experience of mattering to someone, if only for an hour, and of being able to offer something of importance that would contribute to the life of another.

A final note to all who come after in assuming the role of clinician-researcher: only a clinician could have done this study or one like it, and none but a clinician should try.

APPENDIX A(1)

PARENTAL PERMISSION FOR PARTICIPATION IN RESEARCH STUDY

## PARENTAL PERMISSION FOR PARTICIPATION IN RESEARCH STUDY

Institute for Clinical Social Work

Title of study: *Attachment Narratives of Adolescent Psychiatric Inpatients*

### What is the purpose of this research?

I am asking your teenager to be in a research study because we are trying to learn more about the possible connection between adolescent thinking about significant relationships, and problems in behavior or emotion. The goal of the research is to more fully understand how the attitudes of teenagers about relationships may influence later development. Your teen is invited to participate in this study because she or he is currently experiencing problems in one or both of these areas that necessitated admission to Royal Oaks Hospital. This study is being conducted by Curtis Hyde, MSW, LCSW, at the Institute for Clinical Social Work.

### How much time will this take?

This study will take about one hour of your adolescent's time.

### What will my adolescent be asked to do if I allow him/her to participate in this study?

If you allow your teenager to be in this study, he or she will be asked to answer questions about your teenager's attitudes and beliefs concerning relationships with parents and other significant people. The interview will be tape recorded. Your teen's medical records will be reviewed to determine the provisional diagnosis and admitting problems/complaints, but the information your teen provides in the interview will not become part of the permanent hospital record.

### What are the risks involved in participating in this study?

The foreseeable risks to your teenager from participation are limited to the inconvenience of having an additional clinical interview, and possible negative emotional responses to answering the interview questions. Some questions on the interview deal with issues of abuse, and may pose a significant risk of emotional reaction, *but* as these questions are similar to those which will be asked in various forms during the regular assessment process, additional inconvenience or negative emotional reaction will be kept to a minimum.

Hospital nursing staff, therapists, and psychiatrists will be regularly available to participating teenagers throughout the course of their hospitalization. In the unlikely event of emotional instability occurring as a result of participating in the interview, the teenager will be stabilized through a combination of psychotherapy and psychiatric intervention before they are discharged. Interviews like the one that will be used have been conducted over many years in a variety of settings with no report of significant negative reaction by participants.

A final foreseeable risk would be that of having your teenager's privacy breached. To protect against this risk, only the primary researcher will have access to information

identifying study participants, and that information will be kept on a password protected removable disk drive and either (a) in the possession of the researcher, or (b) in a locked file cabinet at all times. Audio recordings will be kept in a locked file cabinet prior to their magnetic erasure and physical destruction at the study's end.

What are the benefits of my teenager's participation in this study?

There will be no direct benefit to your teen for participating in this study. The research has a potential benefit to society in general by increasing the knowledge of clinicians about the role of attachment in influencing strengths against and risks for later problems in behavior and emotion, so that there may be a later benefit to other teenagers in treatment.

Can I decide not to allow my adolescent to participate? If so, are there other options?

Yes, you can choose not to allow your teenager to participate. Even if you allow your teen to be in the study now, you can change your mind later, and she or he can leave the study. There will be no negative consequences if you decide not to allow your adolescent to participate or change your mind later. Also, even if you give your permission, your teenager may decide not to be in this study.

How will my child's privacy be protected?

The records of this study will be kept private. In any report we might publish, we will not include any information that will identify your child. Research records will be stored securely, and only researchers will have access to the records.

Whom can I contact for more information?

If you have questions about this study, please contact Curtis Hyde at 606-647-2182, ext. 213, or 816-806-7648, or Dr. Joan DiLeonardi (dissertation chair) at this phone number (312) 726-8480 day or evening.

If you have questions about your child's rights as a research subject, you may contact: Daniel Rosenfeld, M.A., Chair of Institutional Review Board, ICSW, 200 N. Michigan Ave., Suite 407, Chicago, IL 60601, (312) 726-8480.

You will be given a copy of this information to keep for your records.

Statement of Understanding:

I have read the above information. I have all my questions answered.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Statement of Consent:

I permit my child to be in this study.

Child's Name: \_\_\_\_\_ Grade in School: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

APPENDIX A(2)

ADOLESCENT CONSENT FOR PARTICIPATION IN RESEARCH

ADOLESCENT CONSENT FOR PARTICIPATION IN RESEARCH  
Institute for Clinical Social Work

I, \_\_\_\_\_, agree to take part in the research entitled *Attachment Narratives of Adolescent Psychiatric Inpatients*. This work will be carried out by Curtis Hyde, MSW, LCSW under the supervision of Joan DiLeonardi, Ph.D.

