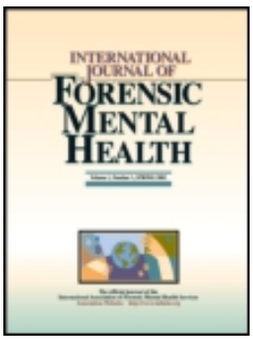

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Relational Pathways to Substance Misuse and Drug-Related Offending in Women: The Role of Trauma, Insecure Attachment, and Shame

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ABSTRACT

Dysfunctional relationships are highlighted as a potential mediator between women's substance misuse and offending, but few studies have explored how. This qualitative study explored the role of interpersonal relationships to substance misuse and offending in women, and underlying psychological processes involved. Seven women offenders in community treatment for heroin dependence were interviewed. Data were analyzed using social constructivist grounded theory. A provisional model was constructed of the interconnection between family disconnection, dysfunctional intimate partner relationships, loss of children, and substance misuse and drug-related offending, within the context of complex trauma, insecure attachment, and shame. The potential significance of shame to women's substance misuse and offending has had little prior investigation. Interventions for women offenders with heroin addiction may need to consider all these relational psychological processes to adequately address recidivism risk.

KEYWORDS

Female offenders; relationships; addiction; trauma; attachment; shame

Women are a marginalized and growing population in the criminal justice system (Sheehan, McIvor, & Trotter, 2007). In the United Kingdom this has prompted increased policy focus on women offenders' specific needs and risks, and how best to address these to reduce recidivism (Commission on Women Offenders [CWO], 2012; Corston, 2007). Substance misuse is a key criminogenic need (i.e., a treatable dynamic risk factors for reoffending; Bonta & Andrews, 2007) and offender rehabilitation treatment target across gender (Blanchette & Brown, 2006; Hollin & Palmer, 2006). However, research suggests that contextual and motivational gender differences for substance misuse may exist, particularly for drug use.

Empirical findings suggest that women's drug use commonly precedes their criminality, particularly property crime, whereas criminality more commonly precedes men's drug use (Light, Grant, & Hopkins, 2013; Loxley & Adams, 2009; McClellan, Farabee, & Crouch, 1997; Swan & Goodman-Delahunty, 2013). Compared to male prisoners, female prisoners have been found to have higher levels of drug dependence including more problematic drug use patterns (e.g., opioid dependence) prior to incarceration (e.g., Fazel, Bains, & Doll, 2006; Langan & Pelissier, 2001; Light et al., 2013; McClellan et al., 1997; O'Brien, Mortimer, Singleton, & Meltzer, 2001; Peters, Strozier, Murrin, & Kearns, 1997; Singleton, Meltzer, Gatward, Coid, & Deasy, 1998). Female prisoners also report higher rates of lifetime trauma experiences and emotional and mental health problems than male prisoners and women in the general population (e.g., DeHart, Lynch, Belknap, Dass-Brailsford, & Green, 2014; Fazel & Seewald, 2012; Grella, Lovinger, & Warda, 2013; Light et al., 2013; McClellan et al., 1997; O'Brien et al., 2001; Singleton et al., 1998). Substance dependence is strongly associated with childhood maltreatment, particularly neglect, in female prisoners (Mullings, Hartley, & Marquart, 2004), more so than in male prisoners (McClellan et al., 1997). More female than male prisoners also report using drugs to cope with psychological pain (Gutierres & Van Puymbroeck, 2006; Langan & Pelissier, 2001). Thus, the association between substance misuse and offending in women is likely complex and multi-dimensional, and may interact with various other factors to increase risk of recidivism (Hollin & Palmer, 2006; Salisbury & Van Voorhis, 2009).

Dysfunctional interpersonal relationships, particularly with family and intimate partners, have been highlighted

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as an important criminogenic need for women that may mediate their substance misuse and offending (Blanchette & Brown, 2006; Cobbina, Huebner, & Berg, 2012; Hollin & Palmer, 2006). However, the empirical evidence base for this is scarce and findings inconsistent, particularly in relation to adult women (Kreis, Schwannauer, & Gillings, 2014). Most quantitative studies on the association between relational risk factors and recidivism in women have failed to explore dynamic relationship processes and underlying psychological processes that may impact on offending (Kreis et al., 2014). Although qualitative studies have greatly informed understanding of female pathways to crime (see e.g., Bloom, Owen, & Covington, 2003), only few published qualitative studies have directly explored the role of relationships to recidivism in women offenders (Cobbina, 2010; Harm & Phillips, 2001; Leverentz, 2006).

Cobbina (2010) interviewed current and previously incarcerated women and found that unsupportive and negative social networks, particularly criminal family members and abusive intimate male partners, and lack of social support was particularly relevant to community reintegration failure. A similar study found that women's offending was directly related to their drug use, which was central to their relationships (Leverentz, 2006). Drug use introduction was commonly through family members, particularly parents, and drug addiction was commonly preceded by traumatic experiences and functioned as an escape from emotional pain. Abusive relationships with criminal and drug-addicted partners were central to women's ongoing addiction, and dynamically related to their desistance and recovery process. Although both studies are very informative, neither fully explored the relational psychological processes that may impact on women's substance misuse and offending.

