UNIVERSIDAD SAN FRANCISCO DE QUITO USFQ

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Group psychoeducation for repairing attachment and achieving abstinence in addicted populations

Propuesta de Investigación

.

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Group psychoeducation for repairing attachment and achieving abstinence in addicted populations

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RESUMEN

La exposición a las drogas es muy común, pero la forma en que la persona lo enfrenta es lo que marca la diferencia. Se cree que aquellos que han tenido una relación deficiente en su infancia temprana tienen un mayor riesgo de desarrollar problemas de abuso de sustancias en el futuro. Esto se debe al hecho de que las personas con sistemas familiares débiles tienden a ser emocionalmente inestables, tienen malas relaciones interpersonales y, por lo tanto, están más inclinadas a comportamientos adictivos. Estudios anteriores han encontrado que la psicoeducación es muy eficaz para tratar los trastornos por abuso de sustancias, por lo que el presente estudio usará esto como el principal modelo de intervención para tratar a los participantes. Se utilizará una muestra de 40 individuos ecuatorianos para medir la efectividad de la psicoeducación grupal en la reparación de apego. En base a la revisión de la literatura, se espera que los participantes reparen sus apegos, las relaciones interpersonales mejoren y logren la abstinencia.

Palabras clave: drogas, adiccion, apego, sistema familiar, psicoeducación.

ABSTRACT

Exposure to drugs is very common, but the way a person confronts it is what makes the difference. It is believed by psychologists that those who have had poor attachments in their early childhood are at greater risk of developing substance abuse problems later in life. This is due to the fact that individuals with weak family systems tend to be emotionally unstable and have poor interpersonal relationships, therefore they are more inclined to addictive behaviors. Previous studies have found psychoeducation to be very effective in treating substance use disorders, so this study will use psychoeducation as the main intervention model to treat participants. A sample of 40 Ecuadorian individuals will be used to measure the effectiveness of group psychoeducation in repairing attachments. Based on the literature review it is expected that if participants repair their attachments, interpersonal relationships will improve, thus leading to their abstinence from drugs/substances.

Key words: drugs, addiction, attachment, family system, psychoeducation.

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RESEARCH PROPOSAL

PROBLEM STATEMENT

Substance use disorders affect people from all age groups and social classes. It was determined that, in 2014, 21.5 million Americans over the age of 12 battled with a substance use disorder (National Survey on Drug Use and Health, 2019). This data shows just how common drug addictions are in the general population. Being addicted to drugs is a chronic disease characterized by drug seeking and compulsive consumption (Abuse, n.d.). This disease arises from a combination of many factors. Included among these factors are genetic and environmental factors, as well as brain wiring and the place where the person was born and grew up (Smith, Seymour, & Ebrary, 2001). It is important to view the family as a system and recognize that it is imperative in addressing the problem of alcohol and drug dependency (Fields, 2013). Growing up in a healthy family system is in no way similar to growing up in a dysfunctional family: imbalanced families are not as strong and predictable as those which are well balanced, and they do not have the same ability to confront problems. For this reason, it is so important to analyze attachment and realize that the infant-caregiver relationship will have strong repercussions in the child's life.

Exposure to drugs is very common, but the way a person confronts it is what makes a remarkable difference. It is believed by psychologists that those who have had poor attachment in their early childhood are at a greater risk of developing substance abuse problems later in life (Fields, 2013). Frequent exposure to drugs is a reality and, as previously stated, does not discriminate based on age, gender or social class. This reality is no different in Ecuador than in the United States, in fact, Secretaria Técnica de Prevención de Drogas (Ecuador), conducted a study of 34,905 students and found that 12.65% of those surveyed had used illicit drugs. The

parenting styles of each family is unknown, but it appears that the incidence in drug use was 8.85% in children whose parents “always know where their child is” as opposed to 34.11% for children whose parents “never or almost never know where their child is” (Guadalupe, 2017). This short report demonstrates just how important family is to children, and how having strong attachments could truly help them confront a world of temptations.

The production and expansion of drugs around the world has increased significantly during the last years for two main reasons. The first is that a larger amount of people, regardless of age or gender, consume drugs, either by use, abuse, habit, or dependence. This leads to the second reason, which is the profitability of the narcotics business. As more people consume psychoactive substances, addiction levels rise. The American Society of Addiction Medicine (ASAM) focuses on the cognitive aspects, the brain reward system, and the neurological changes that occur with addiction regardless of its cause

> Addiction is a primarily, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunctions in these circuits lead to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief through substance use and other behaviors. (American Society of Addiction Medicine, 2011)

When referring to other behaviors, it is referring to addictions related to sex, gambling, and other actions that are compulsively repeated for the rewarding changes they produce in the brain. So, while it is a fact that an addiction may encompass many different factors, it is important to clarify that for the purpose of this investigation the discussion will be specifically related to drug and alcohol addictions. DSM V diagnoses addiction, or substance related and addictive disorders when there is a dependence to ten separate classes of drugs.

> The substance-related disorders encompass 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens (with separate categories for phencyclidine [or similarly acting arylcyclohexylamines] and other hallucinogens); inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances (American Psychiatric Association, 2013. p. 253).

