What is the link between insecure attachment, alexithymia and addiction in adolescence and the psychotherapeutic treatment options available?

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What is the link between insecure attachment, alexithymia and addiction in adolescence and the psychotherapeutic treatment options available?

Introduction

This extended literature based exploration will look at the subject of insecure attachment, alexithymia and addiction in adolescence and psychotherapeutic treatment options available. The reason for my choosing this subject matter is because of my own personal experience with relational attachment difficulties with my primary caregiver as a child and the subsequent addiction issues I struggled with as a young person and adult. As a trainee child and adolescent psychotherapeutic counsellor, and person in long term recovery, I am also increasingly aware of my own struggles with alexithymia and this created a wondering as to whether there was a link between insecure attachment type, alexithymia and addiction that starts in adolescence and persists into adulthood? The larger question that this then prompts, which is too big for this piece of work, is if I had experienced restorative relational therapy as an adolescent and been able to work on and overcome my alexithymia would my addiction have been stopped from developing or reduced in severity? Within this assignment I will explore and critique the literature around the three distinct subjects of insecure attachment, affect regulation and alexithymia and addiction in adolescence and how one may lead to and influence the other. Then I will explore the psychotherapeutic treatment interventions currently available and look at potential future areas for research development and any study limitations. I am aware of extensive literature looking at the subjects in adults but was less aware of research pertaining to children and adolescents so this study is both to inform you and help me learn more about this specific and important, but apparently under researched, area of psychotherapeutic counselling need. It feels appropriate to focus first on attachment and then affect regulation and alexithymia and the relationship between the two and then finally on addiction and how alexithymia impacts this issue in adolescence before the treatment interventions and conclusion.

Literature searches were carried out on PsycINFO using the search terms, insecure attachment and addiction, insecure attachment & alexithymia and alexithymia and addiction. Books searches were done at the Education Library regarding affect regulation. Emails were sent to key researchers in the field asking for their input and an approach was made to the local Child and Adolescent Substance Abuse Service (CASUS) for Cambridgeshire. This is an increasingly rare and unusual Child and Adolescent Mental Health Service (CAMHS) but I had been lucky enough to have some training from them in a former role so
had their contact details. All were hugely helpful and supportive with their time and advice which I have included as part of this literature review. As a person in long term recovery from substance misuse I already owned some of the key texts and had read around the subject as part of my recovery process. So with that in mind I will first review attachment looking particularly at insecure attachment.

**Attachment**

It is both interesting to me and informative that attachment theory has formed a thread that has woven itself through all the three pieces of work I have completed this year as part of my Post Graduate Diploma with the University of Cambridge. It suggests that I am still actively working on understanding the impact that this has had on me both personally and in terms of its resonance for the young people I will meet as a child and adolescent counsellor. Its importance within child and adolescent psychotherapeutic counselling should not be underestimated. That said there has been an ongoing debate within psychology regarding nature vs nurture as discussed by Sroufe and Siegel in their paper ‘The verdict is in – the case for attachment theory’ (2011). Within this piece of research they curated many of the ‘hard-nosed academics and researchers who’ve remained unconvinced’:

‘Back in 1968, psychologist Walter Mischel created quite a stir when he challenged the concept that we even have a core personality that organises our behaviour, contending instead that situational factors are much better predictors of what we think and do. Some developmental psychologists, like Judith Rich Harris, author of The Nurture Assumption, have gone so far as to argue that the only important thing parents give their children is their genes, not their care. Others, like Jerome Kagan, have emphasised the ongoing influence of inborn temperament in shaping human experience, asserting that the effect of early experience, if any, is far more fleeting than is commonly assumed.’

So attachment theory, what is it? The central tenet of attachment theory is that babies and children learn about the world in a relational way. Bowlby (1973, 1988) believed that it was a child’s relationship with their primary care giver that set the template in their minds about how relationships worked. This template is known as the ‘internal working model’ (IWM). The IWM has three elements: a model of self, a model of ‘other’ and a model of the relationship between these.

Another attachment researcher and theorist Mary Ainsworth then developed the attachment theory further by identifying the three different types of attachment categories and
developing a standard method for assessing attachment in infants aged around 1 year old, known as the Strange Situation. This became the ‘gold standard’ laboratory technique for attachment research (Ainsworth et al, 1978) still now widely used to study the influences on attachment and its developmental consequences. Ainsworth observed that, although there were some important differences in how children behave when they are separated from their mothers, it was during reunions after separations that differences between children’s behaviour were most evident.

According to attachment theory, these three different types of attachment category show the main forms that a child’s IWM can take and are divided into. These different types are: insecure avoidant attachment (Type A), secure attachment (Type B) and insecure ambivalent attachment (Type C). A fourth category was also added by Main and Solomon (1990) called disoriented or disorganised attachment (Type D). Each type of attachment is associated with a different IWM of self, other and the relationship.