One relational psychological process hypothesized to be relevant to substance misuse is insecure attachment (Flores, 2004). Attachment refers to a deep emotional bond between an individual and their primary attachment figure, for example between a child and parent, based on the need for security, safety, and protection (Howe, 2011). A primary function of the attachment system is to regulate affect (Padykula & Conklin, 2010; Schore & Schore, 2008). Within an *attachment theory* framework, substance misuse may develop as an affect regulation strategy where this ability has become impaired due to insecure attachment. This may result from a number of factors compromising the security, attunement, and consistency of the relationship between an infant and primary caregiver. Complex trauma, involving repeated exposure to multiple forms of relational traumatic stressors, is known to compromise attachment security and increase the likelihood of insecure or disorganized attachment styles developing (Courtois, 2004; Herman, 1992; Howe, 2011; Padykula & Conklin, 2010). Substance misuse exacerbates self-dysregulation and may lead to further relational discord, and to more substance use to cope (Padykula & Conklin, 2010). Some empirical support for this notion exists. Males and females with substance misuse problems have been found to present with higher levels of insecure attachment than non-substance misusing controls (e.g., Caspers, Cadoret, Langbehn, Yucuis, & Troutman, 2005; De Rick & Vanheule, 2007; Schindler et al., 2005; Thorberg & Lyvers, 2010). Findings are limited by the predominant use of self-report attachment measures and cross-sectional correlational research designs that cannot inform on causality. Yet, they suggest that insecure attachment may be relevant to substance misuse.

Adverse relationship experiences are also central to *relational theory*, which dominates the literature on women's substance misuse and criminal justice involvement (Covington, 2007; Covington & Surrey, 1997). The theory posits that positive human connectedness is a core need essential to healthy psychological growth across gender, but considers it particularly salient to women's sense of identity and self-worth. Relationship disconnection or violation is therefore thought to be key to women's psychological problems (Covington, 2007). Substance misuse is hypothesized to develop to cope with relational pain, as a relationship substitute or in an effort to maintain relationships (Covington & Surrey, 1997). Relational theory, together with trauma and addiction theories, underpin gender-responsive treatment programs for women offenders (e.g., Bloom et al., 2003). However, there has been little empirical investigation of this theory to women's—or indeed men's—risk of reoffending (Blanchette & Brown, 2006).

In summary, substance misuse may interact with other criminogenic needs, particularly dysfunctional relationships, to increase risk of recidivism in women offenders. Yet, the underlying psychological mechanisms for this remain unclear and underexplored (Hollin & Palmer, 2006). Insecure attachment (Padykula & Conklin, 2010) and relationship disconnections or violations may be implicated (Covington & Surrey, 1997). There is a need for more research exploring this, particularly research using qualitative research methodologies to capture the lived experiences of women offenders and aid conceptual understanding and theory development (Hedderman, Gunby, & Shelton, 2011). As most research in this area has been conducted in North America, studies examining the experiences of women offenders in other parts of the world are needed (Caulfield, 2012). This study explored a sample of Scottish women offenders' experiences of close interpersonal relationships in relation to their substance misuse and

offending behavior, and underlying psychological processes involved.

Method

Design

A qualitative research design was employed using Charmaz's (2006) social constructivist version of grounded theory, which encourages flexible application of grounded theory methods to enable further analytic innovation. Due to time and resource constraints the abbreviated version of grounded theory was used. That is, only original data were used and analyzed according to grounded theory principles, and a provisional model of understanding of the phenomenon was constructed rather than a substantial theory (Charmaz, 2006; Willig, 2008). Dey's (1999) notion of theoretical sufficiency was used rather than theoretical saturation. It refers to the point where sufficient categories have been suggested by the data to provide an adequate theoretical explanation. Social constructivist grounded theory posits that data is interpreted and theory constructed through the researcher's interaction with participants and the social context of both, and that "any theoretical rendering offers an *interpretive* portrayal of the studied world, not an exact picture of it" (Charmaz, 2006, p. 10). Researcher reflexivity is therefore important. This requires the researcher to be actively (e.g., through memo writing) aware of how their own social context, values, assumptions, prior personal and research experiences, and any power imbalance in the researcher-participant relationship unavoidably influence the research process, including the construction and interpretation of meaning from the data. Relevant contextual factors for the researcher (the first author) included her role as a trainee clinical psychologist working with marginalized people in substance misuse treatment and forensic mental health services, who present with high levels of trauma, and prior interest in and research experience with women offenders.

Participants and recruitment

Participants were recruited from community substance misuse treatment services within one Scottish National Health Board, primarily from court-ordered drug treatment programs. Inclusion criteria included women with previous criminal convictions, minimum age 18 years old, and English language proficiency. Exclusion criteria included learning disability, acute psychosis, and intoxication at consent or interview stage. At time of recruitment (November 2012 to June 2013) there were approximately 30 women in court-ordered drug treatment and 265 across generic substance misuse treatment services. Due to recruitment procedures (see below) the exact number of potential participants is unknown. Twelve participants were originally recruited; however, recruitment and data collection was challenged by the nature of the population, which is hard to access for research partly due to high levels of instability and treatment non-attendance, and by service issues (i.e., service redesign and high levels of staff absences at time of recruitment). Several recruited participants failed to attend for interview at least once and four became too unstable to participate post recruitment. Due to time constraints it was not possible to extend recruitment.