It is evident that the expansion of drugs has made the problem of addiction worse, thus making it a widespread health and social issue. At the start, drugs are pleasant and showy, but soon they become problematic for both the health of the individual and that of the surrounding public (Leshner, 1997). However, for the benefit of the business, drugs are only advertised for their satisfying effects and no discussion of the effects of intoxication and addiction are ever mentioned. The industries, whether they may be using commercials, television shows, or simple colloquial expressions, paint drugs in a positive light. For example, the commonly used phrase "feeling high" suggests power and or feelings of superiority (Fields, 2013). Likewise, drugs symbolize seduction and sexuality which catches more widespread attention.

As of 2017, studies showed that 30.5 million people used psychoactive substances in the past 30 days (Substance Abuse and Mental Health Services Administration, 2017). These numbers are higher than in previous years which is no surprise. As mentioned above, drugs are not only attractive, but indisputably addictive. The question arises, if drugs are consumed by a large number of people and have such addictive components, then why is it that some people solely consume them, and others later become abusers? While there are many factors that may contribute to the development of a substance abuser, can the attachment that the user has with his or her attachment figure be a predicting factor in later abuse?

Research has shown insecure attachment styles can be correlated to substance abuse, emotional distress, and interpersonal problems (Borhani, 2013). This occurs because individuals with insecure attachment tend to have poorer interpersonal relationships, which causes sadness and grief thus making it more likely for them to regress to addictive behaviors. Often, these people tend to abuse substances as a way of coping with the lack of supportive and intimate relationships. For this reason, it is imperative that attachments be repaired in order to expect long-lasting abstinence results. These findings lead to the question of the present experiment, *"how, and to what extent, can group psychoeducation achieve abstinence and repair poor attachments in order to prevent addiction in a group of Ecuadorian adults that meet the criteria of substance dependence and addictive disorders?"*

SIGNIFICANCE

There is limited information about parenting styles and addictions in Ecuador. It is known that addictions are affecting people from all over the world, and that Ecuador is no different. There is evidence that suggests that insecure attachment, which is the poor bonding that a child has with his or her parent or caregiver, could be related to substance dependence and addictive disorders. This study seeks to help people suffering from an addictive disorder repair their attachment to their caregiver. Researchers believe that, if this happens, addicts could develop secure attachments with their own children. Therefore, the purpose is to avoid a vicious cycle within the family, with the hopes that the next generations will have better attachments, thus reducing the likelihood of addiction.

OBJECTIVES

This investigation aims to create a link between attachment problems and addiction. It was hypothesized that if a person has poor attachment with his or her attachment figure, then the child would be more likely to have addictive behaviors. The purpose of this research is therefore to treat the poor attachment found in addicts through group psychoeducation. The literature review seeks to reveal information about each topic in order to thoroughly understand the issue and be able to draw conclusions on the subject. Since there is an evident inverse relationship between addiction and healthy interpersonal relationships, it is in the best interest of this experiment to repair the attachment for parents that have a substance dependence disorder. When accomplished, investigators will attempt to teach these parents to form healthy relationships with their own children, thus avoiding neglect and future possible addictive behaviors.

LITERATURE REVIEW

Drugs

Substance related and addictive disorders are a widespread and constant issue in the world today. While it is true that the consumption of psychoactive substances has been observed throughout history in varying countries and cultures, the phenomenon of drug addiction has had a significant increase during recent decades. Psychoactive plants have always existed and been consumed, but the use and purpose of their consumption has changed. In the past, these plants had great value, and were treasured because they were commonly used in religious rituals to perform magic in ceremonies, or to serve important medicinal purposes, improve productivity, aid in connections with gods, amongst many other uses. For thousands of years, the shamans or religious practitioners used psychoactive plants to mediate between their society and the supernatural force to generate effects of protection and welfare to their society (Kvist & Moraes R., 2006). It is evident that these psychoactive substances were greatly valued by the communities for their extraordinary effects and were not consumed just for personal enjoyment. Although the effect of drugs has always been pleasant, the consumption of these was more moderate, usually serving a purpose and seeking to reach a predetermined goal.

In the current culture, the definition of a drug is fairly ambiguous and broad, encompassing many different things. To narrow it down, the World Health Organization (WHO) defined drug as any substances of non-medical use with psychoactive effects, capable of producing changes in perception, mood, awareness and behavior, and susceptible to being self-administered (1982). However, Lorenzo, Ladero, Leza, Lizasoain defined drugs as "psychoactive substances with positive reinforcing action, capable of generating psychological and physical dependence, and which cause, in many cases, a serious psycho-organic

deterioration and social behavior," which is a suitable definition that can be adopted for the purpose of this study (2009). Not only does this definition seem to eliminate ambiguities, but it is contemporary and suggests a brief introduction to the drug problem.