Because it was believed that IWM’s were enduring beyond childhood and continuous across generations, there was an expectation of an association with an adult attachment type. An Adult Attachment Interview (AAI) was developed by Main and others (George et al, 1985, Main and Goldwyn, 1994) to assess an adult’s ability to integrate early parental relational memories into an overarching working model of relationships. The narratives for each type of attachment were therefore predicted to align with the attachment type and fell into one of three narrative categories, classified as dismissing, autonomous or pre-occupied. The logical predictions were that Type A insecure avoidant presented with a dismissing narrative and therefore adult attachment classification, Type B secure attachment with an autonomous narrative and Type C insecure ambivalent with a pre-occupied narrative. Because this literature review focuses on adolescents it is important to highlight that there is an adolescent version of the Attachment Style Interview (ASI) (Bifulco, Moran, Ball, & Bernazzani, 2002), an investigator-based interview which uses a contextualised, support-focused approach to assess current interpersonal behaviour and attitudes.

Within this piece of work I am going to focus on the Type A insecure attachment type as this reflects my attachment style as to try to explore all types of attachment is beyond the word limit of this research review. With an insecure attachment bond the IWM consists of negative representations of the self and the other and therefore hampers the development of self-confidence and emotional-regulation (Oskis et al, 2013). These adolescents expect unavailability or insensitivity from their primary carers and consequently develop insecure strategies of either avoidance or anxiety for trying to cope with their distress (Mallinckrodt & Wei, 2005). These strategies could be considered ‘self-soothing strategies’ and are
misguided attempts to organise affects and internal states meaningfully (Goodsitt, 1983) and this definitely resonates with my experience. The personal therapist I have had this past year is a specialist in family, trauma and addiction and her role and therapeutic presence have been vital in my own reparative work around attachment. She has consistently role-modelled a secure attachment so that I have been able to learn to relate and experience this. I am confident that this will help my ability to provide a restorative relational presence around the children and adolescents that come to see me as a trainee child and adolescent counsellor as it has already begun to impact on my relationship with my own children.

When looking at attachment and addiction there was an excellent review on attachment and adolescent substance misuse which looked at the empirical evidence and implications for prevention and treatment. By Schindler and Broning it was published in 2014 and recognised that to date the role of attachment in developing substance use problems is understudied therefore research linking insecure attachment with Substance Use Disorder (SUD) is limited. They also acknowledge that interventions for SUD in adolescence are of special importance because they can help to prevent long-lasting addictive disorders and so supported my initial wondering.

They define attachment as a ‘motivational, behavioural, and interactional system that provides security’ (Schindler & Broning, 2014). At the same time, this security in attachment is the base for explorations of both the external world and the child’s own inner world and that of others, therefore learning the ability to ‘mentalize’ (Bateman and Fonagy, 2012) and for gaining a coherent picture of mental processes. Within attachment at adolescence Schindler and Broning report that ‘longitudinal as well as cross-sectional studies have shown that dismissing-avoidant attachment is linked to externalizing disorders, whereas preoccupied attachment in adolescence is linked to internalizing disorders’ (2014). They report that recent multilevel analyses have identified 2 prototypic pathways to SUD. The externalizing pathway (Zucker et al, 2011) is characterised by a tendency toward disinhibited behaviour leading to risk-taking behaviour in adolescence. The internalizing pathway (Hussong et al, 2011) is characterised by impaired emotion regulation capabilities from early childhood on, possibly leading toward the desire to self-medicate when facing negative affect. They found that all studies in the review showed a link between insecure attachment and SUD and concluded that meta-analytic calculations and 2 longitudinal studies show that insecure attachment was a risk factor for substance abuse. They argued that the closeness of attachment and substance abuse was also ‘underpinned by animal studies, which showed that psychotropic substances (especially opioids) had a strong impact on brain circuits regulating attachment processes’. Based on this data they felt that substance abuse in
adolescence could be understood as an attempt to regulate affective states, as a means of self-medication for individuals with insecure attachment.

Research by Schore & Schore (2008) argued that Bowlby’s fundamental goal was the integration of psychological and biological models of human development. In their words:

‘The recent interest in affective bodily-based processes, interactive regulation, early experience-dependent brain maturation, stress, and nonconscious relational transactions has shifted attachment theory to a regulation theory. This emphasis on the right brain systems that underlie attachment and developmental change has in turn forged deeper connections with clinical models of psychotherapeutic change, all of which are consonant with psychoanalytic understandings.’

Thorberg et al (2010) argued that attachment theory could be conceptualised as an affect regulation theory also, proposing that attachment was associated with the expression and recognition of emotions as well as interpersonal functioning. In the words of Kraemer and Loader (1995) from the Tavistock, London: ‘An insecure attachment may lead to a failure to learn how to feel, setting the stage for an alexithymic personality.’ Further research by Thorberg et al (2011a) completed the first meta-analysis of parental bonding and alexithymia and their findings confirmed an especially strong association between maternal care and key elements of alexithymia. Attachment theorists regard affect regulation and the quality of attachment as closely linked so this is what I will explore next – affect regulation and alexithymia.