This work is conducted under the auspices of the Institute for Clinical Social Work, 200 N. Michigan Ave., Suite 407, Chicago, IL 60601, (312) 726-8480.

**PURPOSE**

The purpose of this study is to see if there is any connection between the way teenagers think about important relationships and problems with feelings or behavior. The goal of the study is to better understand how the attitudes you have about relationships may affect you later in life.

**PROCEDURES USED IN THE STUDY AND THE DURATION**

The study will use an interview that asks questions about your attitude and beliefs about relationships with parents and other people who are important to you. The interview will take approximately one hour, and will be tape recorded. Your medical records will be reviewed to see what problems brought you to the hospital, but the information from the interview will not become part of the official record, or be seen by anyone in the hospital but the researcher, Curtis Hyde.

**BENEFITS**

There will not be a direct benefit to you from taking part in this study. The research might help other teenagers with problems like yours in the future by helping us understand how relationships affect problems in behavior and feelings.

**COSTS**

There will be no costs to you for participating in this study.

**POSSIBLE RISKS/SIDE EFFECTS**

The main risks to you from taking part in the study are 1) the bother of having to answer more questions about your thoughts, behaviors, and feelings, and 2) possibly being reminded of bad feelings from thinking about the answers to the interview questions. Since these questions are like ones you have been asked in the meetings with your therapist and psychiatrist, it is not likely that you will have a bigger problem with these questions.

Hospital nursing staff, therapists, and psychiatrists will be available to you the whole time you are in the hospital. If you do think your problems have been made worse because of answering the interview questions, the staff will help you feel better before you go home. Interviews like the one that will be used have been done for many years in many different kinds of places without problems being reported by people who answered the questions.

**PRIVACY/CONFIDENTIALITY**

Your taking part in this study will be strictly confidential. Results of the study will be made available to other professionals who work with teenagers, and might be published. Your identity will be kept private. Only the researcher will be able to tell what information in the study was yours; a secret code will be used so that only the researcher will be able to tell who gave the answers to the interview questions. Tape recordings, and written copies of the recordings, will be identified only by the secret code number. Both the recordings and written copies will be destroyed when the study is finished.

**SUBJECT ASSURANCES**

By signing this consent form, you agree to take part in this study. You have not given up any of your rights as a patient or released this institution from responsibility for carelessness.

You may cancel your consent and refuse to continue in this study at any time without penalty or loss of benefits. Your relationship with the staff of Royal Oaks Hospital or the ICSW will not be affected in any way, now or in the future, if you refuse to take part, or if you begin the study and then change your mind.

If you have any questions about the research study, you can contact Curtis Hyde (principal researcher) at 660-647-2182 (day) or 816-806-7648 (evenings), or Dr. Joan DiLeonardi (dissertation chair) at this phone number (312) 726-8480 day or evening.

If you have any questions about your rights as a research subject, you may call Daniel Rosenfeld, M.A., Chair of Institutional Review Board, ICSW, 200 N. Michigan Ave., Suite 405, Chicago, IL 60601, (312) 726-8480.

**SIGNATURES:**

I HAVE READ THIS CONSENT FORM AND I AGREE TO TAKE PART IN THIS STUDY AS IT IS EXPLAINED IN THIS CONSENT FORM.

\_\_\_\_\_  
Signature of Adolescent Participant

\_\_\_\_\_  
Date

I CERTIFY THAT I HAVE EXPLAINED THE RESEARCH TO \_\_\_\_\_  
AND BELIEVE THAT THEY UNDERSTAND AND THAT THEY HAVE AGREED  
TO PARTICIPATE FREELY. I AGREE TO ANSWER ANY ADDITIONAL  
QUESTIONS WHEN THEY ARISE DURING THE RESEARCH OR AFTERWARD.

\_\_\_\_\_  
Signature of Researcher or Designee

\_\_\_\_\_  
Date

APPENDIX B(1)

MODIFIED BRIEF ATTACHMENT BASED INTERVIEW

## **MODIFIED BRIEF ATTACHMENT BASED INTERVIEW**

Used with permission of the author, Jeremy Holmes, MD

### **Secure Base**

[As a child]

- To whom did you turn when upset, sick, or tired?
- Who did you feel understood you best as a child?
- Please give me five words that describe your relationship with your mother. Now I will ask you to give me an example that explains why you chose each word.
- Please give me five words that describe your relationship with your father. Examples.
- What was your most frightening situation or moment as a child? {Were you physically or sexually abused? If so, by whom?}
- How did you get comfort when you were frightened?