The total sample consisted of seven White Scottish women aged between 26 and 40 ($M = 34.14$, $SD = 5.0$). All participants were receiving Opioid Replacement Therapy (ORT) for heroin dependence through community drug treatment programs; five of them through court orders and two voluntarily (one of these had progressed to voluntary treatment from court-ordered treatment). The average time in (current) treatment was 10 months ($SD = 6.20$, range = 3–18). All participants had past and/or current criminal justice involvement. Number of self-reported previous criminal convictions ranged from 5 to 75 ($M = 26.42$, $SD = 22.94$). Acquisitive (theft and fraud) offenses were reported by all participants, with drug offenses the second most common type (reported by four participants). Four participants had previously been incarcerated, with average number of incarcerations 3.8 ($SD = 5.75$, range = 2–15) and longest time in custody ranging from 7 days to 12 months. None of the participants were currently married but three were in a relationship, and three reported being separated/divorced/widowed. Five lived in their own tenancy. All but one participant had children, most aged below 16 years old, but only two participants were the primary carer of their children. Five participants had completed secondary school, but none were employed and all were financially supported by state benefits. All participants self-reported experiences of childhood trauma (i.e., being physically, sexually, or emotionally abused or witnessing others being abused; suffering physical neglect; parental substance misuse or mental health problems; or having spent time in care), particularly of emotional abuse. Five participants reported experiencing multiple forms of trauma. Five participants also reported having experienced adulthood victimization (i.e., being physically, sexually, or emotionally abused or witnessing others being abused). All participants self-reported currently suffering from mental health problems (e.g., anxiety or depression).

Measures

Semi-structured interview schedule

Participants' experiences of close interpersonal relationships in relation to their substance misuse and offending behavior were explored using a semi-structured interview schedule (see the Appendix). This was designed for the purpose of the study according to grounded theory method and recommendations by Charmaz (2006). That is, the interview schedule was brief and relatively general, with the use of open-ended questions and prompts (e.g., 'describe your relationship with people closest to you when you first started using drugs/when you were last in trouble with the police'), to allow participants to tell their own stories and for unanticipated material to emerge from the data. The interview commenced and ended with more neutral questions about participants' drug treatment to allow for rapport building and sensitive interview closure.

Background information form

A background information form, designed for the purpose of the study, was used to collect demographic self-reported information about, for example, age, marital status, housing, offending history, trauma experiences, and mental health.

Ethical considerations

The study was approved by the National Health Service (NHS) East of Scotland Research Ethics Committee and the local NHS Research and Development Office. Participation was voluntary and confidential within standard clinical guidelines, with interview data anonymized and stored according to the Data Protection Act. The researcher (first author) was transparent to participants about her dual role as a doctorate student and trainee clinical psychologist in the substance misuse treatment services. None of the participants were or had been seen for psychological therapy by her or any of the other authors.

Procedure

Eligible participants were identified by clinical treatment staff and provided with verbal and written information about the study from their keyworkers. They were given at least 24 hours to decide if they wanted to participate. Interviews were conducted by the first author either before or after keyworking sessions at substance misuse service premises. Interview sessions were tied in with keyworking sessions for the participants' convenience and to try to maximize interview attendance. Participants completed a consent form and a background information form (self-reported demographic information about, e.g., age, marital status, housing, offending history, and trauma experiences), with support from the researcher if needed. All participants were interviewed once. Interviews lasted on average 34 minutes ($SD = 13.27$, range = 15 to 52 minutes; note that only one interview lasted 15 minutes only). They were recorded using a digital voice recorder and transcribed verbatim by the first author.

Data analysis

Transcribed interviews were analyzed using grounded theory methods following guidelines by Charmaz (2006). NVivo Version 10 software (Qualitative Solutions Research, 2012) was used to aid analysis. Transcripts were initially line-by-line coded, with common codes organized into higher-order categories. Themes were discovered and constructed through constant comparative analysis of codes and reflective memos written during data collection and analysis process. Iterative coding was also used whereby initial codes were re-examined for fit to broader themes. To ensure internal validity the fourth anonymized interview transcript was cross-coded by a consultant clinical psychologist (the third author) supervising the first author's clinical work. Themes were also cross-validated through a second literature review.

Results

The themes discovered in the data suggested that participants' substance misuse and offending was related to adverse relationship experiences. Two themes related to participants' substance misuse pathways: *Traumatic early experiences/dysfunctional parenting* (subthemes: abuse, parental substance misuse, parental rejection/absence/abandonment, lack of parental affection) and *Dysfunctional intimate partner relationships* (subthemes: abusive relationship, substance misusing partner). Three themes related to participants' offending pathways and recidivism: *Family disconnection* (subtheme: loss of family support), *Dysfunctional intimate partner relationships* (subthemes: abusive relationship, shared addiction, partners in crime), and *Losing a child*. Substance misuse and offending pathways were complexly interlinked. Themes are reported below according to the key relational themes across pathways. Anonymized quotes from transcribed interviews are included to illustrate themes.