Affect regulation and alexithymia

My academic joining of the interlinking subjects of affect regulation and alexithymia feels primitive and unsophisticated and reading some of the literature around the neurobiology of attachment I feel very out of my depth at times. Stephen Porges in The Polyvagal Theory (2011) draws on many other researchers linking the right hemisphere with the expression, interpretation and regulation of emotion and cites several investigations that have argued the right hemisphere provides the primary control of emotion. One such survey of studies by Silberman and Weingartner (1986) suggested superiority of the right hemisphere in recognising emotional aspects of stimuli. They proposed that right hemisphere dominance for emotion regulation reflected a nervous system organisation that gave priority to avoidance or defensive mechanisms that had a high survival value. Porges also argues that vagal tone and the vagal system might provide a ‘physiological metaphor’ (Porges, p143) for the regulation of emotional states as show in the study of 3 month old infants by Huffman et al (1998). The polyvagal theory of emotion proposes that ‘the evolution of the autonomic
nervous system provides the organizing principle to interpret the adaptive significance of affective processes.’ (Porges, p 152)

Schore’s interpretation helps build on my understanding of Porges’ work providing further windows of insight that help light the way as this summary shows:

‘In keeping with the principle that the right hemisphere develops before the left, the early language that appears in the second year represents the output of the right hemisphere. The socioaffectively-driven expansion of language in the service of the right hemispheric cognition thus mediates the development of self-regulation through private speech that is, thought. Thought originates in silent imaginal dialogs that represent the child’s autobiographical narrative construction of his affective transactions in the world. Maternal stress regulating verbalizations are also internalised into the multi-modal interactive representations that encode the self-caring functions of evocative memory. The child who is deprived of such affective communication experience in this critical period is in danger of developing the regulatory disturbance of alexithymia’ (Schore, p489).

So for me my primary care-givers negative and angry responses to my expressions of self and my needs, cognitively and affectively encoded for me a physiological and emotion message that I was not wanted and a nuisance. This translated into a negative sense of self and inability to self-care because I believed I was not good enough. But equally I was unable to express this because I did not have the words and felt I didn’t have the right to express it and was left unable to self-sooth this as I had not been role-modelled this either. Hence I related in an anxious and avoiding manner because this felt safer. Schore goes on to say:

‘Taylor (1987) concludes that deficiencies in the early mother-infant relationship result in an alexithymic deficit associated with a limitation of symbolic function and an impaired capacity for self-regulating emotional states and physiological functioning when under stress. It is tempting to speculate that this relational environment also generates high levels of unregulated shame, and that shame, an affect that uniquely causes a 'loss of words' (Izard, 1991) always accompanies alexithymic syndromes’ (Schore, p485).

This resonated very strongly with me and expressively encapsulates my felt sense of shame, creating a loss of words which is both a feature of alexithymia and a result of traumatic early attachment relationships. Schore goes on to quote researcher’s such as Kaufman (1992) who argued that shame can ‘bind individual affects such as fear, distress, anger or even
positive affects’. To me this suggested that those that had had some positive relational experiences in their early attachment relationships may have developed what he called ‘focal’ alexithymic deficits where specific affects were ‘silenced’ and could not be identified and verbally labelled. I feel this strongly around the emotion of anger in particular as this was not a tolerated emotion in my family of origin in its direct expression and therefore was expressed in a more damaging passive-aggressive manner. I have been reclaiming the ability to express healthy anger during personal therapy as part of my own re-connecting with my previously alexithymic self. Schore expressed this so eloquently by quoting Kaufman (1992) as saying ‘returning internalised shame to its interpersonal origin with an empathetic focus on the child who experienced it’. I am hoping to mirror this empathetic focus in my practice as a trainee child and adolescent counsellor as it has been role-modelled to me in personal therapy.

So what is alexithymia? De Haan (2012) writes that alexithymia refers to the difficulty in identifying and describing feelings, the inability to discriminate between feelings and physical sensations, having a limited fantasy life and the inclination to an externally oriented way of thinking (Sifneos, 1973). Externally oriented thinking can be described as concrete, realistic, logical thinking, often to the exclusion of emotional responses to problems, and is resonant of the dismissing narrative identified in AAI and linked to the avoidant attachment style. Alexithymia is typically measured using the Toronto Alexithymia Scale (TAS-20; Bagby, Parker, & Taylor, 1994) which worldwide is the most frequently used assessment instrument. It includes three factors: (1) difficulty in identifying feelings (DIF), (2) difficulty in describing feelings (DDF) and (3) externally oriented thinking (EOT) (Bagby et al, 1994). There is an alexithymia questionnaire for children, which is based on the original Toronto Alexithymia Scale 20 that assesses alexithymia in adults. The Alexithymia Questionnaire for Children consists of 20 items that represent the same three factors with the item response format being: not true, a bit true, true (Rieffe et al, 2006).