Drug addiction

It was not until recent decades that drug addiction reached an extraordinary importance in its dissemination (Lorenzo, Ladero, Leza, Lizasoain, 2009). This expansion points to the characteristics of today's industrial society. The natural changes that psychoactive plants produced in the brain were no longer enough, therefore society began modifying the chemical structure of drugs to increase their psychoactive effects. As a result, not only are there natural psychoactive substances, but also synthetic and semisynthetic drugs. The problem with these synthetic drugs, or "designer drugs," is that very little is known about them in comparison to natural drugs. It is not known how long they stay in the body, how they are metabolized, at what doses their psychological or physiological effects occur, and how toxic they are (Nora & Volkow, 2013). Not only is this frightful for the individual's health because of their components, but they are also extremely addictive. With the passing of time, less expensive, psychoactive synthetic drugs will be produced, which may become an indicator of an increase in people with a substance use disorder. The number of heroin users has doubled between 2002 and present day (Miller, September 8, & ET, n.d.).

Substance use disorders occur when the recurrent use of psychoactive substance causes clinically significant impairment, including health problems, disability, and a failure to meet major responsibilities at work, school, or home (Hedden et al., 2014). Of course, this does not present itself from one day to the next, but rather progresses over time. The disease presents itself in stages: initial, progressive and advanced (Waisman Campos & Benabarre Hernández,

2017). At the start, people consume only for pleasure, then they consume to avoid feelings of abstinence or feeling unhappy or sick, and finally they use because they do not feel well without the aid of the substance. This occurs because psychoactive drugs condition the mesolimbic dopaminergic reward circuit, as they present differences in their mechanism of action with natural reinforcers (Waisman Campos & Benabarre Hernández, 2017). This is greatly rewarding at a given moment, which is another reason why people become dependent. All people want to feel good and avoid these adverse feelings caused by withdrawal.

Drug dependence

There are three types of substance dependencies, varying according to the type of substance the person consumes. When a person consumes opioids (drugs such as heroin, morphine and methadone) they may become physically and psychologically dependent on them. The same occurs with depressants such as alcohol and barbiturates. After a prolonged consumption, the person may develop a physical dependence, which means that he or she feels the need to maintain a minimum quantity of the substance in their body at all times. The organism seeks the drug, and it may develop acute withdrawal symptoms. The intensity of these symptoms depends on the type of drug, the way in which it is administered, the dosage, the frequency, and metabolic rate of the person. Conversely, psychological dependence refers to the thought, the irresistible desire to repeat the administration of the drug to obtain the pleasant effects, suppress conflicts, drug seeking activities, and pathological patterns of behavior (Lorenzo, Ladero, Leza, Lizasoain, 2009). This is typical from stimulant drugs such as cocaine and some other amphetamines. Thirdly, there is a social dependence to certain types of drugs, usually inhalants. This dependence means that the user feels they need to consume the drug in order to belong. It is very common to find scenarios such as this in gangs or soccer hooligans.

Nonetheless, it is important to clarify that such effects arise from problematic ingestions of drugs. When a person uses drugs sparingly, which is the consumption of a substance without causing social or medical effects, they do not develop any type of dependence. Conversely, if their consumption is by habit, abuse, or dependence, then it is likely that they will develop one of the three types of drug dependencies mentioned above. Habit is the consumption, per pattern or routine, that has adapted to the substance's effect. Abuse is the consumption that advances and or damages the social and psychological well-being of the person, and dependence is the state of chronic intoxication where the desire to continue consuming is dominant; there is a tendency to increase the dose, and there is a physical and psychological dependence on its social effects (Lorenzo, Ladero, Leza, Lizasoain, 2009). Nonetheless, use, habit, abuse, and dependence are Lorenzo, Ladero, Leza and Lizasoain's way to define the stages of substance use. Defining these stages and patterns is more challenging than defining addiction, and thus why many authors differ in definitions and points of view. Fields (2003), outlines six stages of drug use. According to him, the first stage is the safest, and it is the non-use of psychoactive substances. Once this happens, the person automatically enters the initial contact stage. This stage is similar to the "use" stage described above, because it is when the person first tries a drug. Although being at this point has its risks, it may be relatively harmless for the person. Next is the experimentation stage. In this stage, the person experiments with a drug in different situations and explores his or her capacities to use it (Fields, 2013). People either stop here, or they move on to the integrated stage. In the integrated stage, the person starts associating with those that use the same drug, because they dedicate much of their time to it. The individual in this stage has to constantly make sure that the drug is available wherever they go at all times. Once again, the person either stops, or moves on to the excessive use stage. Excessive use is similar to the "abuse" stage, because the

dose that they need has increased, and is possibly causing the individual significant problems or negative consequences. This is the last stage from which the person can return, because afterwards comes the final and most serious stage, which is addiction, which is considered a disease. The person cannot return to any of the previous stages; they may recover and remain sober, but they can never go back (Fields, 2013). There is no right or wrong in describing the stages; it is solely a matter of how the author understands them. The four stages and the six stages both describe a developing process that shows how a alcohol and drug use problem may become worse over time.