"And that was the beginning of my drug problem, my mother": Traumatic early experiences/dysfunctional parenting

All participants reported that they started using drugs or alcohol in their teens. For most this appeared to be in

response to adverse relationship experiences, possibly as a way to cope with psychological distress and unmet emotional needs. A key theme and pathway to substance misuse onset was traumatic early experiences and dysfunctional parenting involving abuse, neglect, rejection, lack of affection, abandonment, parental substance misuse, and witnessing domestic violence. This is likely to have led to unmet psychological needs for security, safety, love and connection, and to the development of insecure attachment to one or both parents. All but two participants described suffering emotional and/or physical abuse by their parents, particularly their mothers:

> P3: I had quite a bad upbringing with my mum (…) my mum tried to get me put in a home but because there were no behavioural difficulties and that at the time, the social work wouldn't do that. She had started drinking and that so (…) she'd always been good for lifting her hands and that for as far back as I can remember. More nastiness from her mouth like telling me she'd be happy if I hadn't come into her life (…) I kind of rebelled when I got to 14 (…) I started going to under-18 raves kind of thing and I started taking amphetamines and acid and stuff.

One participant reported abuse involving being secretly drugged by her mother, resulting in her developing a drug addiction:

> P2: My mother, she was putting Diazepam in my sandwiches (…) crushing it down (…) I was still going to high school at the time. And when she stopped doing it I started feeling funny, eh, my dad knew nothing of this and still doesn't (…) and she told me what she had done, and my mother actually went away out and scored drugs for me (…) and that was the beginning of my drug problem, my mother.

A common subtheme was that of parental substance misuse. For some participants, including P3 (quoted above) and P2 below, this was closely interconnected with other types of abuse and with their own substance misuse:

> P2: Because she didn't want me getting on with my dad (…) it was like emotional blackmail. I found a bottle of, eh, vodka in the washing machine when I was putting my dirty clothes in and she said, because of course I said 'what's this?', and she said 'put that back or I'll tell your dad what you're doing' and I thought right, I better, because I need her to get what I need or I'll be not well.

Most participants described parents who were rejecting, emotionally or physically absent, or who had abandoned them:

> *Interviewer*: And you mentioned just before, before you started using Diazepam, it sounded like you were in a difficult place there.
>
> P1: See I had no family and all that round about me. I was 16. I had come straight out of care and moved in with a boyfriend (…) from I was 14 right up till I was 16, I've had to look after myself you know.
>
> *Interviewer*: If you think back to when you first started using drugs (…) describe the relationship you had with the people who were closest to you at that time.
>
> P7: My father (…), well, I only really seen him when it was my birthday or Christmases because he was in the pub.

Some participants, including P2 and P6 below, described parental rejection and shaming due to their substance misuse:

> P6: He [father] was absolutely disgusted with me when he found out that I was on heroin. He actually shouted out of a window of a car 'you junkie bastard' when he was driving past, and I was devastated I really was, I was heartbroken that he'd done that to me.
>
> P2: Because I was so young and he [father] knew I was taking drugs, but he didn't know my mum had anything to do with it, he just ignored me basically.

Experiences of abusive and rejecting parenting may be related to feeling unloved and unwanted as expressed by some participants including the below:

> P2: My mum loved my brother, but she didn't love me (…).
>
> P7: They [parents] never told me that they loved me. I was always wanting to hear that. They've still not told me that.

"I had to detach myself from them as soon as I went onto heroin": Family disconnection

Most participants reported initially funding their drug habit by borrowing money from family but deceiving them about the purpose. This behavior, and their addiction, eventually led to participants disconnecting themselves from or being disconnected by their families, including from positive family relationships with, for example, grandparents or siblings. Shame, that is, a sense that one is damaged, flawed, or bad due to being negative judged by disapproving others (Tangney, Stuewig, & Hafez, 2011), appeared to be central to this disconnection; being shamed and rejected by family (as mentioned above) or detaching oneself from them to avoid painful feelings of shame:

> P3: She'd [grandmother] stick by me, I could go out and murder someone tomorrow, my gran would stick by me for that but drugs is different, so I had to detach myself

from them as soon as I went onto heroin. I started going and borrowing money from my gran constantly and it was getting out of hand so I just cut myself off completely from them.

P6: They've [sisters] always stuck by me aye but (…) when I started taking heroin, cause they hated the idea of that eh, I mean, I was the only person in my family really to go and do something like that (…) but me and my sisters, we slipped away a wee bit (…) my older sister aye, she was really disappointed in me, the whole family was.

This disconnection meant a loss of emotional and practical support and a source of drug funding, leading to offending to fund their addiction:

P1: Just really, starting with friends and family, asking them then they obviously clicked 'she's got a habit'(…) you know, so they weren't funding it no more so we started getting into bother [with the police], you know what I mean.