There has been some critical evaluations of the validity and reliability of the TAS-20 scale (Kooiman et al, 2002). Thorberg et al (2016) considers it a trait-like risk. Other researchers such as de Haan et al (2012) consider it not a stable personality trait and ask the question ‘state or trait?’ Bagby and Taylor went on to suggest that there may be two kinds of alexithymia, ‘primary alexithymia’ which is an enduring psychological trait which does not alter over time, and ‘secondary alexithymia’ which is state dependent and disappears after the evoking stressful situation has changed. These two manifestations of alexithymia are otherwise called ‘trait’ or ‘state’ alexithymia (Taylor, 1997 p37). The researchers concluded that the findings suggested that alexithymia in SUD patients is both a state and trait
phenomenon (de Haan, 2014). A multimodal investigation of emotional responding in alexithymia by Luminet et al (2004) describes ‘the personality construct of alexithymia is thought to reflect a deficit in the cognitive processing and regulation of emotional states.’ They found that facets of the alexithymia construct were associated with lower emotional responses at the cognitive-experiential level, but with higher emotional responses at the physiological level as measured by heart rate, which also resonates with Porges Polyvagal Theory.

This raised the question in my mind that if alexithymia can be considered both an emotional stress state and stable personality trait how does this fit with attachment theory? The TAS-20 uses psychometric testing and how does this assess attachment which is a relational phenomenon rather than an individual difference which personality trait is. Research by Abe and Izard (1999) completed a longitudinal study looking at emotion expression and personality relations in early development. They discussed just this issue acknowledging that it had generated considerable debate in developmental psychology. The question remains whether emotion expressions elicited during the strange situation procedure indexes individual differences in security of attachment or in temperament (e.g. Cassidy, 1994; Kagan, 1982; Sroufe, 1985; Vaughn et al., 1992). For me this remains a limitation as does the TAS-20 requiring some level of emotional insight to be able to complete as a self-report measure.

**Alexithymia and attachment in adolescence**

Research by Oskis et al (2013) was the first to look at alexithymia in female adolescents and the role of attachment style. This British study of 60 females ranging in age from 9 to 18 years found that features of anxious and avoidant insecure attachment styles were differentially related to the separate facets of alexithymia. Their research findings reported that the avoidant attachment style characteristic of constraining closeness predicted more difficulty in describing feelings (DDF) and having higher levels of the anxious characteristic of fear of separation predicted greater difficulty in identifying feelings (DIF). A more marked felt attachment to mother predicted less externally oriented thinking (EOT) and age was a significant independent predictor of overall alexithymia levels, as well as EOT. They found ‘of all the attachment style attitudes, fear of separation was the only significant independent predictor of total levels of alexithymia’ (Oskis et al, 2013). Once more my felt experience resonates with this finding as I experienced abandonment at around 9 months and therefore had a fear of separation which probably exacerbated my level of alexithymia. This research closely corresponded with earlier research by Meins et al (2008) where distance from
attachment figures would result in reduced emotional interaction and descriptions because there would be simply less opportunities to share emotional experiences. Therefore their findings were consistent with the view that ‘attachment avoidance involves constraining and deactivating emotional responses and evaluations’ (Griffin & Bartholomew, 1994). Oskis et al (2013) commented that ‘the constant act of thinking of oneself in relation to another, which is characteristic of fear of separation, would expectedly produce difficulty in identifying one’s own feelings’ and this feels like a true reflection of my experience. They conclude that their research indicates that features of anxious and avoidant insecure attachment styles are differentially related to the separate facets of alexithymia in adolescents. In particular, the findings concerning the anxious attachment construct of fear of separation may reflect the adolescent struggle for autonomy and the consequent effects on the affect regulation system. Which causes me to question whether this struggle for autonomy is part of the ‘normal’ developmental tasks of adolescence or whether this is a heightened struggle?

Having looked at the impact on female adolescents I then tried to find research to support the male perspective. I could only find one Italian study where they had researched insecure attachment and alexithymia in 100 young men with mood symptoms. Troisi et al’s (2001) sample group had a mean age of 20.3 years which indicated older adolescents within the cohort. They found that alexithymic traits were more pronounced in those with patterns of insecure attachment and who reported more severe symptoms of separation anxiety during childhood. Among the subgroup with insecure attachment styles, those with a preoccupied or fearful attachment style had a higher prevalence of alexithymia (65% and 73%, respectively) than those with a dismissing pattern (36%). Therefore their data suggested a role for early developmental factors in the aetiology of alexithymia. Having considered affect regulation and alexithymia I will now move on to looking at addiction, or substance misuse, as it is more commonly referred to currently.