Attachment

The theory of attachment was first introduced by John Bowlby, and generated enormous acceptance and attention from society and important organizations, such as the World Health Organization (WHO). This theory revolutionized thinking about the link between mother and child, and focused on its vital role in child development (Bretherton, 1992). Based on the bond a person has with his or her attachment figure during infancy, mannerisms and attitudes such as self-esteem and self-assurance form (Holmes, 2011). These are essential personality aspects that play a crucial role in the decision making process and development of the person. Bowlby's theory was as powerful as other contemporary scientific breakthroughs, such as Jenner's when he introduced modern medicine with the vaccine against smallpox. This analogy is meaningful because it demonstrates just how much the theory impacted society. The responsiveness from mothers when their infants cried, and the body contact they had was now strictly considered, since it was believed that this was closely related with the psychological health of the child. It is assumed that attachment patterns in childhood produce widespread effects in their social abilities and in the way they reflect on and foresee their lives. One could recognize a possible link

between these factors, and the likelihood of the child using drugs, as why it is important to recognize the role of attachment when speaking of and researching addiction.

Bowlby's life

Dr. Bowlby developed interest in analyzing attachment after volunteering at a school for maladjusted children. Here, he had the opportunity to meet two children who inspired his career goals and encouraged him to study medicine and psychiatry. From there, he made an emphasis on early relationships and the pathological potential of loss (Bretherton, 1992). He believed that family experiences were the most influential factor for the emotional disturbance or stability of the child (Bretherton, 1992). He sought to develop a theory based on scientific evidence, so he developed various empirical studies to base his ideas. During World War II, Bowlby had the opportunity to grow as a researcher and, as such, when the war ended, he was invited to work as head of the Children's Department of at the Tavistock Clinic. Soon after, in 1949, he published his first paper in family therapy. Here, he focused on mother-child separation and documented the influences on the child. One of Bowlby's most important conclusions is the fact that "the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment" (Bretherton, 1992). All of Bowlby's theories and conclusions were grounded with experimental and empirical evidence. Nevertheless, it is important to mention that although Bowlby is known as the father and founder of the attachment theory, he had strong collaborations with his student Mary Ainsworth. Dr. Ainsworth was an American born developmental psychologist six years younger than Bowlby. Ainsworth joined John Bowlby's research team and introduced new methodology and innovative ideas that allowed for various discoveries and progress of the theory (Bretherton, 1992). Ainsworth carried out much of the investigation about the relationship

between mother and child, and she looked into the effects of maternal separation and compared the effects that disrupted attachment versus the effect normal maternal bonds had on the child's development (Cherry, n.d.). Much of Dr. Ainsworth contributions were based on her knowledge about the security theory, which she had been exposed to during her studies. Similar to attachment theory, security theory states that "infants and young children need to develop a secure dependence on parents before launching out into unfamiliar situations" (Bretherton, 1992). Many experts agree with this theory, and base their agreement on the fact that there is no baby that is truly by itself, but only a baby and a mother together (Winnicott, 1990). Bowlby would very likely agree with these statements, because he believed attachments are made from the moment the child is born, based on the responsiveness from the mother.

Types of attachment

It is ideal that the bond between the mother and the child is warm and strong, however this is not always the case. There are certain behaviors from the mother or caregiver expressed towards the infant that may produce better or worse styles of attachment. There are four different types of attachment styles that arise as a result of the quality of their relationship. Some infants feel extremely safe and secure next to their mother, while others tend to become anxious and feel insecure about the future. Dr. Ainsworth developed a technique to assess the quality of the mother-child bond. This method is called the Strange Situation Procedure, and it is particularly practiced in children ranging from ages one to two. This procedure is divided into eight different events that simulate different situations (Shaffer & Kipp, 2010). In the first episode, the experimenter introduces the child and mother to a playroom, and then leaves the room. Second, the mother sits and watches the baby play while the experimenter observes their interactions in the presence of toys, and determines if the baby feels safe to explore and interact

with their mother. Thirdly, an unknown stranger enters the room and begins a conversation with the mother. Here the investigator observes any anxiety that the child appears to exhibit in the presence of a stranger. Fourth, the mother leaves the room, and the stranger offers to comfort to the baby. At this point, the investigator observes how the child reacts when faced with the anxiety of having the mom or caregiver become absent. Fifth, the mother returns to the room and offers to comfort the baby if he or she is still crying. At this time, the stranger leaves, and the experimenter observes the behavior of the infant when he or she is reunited with their mother. During the sixth step, the parent leaves the room again, however this time there is no stranger to comfort the child. The experimenter is still examining the anxiety faced during separation, only that this time there is nobody else in the room to offer comfort. After three minutes, the stranger walks into the room to offer comfort, and investigator determines if the baby is capable of calming down with the stranger. Lastly, the parent finally comes back into the room and tries to interest the baby in playing with toys. The experimenter watches how they behave once they are reunited, while acknowledging that as each episode progressed so did the stress level. With the help of this test, one can register and analyze the behaviors and responses observed from the baby and the mother to then classify their attachment to one of the four categories.