The below narrative illustrates how shame and stigma associated with having a drug addiction could stand in the way of asking families for support, thus creating disconnection:

P1: I got a really good relationship with my mum eh, but I don't like asking her for help. You know, because I think she's got, because I'm the oldest like, my family should really look, like brothers and siblings and all, like, they should really be looking up to me you know, whereas they'd be looking up to a drug addict.

Another participant described disconnection by her family related to her offense:

P7: My dad was, says to me, like, 'don't worry, I'll, we'll go to court and that with you' but he never went and…

Interviewer: So he didn't go and support you?

P7: No, nobody did.

Interviewer: Was there no one there for you?

P7: No. And when it came in the paper and that my dad totally disowned me, and, my family disowned me except for my mum.

Even if participants were not disconnected from their family most described lack of emotional and/or practical family support:

Interviewer: [When caught offending] was there anyone there to support you?

P4: No. I would stay with my mum but I don't have a great relationship with her. Eh, no. I was just going about doing my own thing, getting the drugs every day, stealing to fund my habit and got to a stage where you don't bother if you get caught or not. Either way you are gonna get help.

This narrative also highlights how offending could be an escape from a chaotic lifestyle; 'getting caught' in order to get help. A few participants, such as P3 below, described 'escaping' to prison from the bleakness of an addiction lifestyle in which they felt out of control:

P3: My whole life was taken up by drugs, my life, my partner's life. I couldn't get my partner to get it together. We just, he didn't realise that we had the problem that we had, he didn't see it being as bad as it was at the time, and I just couldn't keep in control of my life at all, and I thought that at least in prison I'd have a bit of control in my life.

"It was like we weren't any good for each other": Dysfunctional intimate partner relationships

Being disconnected from family and having no or limited family support meant that participants often only had an intimate partner for support. Such relationships were commonly dysfunctional involving abuse, shared addiction and offending, and often contributed to further family disconnection. Although most participants did not implicate intimate partners in onset of their substance misuse, most described being introduced to harder drugs or developing an addiction with or through partners:

P7: I met [ex-husband] and he was into his heroin but I wasn't at the time.

Interviewer: Was that, did you get into it through him then?

P7: No not through him, I'd touched, I'd touched it before but, I just, I wasn't even thinking about it, and then he came along and it's like 'have you tried heroin?' I says 'I've tried it', he says 'do you fancy getting a bit?' and I was like, when I meet somebody I get all nervous so, like, I says 'aye', my stupid self, and he was actually feeding my habit.

Intimate partners were commonly implicated in ongoing substance misuse. A common subtheme was that of shared addiction; being in a relationship with each other and with the drugs, supporting and encouraging each other's habit, blocking recovery and desistance:

P5: I had started injecting, [partner] didn't really like injecting so when he was at home I was sneaking around behind his back but, he was really against injecting but eventually I talked him in to doing it as well and, it was like we weren't any good for each other because, like, if he was having an off day then I would get it and if I was

having an off day then he would get it. We would kind of lean on each other that way.

Some intimate relationships involved offending together to fund a shared addiction:

P6: Just basically, me and my partner, struggling for money and started selling heroin and, just an easy way for money because the two of us were obviously still taking heroin ourselves at the time.

A few participants described being the driving force in this criminal partnership, although sometimes the male partner took the legal consequences:

P2: Well, to tell you the truth, I was the business person, I was the person that made the money. He just sat back (…) in the background. But if the door was to go in and anything was to be found, the rules are, as you know, the man takes the blame, and if anything like that happened he took the blame, every time.

Another participant reported both committing the offenses and receiving the convictions:

P5: That was how I funded my habit the first time around, shoplifting, and I just started doing that (…) and because I'd know what I was doing and I'd done it before, [partner] would stay at home and watch the kids and I'd go out, and that's why I've got so many previous [convictions] and he's not.

Most participants described abusive, sometimes mutually violent, intimate relationships, which for two participants resulted in violent offenses against their partners:

P2: For the first start of the [relationship] (…) he used to beat me up, burn me with cigarettes, very jealous (…) and the second half of our relationship I used to beat him up (…) I stabbed him twice.

P3: He turned violent after we started the methadone. I started getting back to my old self, looking well and that, and he just got, oh it was torture after that, he just started getting really abusive and the relationship turned violent and I ended up getting charged with attempted murder and all, I stabbed him.

"It was after a loss of a [methadone] prescription and having a habit with heroin again": Losing a child

All but one participant were mothers but only two were the primary carer of their children, with most children being in foster or kinship care. Loss of a child due to a chaotic lifestyle involving addiction and offending was a common theme. Losing a child appeared to escalate their substance misuse, either as a way of coping with painful emotions or due to the loss of responsibilities of child care (or possibly a combination of both), leading to further offending to fund their addiction and, often, to greater family disconnection:

P4: My youngest boy, eh, got taken into foster care, and it was after a loss of a [methadone] prescription and having a habit with heroin again, eh, so I was out shoplifting, not caring if I did get the jail or coming clean and get a methadone programme again.