**Addiction**

What is addiction? Foote et al (2014) in Beyond Addiction – A Guide for Families cite the Merriam Webster definition of addiction which is ‘a compulsive need for and use of habit-forming substance characterised by tolerance and by well-defined physiological symptoms upon withdrawal’ (p27). I would add from my experience that the withdrawal symptoms can be psychological and there is a set of affective symptoms frequently recounted within the recovery community called Post-Acute Withdrawal Syndrome (PAWS). Koob (2000) in his paper Neurobiology of Addiction describes that ‘withdrawal from drugs of abuse is associated with subjective symptoms of negative affect, such as dysphoria, depression, irritability and anxiety, and dysregulation of brain reward systems involving some of the
same neurochemical systems implicated in the acute reinforcing effects of drugs of abuse' which he argues is why ‘drug addiction is a chronic relapsing brain disorder characterized by neurobiological changes that lead to a compulsion to take a drug with loss of control over drug intake’. Also ‘animal models of craving involve not only conditioning models but also models of excessive drug intake during prolonged abstinence, post-acute withdrawal, that may reflect continued dysregulation of drug reinforcement that could lead to vulnerability to relapse’. Tommy Rosen in his book ‘Recovery 2.0’ (2014) defines addiction as ‘any behaviour you continue to do despite the fact that it brings negative consequences into your life’ (p3). This is why I feel resolution of this in adolescence would be such a powerful therapeutically beneficial outcome.

So before we move on to discuss the inter-relation of attachment, alexithymia and addiction I wanted to discuss the prevalence of substance misuse with the UK adolescent population and to ascertain this I have consulted the Association for Young People’s Health (AYPH) 2015 key data which is produced with the support of the National Child and Maternal Health Intelligence Network and Public Health England. As regards alcohol consumption they report that the latest data suggests that 61% of those aged 11-15 say they have never drank alcohol. Around one in eleven (9%) reported that they had drank alcohol in the last week and the majority of those were 14 and 15 years old of which there were slightly more males than females (25% compared with 19%). The average number of units drunk by those pupils aged 11-15 who drank in the last week has fluctuated in recent years although the overall trend has been down from 16 to 10 units in males and 13 to 9 units in females. This is the lowest rate at any time since the SDDU survey began in 1988 (HSCIC, 2014c).

Of note their data stated that ‘being drunk is a key indicator of alcohol misuse. HBSC reports that among the 10% of 15 year olds in the study who report being weekly drinkers, 83% of the boys and 57% of the girls had been drunk ten times or more in the last month’ (Hagell et al, 2015). This suggests there is a small group of young people who are not following the general trend of reducing consumption.

In older adolescents (16-24 years) according to the Opinions and Lifestyle Survey (OLS) in 2012 half of the age group (50% of men and 48% of women) reported drinking in the last week with two per cent drinking on five or more days in the week. However there is evidence of a fall over time in regular drinking in this 16-24 age group (Hagell et al, 2015)

They reported there was a considerable amount of data relating to substance and illegal drug use among young people and that overall, there had been a downward trend, with a fall from 41% to 26% for males, and from 36% to 22% for females. Concern often centred on
young people and polydrug usage as an indicator of particularly problematic use, although the data suggested that cannabis on its own was the most common drug used.

Flores (2004) argues that addiction was an attachment disorder. Gabor Mate (2008) believes that substance addictions are an attempt to self-medicate emotional pain – but he says importantly more than that, brain development was sabotaged by traumatic experiences such as poor attachment experiences with early care-givers. He also believes that addiction is a deeply ingrained response to stress in early life, an attempt to cope with it through self-soothing. He says ‘maladaptive in the long term, it is highly effective in the short term’ (Mate, p198). Interestingly research by Suh et al (2008) looked at how the type of drug chosen represented the need to address a particular impairment in affect regulation (Flores, 2004). Emotional repression was associated with alcoholism, restlessness predicted cocaine preference, and more angry or negative behaviour was predictive of heroin use.

Thus, Fletcher (2015) argued that the aetiology of addictive behaviour could arguably begin with an unmet need that fuels an individual’s attraction to a particular substance. Again my lived experience supports this statement and resonated very strongly. I attempted to numb and manage difficult emotions that I experienced around my primary care-giver with alcohol because environmentally that is what I had learned and had been role-modelled to me but equally because it was so effective in anaesthetising any felt sense attached to those thoughts, feelings and emotions. It allowed emotional repression for me. As alcohol is a legal, widely and readily available socially sanctioned drug I worry that this makes it an easy salve for emotionally discordant adolescents and so there is a need to ensure that we as trainee child and adolescent counsellors are aware of its potential to create further dysregulation for the young people who require our services.

Gabor Mate also writes about addiction:

‘The three dominant brain systems in addiction – the opioid attachment-reward system, the dopamine-based incentive-motivation apparatus and the self-regulation areas of the prefrontal cortex – are all exquisitely fine-tuned by the environment. To various degrees, in all addicted persons these systems are out of kilter. The same is true, we will see, of the fourth brain-body system implicated in addiction: the stress-response mechanism’ (Mate, p188)

Gabor Mate cites the Felitti et al (1998) published landmark research – the US Adverse Childhood Experiences (ACE) study which had a cohort size of 9367 women and 7970 men in which they found that:
‘Overall these studies provide evidence that stress and trauma are common factors associated with consumption of alcohol at an early age as a means to self-regulate negative or painful emotions.’ (Dube et al, 2002)

And these were within a relatively healthy and stable adult population where one third or more were graduates of college and most had at least some university education. With this in mind the literature reviewed has been mainly on adults as there is very little research on addiction in adolescence as regards substances, notably studies on cannabis usage in adolescents and young adults (Dorard et al, 2008) although there are increasing amounts of research on behavioural addictions, such as internet usage in late adolescents (Schimmenti et al, 2015)