As previously stated, there are four types of attachment styles. The ideal attachment style is secure attachment, which 65% of babies in the United States have at the age of one (Shaffer & Kipp, 2010). When one speaks of secure attachment, he or she is referring to the fact that the baby explores freely, misses their mother when she is not there, but when she comes back he welcomes her and tries to have physical contact with her to calm down. These babies are also capable of socializing with strangers while the mother is present in the room, which comes to show that the child feels safe. On the other hand, 10% of children have a type of attachment style

called ambivalent attachment. This attachment means that the child is too afraid to separate from the mother, so he hardly explores while she is there. When she leaves, he is fidgety. When she returns, he once again wants to stay close to her, but seems angry and might possibly reject any type of physical contact. These babies usually do not socialize with strangers (Shaffer & Kipp, 2010). There is a third type of attachment style known as avoidant, which 20% of babies are categorized under. These infants tend to have observable insecure attachments, and they often appear careless when the mother leaves, and can continue with their activities easily. They are usually very social with strangers, although sometimes they can ignore them just as they do with their mother. Finally, there is a disorganized attachment style, which is considered the most problematic of them all the other styles. In this case, children tend to be stressed under almost any situation of uncertainty. There is a mix of ambivalent and avoidant attachment styles, because they tend to search for the mother in order to later avoid her (Shaffer & Kipp, 2010).

Parenting Styles

The analysis of attachment styles is especially important, because it says much about the wellbeing and status of the infant. Children will value themselves as they have been valued at home by their parents (Corkille, 2004). Children who had caring and loving parents tend to be more secure about themselves than those who have felt abandoned. The importance and value that parents give their children is the first perspective that they have of themselves. A perceived happy child is related to those who have a better understanding of their self-esteem. This is why the context in which a child grows up is important. When one considers this, the first thing to take into account is the status of the parents: married, divorced, in a communicative relationship, etc.. Then, the age of the parents is also considered. In many cases, adolescent parents tend to have a stronger connection with their children (Corkille, 2004). Availability and capability of

parents to make decisions is also influential. Nonetheless, the main aspect to consider is that parents have agreements to exercise loving authority over children (Eguiluz Romo, 2004). The infant should know that the parents have a good relationship and that his or her attitudes and behaviors will not compromise that. Parents need to agree on the rules and expectations they have of their children so the infant is clear on how to act. A set of these elements is what defines the different parenting styles. One style is the authoritarian parent; the one who may say, "What I say is what must be done". These types of parents are not flexible, and they tend to make their children feel insecure. There is a very weak bond between the parent and the child, so they tend to have a low perspective of love. Parents tend to have high expectations from them, but these children are insecure about their capabilities. There are also the permissive parents, who are the ones that do not impose any rules. While these children do have a good perspective of affection, they do not have any schemes of protection. Some parents, however, are negligent. Negligent parents are those that are usually absent, and are rarely concerned for their children. Children from a group that has had this type of parenting style tend to have a negative outlook on love, because their caregiver is often absent; hence there is no dialogue between them. There is a fourth type of parenting style known as authoritative or with authority. This is the ideal type, because parents combine authority with love. There is proper caregiver-child communication, and both parties negotiate important decisions. These children have a high perspective of affection, and they value themselves much. One of the more important things a parent can do is teach their child socially acceptable and expected behaviors.

Risk factors

A stable family system, meaning parents that are flexible and available, open and predictable, are key to preventing substance disorders in children. These children tend to be more

secure and have better intimate and interpersonal relationships. On the other hand, insecure-avoidant children are at a higher risk for developmental, interpersonal, and substance abuse disorders later in life (Fields, 2013). There are numerous situations that may put one at risk of using drugs, and thus it is vital for parents to provide adequate nurturing and to develop a strong bond with their child. Abandonment and depression are connected to poor attachment, so it is evident that these children are highly susceptible to becoming involved with drugs. The circumstance as to why the parent is not present varies from case to case. Some parents are away at war, some have criminal justice problems, others are going through a mental episode, or some may have passed away. Regardless of what the situation may be, it is more likely that these children will begin using drugs and alcohol. Likewise, there are risk factors related to traits and temperaments. Some temperamental traits, such as high activity level, emotionality, attention span, and sociability, may predict later behavior and substance abuse problems (Fields, 2013). Sexual violations and shame are another evident risk factor. These children tend to feel responsible for what has happened and use drugs as an escape.

Children of alcoholic parents are an extremely vulnerable group in terms of drug use. Families with addicted parents are highly unstable and unpredictable, thus forming a very weak and insecure family system. Alcoholic parents are often unavailable for their children, which creates negative barriers in their relationship. These children tend to lack trust and to mistrust everything and everyone, as well as have trouble forming bonds with other people. The stress of growing up with an addict is emotionally devastating, and creates a great deal of stress and anxiety. All of these, along with peer use, poor grades in school, low self-esteem, psychological distress, low sense of social responsibility, lack of purpose in life, early use of alcohol and

disruptive life events are some of the numerous factors that increase the probability of a person developing a substance use disorder (Newcomb, Maddahian, & Bentler, 1986).