P3: See if my son hadn't been taken, if I hadn't made a mistake, I don't think I would have gotten into the heroin, I was so against it (…), but I was just lost without my wee boy there.

P5: Because I got caught shoplifting and I had to eventually get my dad to look after the kids, and then the last time that I was in the cells, I got out and my dad said 'I'm not giving you the kids back until you get your house sorted'(…) social work intervened and said on a voluntary basis we're going to say that your dad keeps the kids until you get yourself together (…) it was really really bad at first, but then it kind of gave me an excuse just to do what I wanted and take more drugs.

Relational pathways to substance misuse and drug-related offending: The role of trauma, insecure attachment, and shame

Figure 1 presents a model of the hypothesized relational pathways to substance misuse and drug-related offending in *some* women, and psychological processes involved. The model should naturally be viewed as provisional (as should any grounded theory) due to the exploratory nature of the study and the small sample size.

In the current sample substance misuse commonly began within the context of traumatic early experiences and dysfunctional parenting, which seemed to have resulted in unmet emotional needs (e.g., for feeling safe, loved, and connected to others) and insecure attachment. A parsimonious explanation for this association could be the use of substances to regulate affect, as has been widely demonstrated (see e.g., Flores, 2004; Fowler, 2006; Padykula & Conklin, 2010). Some participants were also exposed to substance use as a way to cope with stress and regulate affect through parental modelling. Shame appeared to both precede and be a consequence of substance misuse, and to become the context for ongoing negative relationship dynamics, substance misuse, and drug-related offending in complex ways. Participants commonly used their families to fund their growing drug habit through misrepresentation. This appeared to lead to shame and to family disconnection as participants were rejected by their families or detached themselves from them, perhaps both to avoid painful feelings of shame and

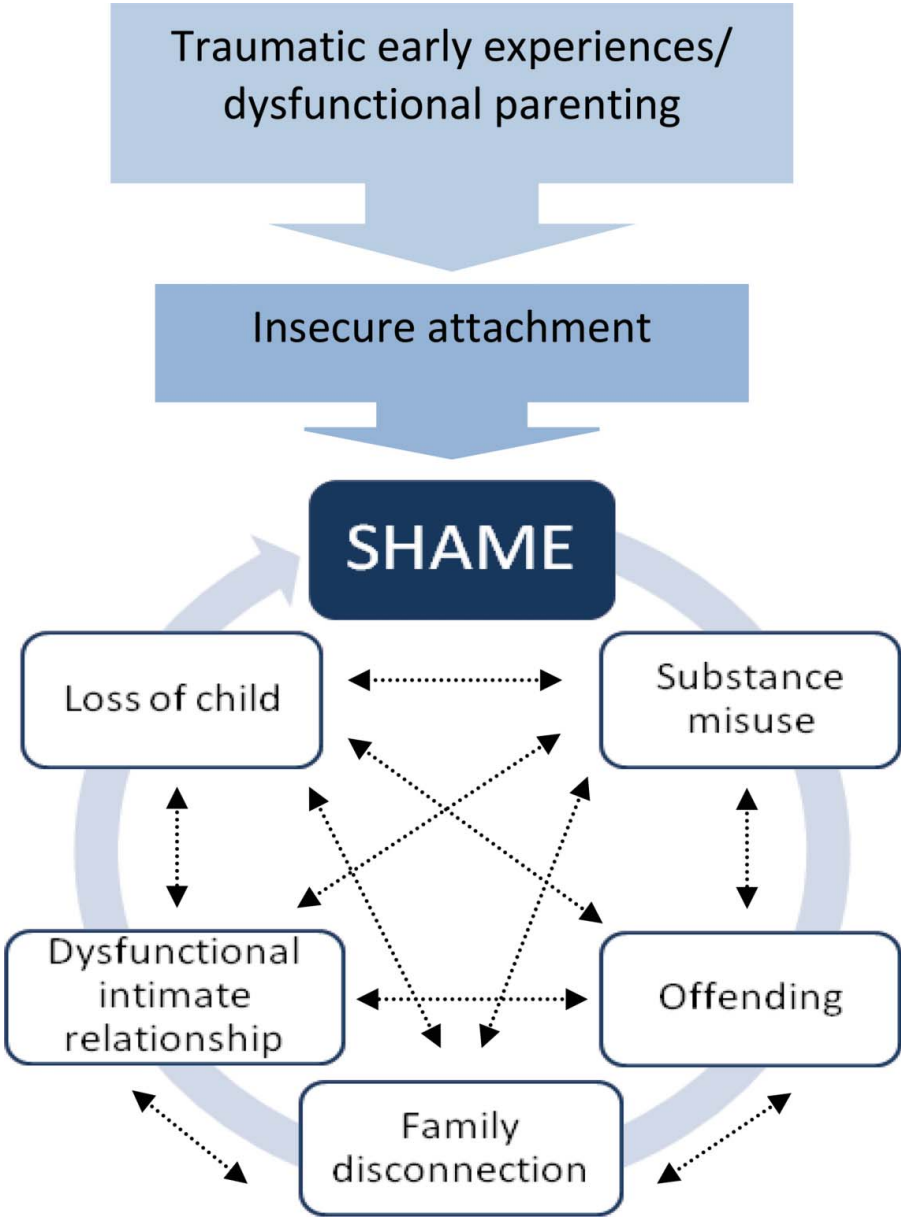

Figure 1. Hypothesized model of relational pathways to substance misuse and drug-related offending in some women.

out of a sense of responsibility to their families. The loss of family financial support meant participants began offending to fund their drug habit, which appeared to create further shame and family disconnection.