Thorberg et al (2016) describes alexithymia as a trait-like risk factor for the development of alcohol use disorders. It is considered an affect-regulation disorder with a prevalence of up to 67% in alcohol-dependent populations (Taylor, Bagby, & Parker, 1997; Thorberg, Young, Sullivan, & Lyvers, 2009). He goes on to say that ‘few studies have investigated the absolute (whether mean scores change over time) and relative (extent to which relative differences among individuals remain the same over time) stability of alexithymia among men and women with alcohol dependence, or have considered potential underlying mechanisms’. Research by De Rick and Vanheule (2007) looked at the understudied relationship between perceived parenting, adult attachment style and alexithymia in a group of 101 alcoholic inpatients and observed that the avoidant attachment style was a strong predictor. They also tested whether three dimensions of alexithymia--affective, cognitive and social--were meaningfully linked to adult attachment and perceived parenting and noticed that cognitive alexithymia especially was predicted by the avoidant attachment style and a lack of warmth perceived in the relationship to the father.

Equally research by Thorberg looks mostly at alcohol use disorders and in the discussions he comments that comparatively other research in a psychoactive substance-dependent population revealed no mean changes in TAS-20 total DIF, DDF, and EOT scores (Pinard et al, 1996). Alexithymia’s presenting difficulties in identifying emotional states, distinguishing emotions and sensations, and expressing emotions using words (Sifneos, 1973) means it appears to be over-represented among subjects with substance-use disorders. Interestingly an Australian piece of research by Lindsay & Ciarrochi (2009) found that within their group of 40 adult newly abstinent substance abusers they reported having a deficit in emotional processing or alexithymia. However their actual performance on a task that required them to identify and describe feelings was not significantly different from either a group of university students (after controlling for IQ, age, and gender) or a normal group of adults. In addition,
there was no relationship between self-reported and actual emotional processing performance, which is contrary to what has been found in a normal sample leading them to conclude that substance abusers believe they are more alexithymic than others, but do not perform as if they are so.

A French study by Bonnet et al (2013) hypothesised that ‘it was possible that negative emotionality may lead to 'use' of alexithymia to alleviate negative emotions and that such a use of alexithymia may predict substance use’. The goals of their study were to confirm previous findings on the relationship between emotionality (negative emotionality and emotional arousal), alexithymia and substance use in young adults. The study looked at 256 university students with a mean age of 20.7 years old and found that their statistical analyses indicated positive links between the emotional dimensions of alexithymia, DIF and DDF, and substance use. The more difficulty individuals reported identifying and describing their emotions, the greater the likelihood of reporting substance use. Their findings stressed the importance of both of the emotional dimensions of alexithymia in substance use which seemed to correspond to the manner in which substance ‘consumers’ process their feelings, and have often been observed in studies of addicted patients (Speranza, Corcos, Stephan, Loas, Pérez-Diaz, Lang, et al, 2004). Emotion regulation can be useful in maintaining a form of psychic homeostasis which resonated for me with Porges Polyvagal Theory discussed earlier.

Professor Fred Thorberg is one of the key researchers into insecure attachment, alexithymia and alcohol use disorders in young adults having researched, written and published 20 papers in the last ten years. He argues that previous research had reported affect regulation difficulties in SUD and addiction has been considered an attachment disorder. However, he goes on to say that scarce empirical research exists on the relationship of attachment in relation to affect regulation and interpersonal functioning in those with substance use problems (Thorberg, 2010). He believes it is associated with an increased risk and severity of alcohol-related problems (Thorberg, Young, Sullivan, & Lyvers, 2009) and acknowledged there were several studies that had examined alexithymia in association with other risk factors for alcohol use including attachment.

Thorberg acknowledges that attachment difficulties are a key risk factor for the development of alexithymia and his research in 2011(b) looked at a sample size of 210 adult outpatients where they found significant relationships between anxious attachment and alexithymia factors. The research also highlighted that alexithymic alcoholics reported significantly higher levels of anxious attachment and significantly lower levels of closeness (secure attachment)
compared to non-alexithymic alcoholics. They felt that these findings highlighted the importance of assessing and targeting anxious attachment among alexithymic alcoholics in order to improve alcohol treatment outcomes.

He also completed an extensive critical review in 2009 of all the literature that had been written pertaining to alexithymia and alcohol use disorders where he noted that several authors have proposed that insecure attachment and alexithymia were broad risk factors for the development of alcohol dependence (Haviland et al., 2000, Taylor et al., 1997 and Vungkhanching et al., 2004). He also expressed that contemporary attachment theory considers addiction an attachment disorder (Flores, 2004) and evidence indicated that insecure attachment was associated with harmful drinking patterns (Brennan and Shaver, 1995, Burge et al, 1997, Cooper et al, 1998 and Ognibene and Collins, 1998) and alcohol dependence. He went on to say that alexithymic individuals were possibly using alcohol as a coping mechanism for emotional self-regulation (De Rick and Vanheule, 2007b, McNally et al, 2003, Thorberg and Lyvers, 2006 and Vungkhanching et al, 2004). De Rick & Vanheule, (2007b) found that alcohol dependent individuals with insecure attachment reported higher levels of ‘difficulties communicating their feelings’ compared to a more securely attached group.