Psychoeducation

Psychoeducation has proven to be extremely effective in treating attachment disorders. Group psychoeducation is the most commonly used approach for the treatment of alcoholism and substance use disorders (Nace, 1987). Psychoeducation, along with cognitive-behavioral or psychodynamic therapies, is often combined to achieve an ideal intervention for diagnosed patients. This is because the purpose of intervention is not only intended to achieve abstinence, but to enhance the patient's life by improving their interpersonal relationships (Chandiramani & Tripathi, 1993). Various studies, including one by Mukaddes, Kaynak, Kinali, Besikci, and Issever (2004) have demonstrated the power of a psychoeducation model. In the case of this study, it was the relationship between caregivers and their autistic or RAD child that was at stake. The results showed an improvement in attachment and long-term social skills, self-care abilities and language-cognitive development in children (Chandiramani & Tripathi, 1993). In the case of this study, the authors administered a pretest, post-test, and had continuing observations to re-confirm results.

A study performed by the American Museum of Natural History showed that many parents that were neglected as children have addiction problems as well as trouble forming healthy relationships with their own children. When these parents hear their child cry, it triggers memories of their incessant crying as children (American Museum of Natural History, 2012). These parents had difficult childhoods, and they struggle to be good parents and to be able to meet their children's needs. It is valuable that, through psychoeducation, parents learn about

proximity and contact in order to gradually improve their relationship and form safe and healthy attachments with their children.

Additionally, it is of utmost importance to educate patients who have a substance abuse disorder in order for them to have a better understanding of their disease and take responsibility for the coping methods related to the addiction. Many times, patients have unanswered questions that prevent them from fully achieving abstinence. For this reason, it is important that intervention include lectures to teach and provide answers. Psychologists are coaches for workshops and instruction about the reality of relapse and the prevention methods that are available (Cirque Lodge, n.d.). Recovery is a complex process, but it is key that the patient is fully aware of his or her addiction, and that they learn coping skills and overall healthier life behaviors in order to achieve for long-lasting results.

METHODOLOGY AND RESEARCH DESIGN

This experiment aims to determine how, and to what extent, group psychoeducation can achieve abstinence and repair poor attachments to prevent addiction in a group of Ecuadorian adults that meet the criteria of substance dependence and addictive disorders. This research will be measured quantitatively through a self-reported and assessed by a clinician pretest-posttest.

Design

The present experiment will evaluate the efficacy of group psychoeducation for repairing attachment and preventing future addiction. Adult participants need to meet DSM-5 diagnostic criteria for substance use disorder and poor attachment. These must also complete the ASSIST Screening Test and the Attachment Styles Questionnaire. If the participant does not meet these conditions, he or she will become part of the control group. On the other hand, those who meet all conditions will qualify to be part of the experiment, thus composing the experimental group. This study will be a repeated measures design, because the same people will be measured repeatedly (Pluck, n.d.). Each person will participate in bot, Condition A and Condition B pretest-post test to identify the effect group psychoeducation has in each participant. It is effective to use a quantitative methodology for the purpose of this study, because it will express the effect that the intervention had on the patients. The ASSIST Screening Tool and the Adult Attachment Scale pretest will be carried out before starting the intervention. After the 8-week intervention has passed, participants will be assessed with the same instruments. Each participant pretest results will be compared to those from the post test thus analyzing the effect of group psychoeducation in repairing attachment in addicts with broken bonds. This way, precise numeric data will test the hypothesis (Garbarino, Holland, University of Birmingham, & Governance and Social Development Resource Centre, 2009).

Population

For the purpose of this report 40 Ecuadorian adult participants, who consider to be personally dealing with addiction and have attachment problems, will be recruited to be a part of an investigation. Both genders will be participants, 20 males and 20 females. The age range will be between 25 and 65, with an average age of 45 years old.

Inclusionary criteria:

- Have at least one child over the age of 18 months.
- Have been in a committed relationship for at least two years.

Exclusionary criteria:

- Present a co-occurring disorder.
- Have an addicted partner.
- Meet only one of the two conditions (broken attachment and addiction).

Research Tools

For the purpose of this research, participants will be diagnosed under the *DSM-5* diagnostic criteria for substance related and addictive disorders. Next, participants will interview with a psychologist who will administer the ASSIST Screening Test and the Adult Attachment Scale to them.

DSM-5

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is a tool that serves as the main authority for diagnosing mental health disorders. This manual references all the documented mental disorders, and provides the diagnostic criteria for each one; substance related and addictive disorders are no different. The interesting factor in terms of the DSM-5 and this disorder is that this is the first time that the American Psychiatric Association combines

substance abuse and substance dependence into one diagnosis (American Psychiatric Association, 2013). Previously, on the DSM- IV, substance use disorder was broken into substance abuse and substance dependence, but this changed due to the fact that it was difficult for clinicians to distinguish between the two (Hasin, Fenton, Beseler, Park, & Wall, 2012).

ASSIST Screening Test

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is a tool developed to learn relevant information from clients that point to the use of substances in a harmful manner. Through an eight item questionnaire, this test can identify a range of problems associated with substance use including acute intoxication, regular use, dependent or 'high risk' use and injecting behavior (Humeniuk & World Health Organization, 2010). The ASSIST takes about 5-to-10 minutes to be administered, and it should be overseen by a professional to the client. The test does not require any technology, as it is completed by using paper and pencil. This test is well-validated, being that it was developed by addiction investigators and clinicians under the sponsor of the World Health Organization.