Intimate partner relationships were commonly dysfunctional involving abuse, shared addiction, and offending. These relationships appeared to involve complex dynamics related to insecure attachment and complex trauma. It is well documented that experiences of childhood complex trauma may lead to the development of an insecure or disorganised attachment style and relationship difficulties involving mistrust, fear of abandonment and rejection, and victimization from and/or of others (Courtois, 2004; Herman, 1992; Howe, 2011). Participants' intimate partner relationships appeared dynamically interconnected with ongoing substance misuse, offending, shame, and further family disconnection. The loss of children as a consequence of a chaotic lifestyle may have exacerbate feelings of shame and further substance use to avoid painful emotions, offending to fund a drug habit, and further family disconnection. Hence, a vicious, dynamic, and interconnected cycle appeared to have developed between ongoing adverse relationship experiences, substance misuse, and drug-related offending, in the context of complex trauma dynamics, insecure attachment, and shame.

Discussion

The findings suggest that adverse interpersonal relationships may be central to substance misuse and drug-related offending in some women, and may involve underlying relational psychological processes including complex trauma, insecure attachment, and shame in complex interaction. Due to the study's qualitative nature and small sample size, the hypothesized model is naturally provisional. Yet, the relational pathways to substance misuse and drug-related offending discovered in this study are similar to qualitative findings by Leverentz (2006). The proposed model is also supported by the wider literature on trauma, attachment, substance misuse, shame, and offending (e.g., Cook, 1991; Dearing, Stuewig, & Tangney, 2005; Golder, 2005; Matos, Pinto-Gouveia, & Costa, 2013; O'Connor, Berry, Inaba, Weiss, & Morrison, 1994; Padykula & Conklin, 2010; Potter-Efron, 2006; Wiechelt, 2007). The findings lend some support to relational theory's notion that relationship disconnection or violation may be central to understanding (some) women's substance misuse and criminal justice involvement (Covington, 2007; Covington & Surrey, 1997).

Complex trauma experiences are highly prevalent among substance misuse treatment populations generally (e.g., Ford & Smith, 2008; Mills, Lynskey, Teeson, Ross, & Darke, 2005) and women with substance misuse problems specifically (e.g., Gutierres & Van Puymbroeck, 2006; Simpson & Miller, 2002). Dysfunctional parenting experiences have been related to early onset of substance use in both men and women, with maternal abuse particularly relevant to women (Icick et al., 2013). Such experiences have also been associated with greater adult psychological distress, parenting problems, and lower perceived family support in women recovering from addiction (Harmer, Sanderson, & Mertin, 1999).

Early complex trauma exposure impacts on attachment development, with insecure or disorganised attachment styles a common consequence (Courtois, 2004; Howe, 2011; Padykula & Conklin, 2010). It also impacts on the structural and functional development of the brain (e.g., Ford, 2009; Schore, 2002), particularly in the right regions implicated in the stress response and affect regulation (Schore, 2002). Opiate receptor density may also be reduced (Flores, 2004). Consequently, the ability to regulate affect and self-soothe becomes impaired and chronic emotional instability may develop (Schore, 2002). Substances may thus be used to regulate affect, but may further exacerbate dysregulation and impair brain functioning (Fowler, 2006; Padykula & Conklin, 2010).

Shame is a common consequence of complex trauma (Courtois, 2004; Herman, 1992). Feelings of shame may be defended against through avoidant behaviors including social avoidance (Tangney et al., 2011), which may also function as an insecure attachment strategy to avoid rejection and abandonment (Howe, 2011). Longitudinal research suggests that shame proneness in adolescence is related to harsh and rejecting parenting (Stuewig & McCloskey, 2005). Shaming by attachment figures has also been related to the development of shame traumatic memories and depression (Matos et al., 2013). In this study shame appeared central to ongoing negative relationship experiences, addiction, and offending. Participants' detachment from their families may be understood as a defensive strategy to avoid the pain of shame, but may also indicate an avoidant insecure attachment style. However, it may also be related to a sense of responsibility, and possibly guilt, towards family members about exploiting them financially to fund a drug habit. Guilt and shame are closely related emotions, but shame relates to a sense that the *self* is bad and guilt to a sense that one's *behavior* is bad—an important distinction (Tangney & Dearing, 2002). It is very likely that the women in this study also experienced feelings of guilt about their behavior, but shame (i.e., both external shame related to how they were viewed by others and internal shame related to how they viewed themselves) appeared more central to their relational pathways and ongoing substance misuse and offending.