Psychotherapeutic treatment interventions in adolescence:

The most elucidating research was that by Schindler and Broning. This was because not only did they share empirical evidence that strongly supported the assumption of insecure attachment in samples of adolescent substance abusers but because they went on to consider implications for treatment and prevention. These supported, confirmed and went beyond my instinctively hypothesised intervention ideal in the introduction.

Schindler and Broning felt treatment outcome should benefit from fostering attachment security so as to mirror a secure attachment. They recognised that adolescence was the most promising target age for early interventions that could prevent the development of long-term SUD.

They then outlined three basic approaches to integrate attachment aspects into state-of-the-art treatment of SUD:

1. The therapeutic alliance can be established in a way to become a correcting relationship experience that helps to develop more attachment security. This will often require specific engagement strategies that have to be adapted to the specific pattern of attachment.
2. Attachment-based approaches of individual treatment should be adopted for the treatment of SUD. To date, the most promising approach is Mentalization-Based Therapy (MBT, Bateman & Fonagy, 2012). This is exactly the approach used by CASUS in Cambridgeshire as when I approached the service their Consultant Psychiatrist shared with me their resources, which in the UK includes Adolescent Mentalization-Based Integrative Therapy (AMBIT, Bevington, 2012). These approaches focus on the vicious circle between insecure attachment, anxiety, and other negative emotions, a subsequent loss of mentalization, and substance abuse as a self-medication.

3. Family therapy approaches are of special importance. The family of origin is where attachment relationships develop and can most easily be transformed. Family therapy approaches for adolescent substance abuse are among the best-evaluated treatments (Rowe, 2012; von Sydow et al, 2008) They went on to outline two other explicitly attachment-based approaches, which had not at that time been used in the field of adolescent substance abuse: Mentalization-Based Family Treatment (MBFT, Asen & Fonargy, 2012) and Attachment Based Family Therapy (ABFT, Diamond et al, 2008). MBFT promotes mentalization in a family context and works in an attachment theory framework combined with family therapy setting. ABFT tries to re-establish lost emotional contact between depressed and suicidal adolescents and their parents and might be more easily adapted for youths on an internalizing pathway. It seems very possible to integrate aspects of MBFT and ABFT into family therapy approaches designed for adolescent substance abusers.

I was delighted to hear that AMBIT was being used locally within the CASUS team. Research by Bevington et al (2013) developed this approach for their ‘hard to reach’ young people who often presented with co-morbid mental health issues and may also have substance use disorders. AMBIT is described as an emerging team-based approach to working with highly troubled adolescents and young adults (Bevington & Fuggle, 2012; Bevington, Fuggle, Fonagy, Asen, & Target, 2012) that draws on and applies attachment theory at a number of levels. AMBIT is a mentalizing approach and as with other systemic approaches looks to nurture and scaffold existing constructive family or peer relationships and resiliencies in the young person's life.

The researchers used the term mentalization in the sense used by both neuroscience (Frith, 2007) and psychological therapy (Bateman & Fonagy, 2011), to refer to a form of imaginative mental activity about others or oneself, namely, perceiving and interpreting human behaviour in terms of intentional mental states (e.g. needs, desires, feelings, beliefs,
goals, purposes, and reasons). They argue that mentalizing – the function of coming to understand and communicate about behaviour (one’s own or that of others) in mental state terms is born in the context of an attachment relationship and is the key to social communication and the gathering of social information (Fonagy, Luyten, & Strathearn, 2011). A strong body of evidence (Fonagy, Gergely, Jurist, & Target, 2002) supports the notion that mentalizing is not a biologically heritable function. Bevington et al (2015) maintain that:

‘It develops in the context of attachment relationships, through a process whereby the infant iteratively experiences his/her own mental states being accurately understood and communicated by a trusted other, via imitative facial and verbal gestures. Through experiencing this other mind being changed through contact with (and understanding of) one’s own mind, self-agency, and mind-mindedness (of both one’s own and of others’ minds) develops’.

Within AMBIT robust outcome measurements are expected as a core part of practice, and tools are integrated within the manual as the ‘AMBIT Adolescent Integrative Measure’ (AIM) A goals-based approach to routine outcomes monitoring using the AMBIT AIM was started in 2012 in Cambridgeshire CASUS with some preliminary promising results. An uncontrolled pilot evaluation of 63 key problems identified at start of treatment in 15 cases indicated that 79% showed improvement at discharge, with 9 cases rated as having occasional or no use of alcohol or drugs at case closure.