Adult Attachment Scale

The Adult Attachment Scale is a tool developed by the department of psychology from the University of California Santa Barbara to measure adult attachment. This test has the great benefit that it can be self-administered and self-scored.

The scale is composed of three subscales, each composed of six items. The three subscales are close, depended, and anxiety. The close scale measures the extent to which a person is comfortable with closeness and intimacy. The depend scale measures the extent to which a person feels he/she can depend on others to be available when needed. The anxiety

subscale measures the extent to which a person is worried about being rejected or unloved. (Collins, 1996)

Data collection

The study will be advertised on social media through an ad that invites Ecuadorian adults that are battling addiction to participate in an experiment conducted by a USFQ psychology student. A financial incentive of $30 dollars will be offered to anyone that qualifies. Interested applicants must undergo an interview process, where the investigator will confirm their substance related and addictive disorder DSM-5 criteria diagnosis and if approved, the patient will be put under two pretests. The first test to be administered will be the ASSIST Screening Test in order to analyze their substance use, and then the participant will self-report their attachment through the Adult Attachment Scale. Once confirmed that the group of adult participants match all requirements, these will begin an intervention program of group psychoeducation on attachment and relationship skills.

To commence, an informed consent will be provided to all participants in order to inform them about the research being undergone as well as the experiment protocols to be followed to then begin the intervention. Intervention will take place in one location, and will be delivered by three professional psychologists. Every participant is encouraged to attend each of the sessions. Sessions will run for approximately two hours, taking place at the same time every Saturday. Recruited participants will do participate in sessions for eight consecutive weeks, which is the full length of the research experiment.

During these eight weeks, parents will be instructed by a therapist. The first six weeks will be mainly a teaching process, where practical information related to secure attachments, addiction, and recovery will be taught. In addition, psychologists and other professionals will

lead lectures, group discussions and role plays from which patients could potentially learn a lot about coping mechanisms and improving attachments. Next, weeks seven and eight will be more hands-on. During this time therapists will help parents implement everything they have learned and apply it with their children. Parents will soon notice and respond to their child's social cues, develop reciprocity in the relationship, and either soothe a cranky baby or alert a withdrawn baby (Cornell & Hamrin, 2008). At the end of the eight weeks, when the intervention is finalized, all participants will complete the same two tests, ASSIST Screening Test and Adult Attachment Scale post test, for investigators to analyze the effectiveness of the intervention and test their hypothesis.

ETHICAL CONSIDERATIONS

There are several ethical considerations to take into account prior to starting the experiment. First off, an informed consent form will be delivered to every participant to ensure that they are familiar with the objectives of the investigation and that they are aware of their rights. All recruited participants will be volunteers willing to take part of a USFQ investigation. Participation in the experiment is not required, in fact, only those interested and qualified are encouraged to join. The identity of every participant will be anonymous as well as any personal information. All information and collected data will be fully confidential, and will be used strictly for research by this study. If for any reason the participant feels the need to abandon the project at any point, he or she is completely free to do so. There will be no consequences for leaving the program, regardless of what the reason for doing so may be. Finally, it is key to mention that without the approval of Comité de Ética from Universidad San Francisco de Quito the investigation cannot carried out.

DISCUSSION

The main goal of this study is to answer the question *"how, and to what extent, group psychoeducation can achieve abstinence and repair poor attachments; to prevent addiction in a group of Ecuadorian adults that meet the criteria of substance dependence and addictive disorders?"* Based on the literature review, it is evident that addiction can be viewed as an attachment disorder, and thus why the intent of the experimenters is that, through an eight-week intervention program focused on repairing attachments, this group of Ecuadorian adults can improve their interpersonal relationships, therefore reducing the consumption of illicit drugs, and finally repairing the deficits in the relationship they have with their own children.

Frequently, but not always, "individuals who have difficulty establishing emotionally regulating attachments are more inclined to substitute drugs and alcohol for their deficiency in intimacy" (Flores, 2004). The intervention will be mainly based on repairing relationships rather than the consumption itself. During the first phase of the program, all participants will learn about the importance of safe and healthy attachments, as well as the advantages and disadvantages that a person could develop if these connections and attachments were absent. A great amount of information will be taught and discussed with patients through various activities. Once they have understood the value of attachment and recognized the deficiency, they can begin to develop healthy interpersonal relationships and therefore learn to negotiate and inhibit manipulative and addicted behaviors. Subsequently, it is in the best interest of the researchers that this group of adults can ultimately repair and form secure attachments with their own children by answering their needs. The question of whether or not addicts can be taught healthy attachments remains viable, but previous studies have shown that, although difficult, it is possible.