Shame has been implicated in both the onset and maintenance of addiction (Wiechelt, 2007). Higher levels of shame have been found in substance misuse treatment and recovery populations than in general populations (e.g., O'Connor et al., 1994), and shame but not guilt has been associated with more problematic alcohol use, increased risk of relapse and relapse severity (Randles & Tracy, 2013; Wiechelt & Sales, 2001). Dearing et al. (2005) suggested that shame may produce a "self-defeating cycle of negative affect" (p. 1393) whereby an individual uses substances in an effort to regulate painful feelings of shame.

Some research has related shame to addiction and offending across gender (Dearing et al., 2005; Jackson, Blackburn, Tobolowsky, & Baer, 2011; Tangney et al., 2011), but there has been little specific investigation of shame in women offenders. Milligan and Andrews (2005) found bodily shame (i.e., feeling ashamed of your body or parts of it) to be associated with childhood physical and sexual abuse in adult women offenders, and Tangney et al. (2011) found higher levels of shame in female than male inmates. Longitudinal research suggests that shame proneness may directly increase risk for recidivism whereas guilt decreases it, at least in males (Hosser, Windzio, & Greve, 2008). Although shame has been related to addiction and offending across gender (e.g., Dearing et al., 2005; Tangney et al., 2011), the

possible significance of shame to women's relational pathways to substance misuse and offending does not appear to have been fully considered in the literature. We believe that it warrants further exploration.

Findings by Golder (2005) are consistent with the proposed model. Using structural equation modelling, Golder tested the relationship between trauma, attachment, substance use, and criminal justice involvement (i.e., frequency of adult incarceration) among women. Shame was not examined, but an emotional processing variable including self-esteem, psychological distress and coping was tested. A significant and strong direct relationship was found between trauma and insecure attachment, and between insecure attachment and emotional processing. Trauma and insecure attachment had an indirect effect on substance use and criminal justice involvement via emotional processing. Substance use had a direct effect on criminal justice involvement, but as part of a risk behavior variable also including sexual risk and recent lawbreaking. This makes it difficult to disentangle the unique effect of substance misuse to criminality in the model. Yet, the findings suggest that trauma and insecure attachment may be indirectly related to substance misuse and offending behavior in women via psychological processes involving negative views of the self.

Some limitations but also strengths of the study should be noted. This was a small explorative qualitative study of a hard to access population, limited by time and resource constraints. Findings are necessarily tentative; broad generalizations or firm conclusions from the results to all women offenders with substance misuse problems naturally cannot be made. However, the study provides a valuable contribution to the literature on this hard to access population (i.e., criminal justice involved women in community substance misuse treatment). Procedures for ensuring rigour in qualitative research were employed (e.g., systematic and transparent data collection, analysis and interpretation, and transcript cross-coding), but data analysis, interpretation, and model construction was unavoidably filtered through the researcher as is a central tenet of social constructivist grounded theory (Charmaz, 2006). Participants may differ from women who declined or were unable to take part, non-treatment populations, women with other types of problematic substance use/dependence, and women in other substance treatment and forensic settings. As any theory or model constructed using grounded theory methods, the hypothesized model is provisional and needs further exploration, replication, and empirical validation using both qualitative and quantitative methodologies. This should include qualitative studies employing the full version of grounded theory with larger samples, and robust and large-scale quantitative studies using sophisticated statistical models to explore indirect associations between variables. Future studies may explore the model with women addicted to other types of drugs and to alcohol, women in different forensic settings with different offending backgrounds at varying levels of risk (e.g., violent versus non-violent offenders), and across gender.

In conclusion, relational factors may impact on women's offending in complex ways; some are dynamic but others are not. Childhood trauma is a static risk factor, but it may impact indirectly on offending through its potential consequences including substance misuse (Hollin & Palmer, 2006). For women with heroin addiction who primarily offend to fund their drug habit, relational pathways to offending may involve disconnected and unsupportive family relationships, dysfunctional intimate partner relationships, and the loss of their children. If complex trauma, insecure attachment, and shame are factors significant to this process, they need to be targeted in treatment to adequately address risk for recidivism. Case formulation is essential to establish individual risk and treatment needs (Jackson et al., 2011; Logan & Johnstone, 2013).

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Appendix

Semi-structured interview schedule

- **Can you start by telling me about how you came to be in this treatment program/on this treatment order?** (*Prompts: what was happening in your life before you started the program? Who was in your life? Describe that relationship.*)
- **Tell me about when you first started using drugs – describe your relationship with people (family/partner/friends) closest to you at that time.**

(Prompts: what did that relationship mean to you? How was it different from your other relationships? How do you think that relationship might have influenced (positive/negative) your drug use?)

- **Tell me about when you were last in trouble with the police – describe your relationship with people closest to you at that time**. *(Prompts: what did that relationship mean to you? How was it different from your other relationships? How do you think that relationship might have influenced (positive/negative) your offending?)*
- **Tell me about the people closest to you now (partner/family/children) – describe your relationship with them**. *(Prompts: what does that relationship mean to you? How is it different from your other relationships?)*
- **What advice would you give to someone who has recently come into a similar situation (drug treatment) to you?**