[Now]

- {How do you think the abuse affects your relationships now? How does it affect your feelings? How would your life be different if it hadn't happened?}
- What do you do when you are sick, depressed, worried, or tired?
- Who do you turn to when you are upset or troubled?
- What is your greatest fear?
- Who do you feel most relaxed and comfortable with?
- Do you ever feel cut-off and detached from people?
- Do you ever feel so frightened of people that you avoid them?
- Do you ever fear that those you are close to will leave you? Does this ever cause you to cling to them even though they may find it irritating?
- Is there a basic pattern to your close relationships? (Maybe you as the peacemaker, or the one who has to give in, or the one who has to be strong, the one who takes care of everyone else, or the one who has to be taken care of.)
- In close relationships do you tend to comfort, or be comforted, or does it happen both ways?

### **Exploration, Fun, Companionship**

[As a child]

- What did you find funny, exciting, amusing?
- What was your biggest adventure?
- Who did you associate with fun and excitement?
- What were you mainly interested in doing?

[Now]

- What is your idea of having a good time?
- What are your main interests?
- How do you spend your spare time?
- Who would be a good person to have an adventure with?
- What would you really like to do if you could do anything you wanted?

## **Loss**

[As a child]

- Did you have any major losses, separations, or deaths?
- If so, how did you react? Did you cry? Mourn? Talk to a comforting person about your feelings? Ignore your feelings?
- Did you ever run away or leave so that you parents did not know where you were?

[Now]

- What have been the most difficult losses of your teenage life—deaths, breakups with boy/girlfriends, arguments with friends, getting suspended or expelled from school?
- How have you reacted to loss? How do you cope?
- What loss do you fear most? How do you think you would react if that happened?
- How easy do you find it to express your feelings when you feel disappointed, hurt, or sad?

## **Healthy Protest—Anger and Assertiveness**

[As a child]

- What happened when you felt upset or mad?
- Who took these feelings seriously and listened to you?
- Did you have temper tantrums or “go off”? If so, who provoked you?
- Were you able to say “no” to things you didn’t want?
- Could you ask for what you wanted and expect at least to be listened to?

[Now]

- Describe an incident or an example of a time when you felt angry. What happened? What did you do?
- If a friend or your parents do something to upset you, how do you react? (For example: overt anger, rage, sulking, go quiet, secret revenge, feel miserable and do nothing.)
- Are you able to ask for what you want from those closest to you?
- Do you ever feel abandoned or let down? How do you handle this?
- Has aggression ever caused major problems for you? (For example: trouble in school, lost friends, trouble with the law.)

- Do you ever feel used or mistreated, taken advantage of, by other people, especially those close to you?

### **Internal Working Models (buttons and triggers)**

[As a child]

- Describe two or three important memories of situations that are typical of yourself and your family—like a family vacation, your first day at school, Christmas.

[Now]

- Describe a situation that is a good example of problems you have with friends or parents. Make sure you include how you behave, how others behave toward you, and how you react to these situations.
- Describe a typical “button” for you, and try to think of the labels that would fit its inner and outer sides.

### **Reflective Function and Autobiographical Competence**

[As a child]

- How would you have drawn a picture of or described you and your family? Draw a picture as you would have seen them when you were 5 and 10.
- How would you have described a family event such as Christmas, a birthday, a party, or a funeral?
- Who was (is) your favorite famous person (music star, historical figure, athlete, actor)? What do/did you find special about them?

[Now]

- Describe a happy and unhappy memory from childhood.
- Talk about your hopes for yourself and your family.
- Describe a typical day now. What do you find interesting and fun? What do you find boring, depressing, or worrying?
- Think about how you deal with problems. Are you the kind of person who would rather not think about it, or are you someone who can't leave things alone?
- How would you like things to be different in your life? How would your typical day be different than now?

APPENDIX B(2)

NARRATIVE ANALYTIC PROTOCOL  
GRICE'S MAXIMS

Narrative Analytic Protocol  
Grice's Maxims

QUANTITY:	1. As informative as necessary.	+	-
	2. Not more informative than necessary.	+	-
QUALITY:	1. Does not say what believes to be false.	+	-
	2. Does not say what lacks adequate evidence.	+	-
RELATION:	1. Be relevant.	+	-
MANNER:	1. Avoid obscurity.	+	-
	2. Avoid ambiguity.	+	-
	3. Be brief.	+	-
	4. Be orderly.	+	-

Suggested Attachment Style/Grice's Maxims Correlations (Main, 1995)

Secure/Autonomous = Positive for all.

Avoidant/Dismissive = Negative for quality (generalizations lack evidence, or examples contradict representation).  
Negative for quantity (too brief).

Ambivalent/Preoccupied = Negative for manner (vague, ambiguous, convoluted, not orderly).  
Negative for relevance.  
Negative for quantity (too long).

Disorganized/Unresolved = Lapses in reasoning or/and lapses in monitoring of discourse or/and lapse in reality testing; otherwise F, E, or Ds characteristics.

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