I was also heartened to see that AMBIT is an ‘OpenSource’ approach to therapy and is strongly opposed to the notion that effective ways of working with adolescents could be turned into intellectual property or commodities. The AMBIT manual is freely available, and is built on developments from a wide range of fields. There are parallels between the OpenSource model of software development in computing and many of the ways that AMBIT is conceived of operating. The radical and award winning approach to treatment manualization encourages the development of local expertise and a ‘community of practice’ between the different teams using it, who can make use of ‘comparing and sharing’ functions in their locally adapted versions of the core AMBIT content (AMBIT, 2012) The notion that the work of Cambridge could benefit ‘hard to reach’ young people including those with substance abuse issues all over the UK because of the way this has been organised and structured is both radical and feels very much in the spirit of the relational work that we are doing as child and adolescent counsellors.

Schindler and Broning concluded that ‘to our knowledge, no attachment-oriented preventive programme for at-risk adolescents exists to date’ (2012) and this would be an area for future
development opportunities. Another study that was published very recently gave ideas for future research avenues also. It was looking at the relational pathways to substance misuse – the role of trauma, insecure attachment and shame. Brené Brown has done a great deal of research into shame, shame resilience and the correlation between shame and addiction (Brown, 2006) so further study would be insightful as for me guilt and shame were drivers for my addiction and my felt sense is that these buried emotions were also a hangover from childhood experiences.

There were limitations to the area of research as indicated by the use of the self-reporting TAS-20 tool to assess alexithymia that required some level of emotional insight and the ongoing debate about whether the attachment observation was recording a relational state or a personality trait.

Conclusion:

Oskis et al (2013) conclusion that ‘the presence of felt attachment and emotional and social support may act as buffer to developing an externally orientated cognitive style’ offers insight that if that experience could be role-modelled with a counsellor or specialist service team members during adolescence this may allow repair and integration and help mediate alexithymia. So both Schindler and Broning from an attachment and addiction standpoint and Oskis from an alexithymia and addiction standpoint concurred on the therapeutic value of secure attachment role-modelling through a counselling relationship. Bevington et al have then developed this further linking theory with clinical practice with the implementation of AMBIT within Cambridgeshire CASUS.

Fletcher et al (2015) argues that attachment-focused therapy for addiction treatment remains rare and that while altering an individual’s attachment style may involve longer-term treatment, longitudinal studies of current short-term substance abuse treatments suggest longer-term treatment may be necessary. Additionally, they argue that the costs associated with ‘healing attachment wounding may well be outweighed by the sustained, global benefits experienced by individuals, their loved ones and shared communities’. I would support this view and argue that investment in CAMHS, and particularly in CASUS, is a vital area of support required within the UK.

There were only four research papers (Oskis et al, 2013; Schindler and Broning, 2014 and Bevington et al, 2012 & 2015) that looked specifically at the issue of attachment and addiction or alexithymia and addiction in adolescents as discussed. This is definitely an under-studied area and the need for further research was supported by an email conversation between Professor Thorberg and myself during the research phase of this
assignment where I approached him regarding research pointers into the chosen subject area to which he replied “While I was working for the Centre for Youth Substance Abuse Research at UQ (University of Queensland, Brisbane, Australia) quite a few years back I was looking into this myself thinking about writing a review paper on the subject. However, like you I did not find much. I talked to a colleague of mine last year from Yale that was looking into this area as well and she did not find much either. As such, this is really an ‘open research area’ with very little having been done.”

What the four most pertinent research papers have supported and allowed me to tentatively explore is my initial hypothesis and wondering that if a young person experiences restorative relational therapy where secure attachment is role-modelled as an adolescent and is able to work on and overcome alexithymic states and traits would the addiction have been stopped from developing or reduced in severity? Their findings support this hypothesis but it must be acknowledged that further outcome research results are needed, although the preliminary results from Cambridgeshire CASUS are encouraging. As expressed by Bevington et al (2012):

‘A real priority is now to gather more robust evaluative evidence of effectiveness. The overarching goal is, of course, to divert desperate developmental and psychopathological trajectories toward more adaptive pathways, with a view to reducing the frequency and intensity of those outcomes that are most costly in terms of suffering and the financial implications of later treatment options’.

Within this assignment I have explored and critiqued the literature around the three distinct subjects of insecure attachment, affect regulation and alexithymia and addiction in adolescence and how one may lead to and influence the other. Then I have explored the psychotherapeutic treatment interventions currently available and looked at potential future areas for research development and any study limitations. This literature review and research study has informed and helped me greatly to learn more about this specific and important, but definitely under researched, area of psychotherapeutic counselling need. More importantly the discussions have indicated not only what further approaches may work to support young people with substance misuse issues but what are already working and in therapeutic use within CAMHS, and specifically CASUS, here in Cambridgeshire. It would be valuable for child and adolescent counsellors to have training in the skills used with AMBIT to support and complement other integrative approaches already being used as initial research into what the link between insecure attachment, alexithymia and addiction in adolescents suggests that the lack of positive attachment experiences, and the associated
emotional and social support, is the link and that providing a relational approach where a role-modelled secure attachment is experienced is a psychotherapeutically beneficial treatment approach.

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