Finally, it can be stated confidently that attachment is the base of all relationships, and thus the reason why results are hopeful. They show that group psychoeducation is an effective treatment intervention for addicts. A controversial question that often arises is whether it is necessary to focus on the attachment relationship, or target specific behaviors that lead to improved functioning in attachment-disordered children (Cornell & Hamrin, 2008). It was finally determined that, in order to reach long lasting results, an intervention in relation to the problem, attachment, was required. In order to prevent addictive behaviors, it is key to improve the person's' life. "Difficulty overcoming ineffective attachment styles can leave certain individuals vulnerable to addictive compulsions as compensatory behavior for their deficiency" (Ainsworth, 1989).

It is evident that there is an indisputable link between attachment and addiction, so if there is a possibility of repairing insecure bonds, it is expected that future insecure attachments are avoided and that the use of drugs is significantly reduced. "Previous parenting studies of drug-dependent mothers have shown that interventions can play an important role in the reduction of maternal drug abuse and other behaviors that are harmful to their children and families, as well as themselves" (Coleman, 2014). The intent of the present study is to work similarly by demonstrating that attachments can be repaired, and that the interpersonal relationships will simultaneously improve. This is critical, because it is the lack of interpersonal relationships that often leads to the consumptions of psychoactive substances. People who describe themselves as isolated and having trouble making friends tend to turn to drugs and alcohol to buffer their feelings of sadness, loneliness and fears of being rejected (Flores, 2004). Drugs have the power of evading adverse feelings and interchanging them for pleasant ones.

Moreover, this is the reason why people become dependent and rely on substances rather than risk triggering painful feelings.

No person wants to experience adverse and scary feeling therefore they do anything it takes to avoid them. “Individuals who have difficulty establishing emotionally regulating attachment are more inclined to substitute drugs and alcohol for their deficiency in intimacy” (Flores, 2004). For this reason, if the intervention is successful in repairing attachments, then the person will no longer need to do addictive behaviors, such as consuming illicit drugs, to fill the emptiness and internal discomfort that poor interpersonal relationships have created. It is valuable that every individual suffering from substance related and addictive disorders consider this when trying to recover and refrain from consuming.

Strengths and limitations of proposal

The study had certain critical limitations affecting the precision of the results. First, the participants were mostly from Quito, which fails to accurately represent the Ecuadorian population. Had the study been advertised for any Ecuadorian national, the fact that the study was performed in Quito caused the participants to be mainly from that city. Additionally, the sample size was not large enough, and therefore it would be essential to increase it in order to have more reliable results. Finally, there were some confounding variables that could have impacted the results. The temperament of the participant’s partner was unknown as well as the rapport between the experimenter and the participant.

Future implications

For future studies, it would be beneficial for the duration of the treatment intervention to be extended. If an eight-week intervention had been chosen, based on data from previous studies,

it is possible that the effectiveness of the intervention would show longer lasting outcomes if the program had been longer. Chick et al (1988) found that patients on extended treatment were functioning better, even though abstinence was not more common. It is important to clarify that it is the durable behavior that had longer lasting results and not recovery. Furthermore, with the length of the program, it would be novel to have several post tests. There could be a first, when the intervention is over, but a following one a year later and then another three years after. This would display more conclusive results. Lastly, it may be effective to combine psychoeducation along with psychodynamic or cognitive behavioral therapy to enhance the effectiveness of the intervention.

REFERENCES

Abuse, N. I. on D. (n.d.). Nationwide Trends. Retrieved April 9, 2019, from https://www.drugabuse.gov/publications/drugfacts/nationwide-trends

American Museum of Natural History. (2012). *Science Bulletins: Attachment Theory—Understanding the Essential Bond*. Retrieved from https://www.youtube.com/watch?v=kwxjfuPlArY

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition). https://doi.org/10.1176/appi.books.9780890425596

Borhani, Y. (2013). Substance Abuse and Insecure Attachment Styles: A Relational Study. *LUX*, *2*(1), 1–13. https://doi.org/10.5642/lux.201301.04

Bretherton, I. (1992). The Origins of Attachment Theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*, *28*, 759–775. https://doi.org/10.1037/0012-1649.28.5.759

Chandiramani, K., & Tripathi, B. M. (1993). PSYCHO-EDUCATIONAL GROUP THERAPY FOR ALCOHOL AND DRUG DEPENDENCE RECOVERY. *Indian Journal of Psychiatry*, *35*(3), 169–172.

Cherry, K. (n.d.). Why Mary Ainsworth Is Important in Child Psychology. Retrieved April 9, 2019, from Verywell Mind website: https://www.verywellmind.com/mary-ainsworth-biography-2795501

Chick, J., Ritson, G., Connaughton, J., Stewart, A. & Chick, J. (1988). Advice versus extended treatment of alcoholism: A controlled study. *British Journal of Addiction,* 81,159-170.

Coleman, M. J. (2014). An Attachment-Based Parenting Training Program for Opiate Dependent Carers. *Journal of Addiction Research & Therapy*, *05*(04). https://doi.org/10.4172/2155-6105.1000201

Collins, N. (1996). Adult Attachment Scale. Department of Psychology in University of California Santa Barbara.

Corkille, D. (2004) *El niño feliz. Su clave psicológica*. Barcelona: Gedisa.

Cornell, T., & Hamrin, V. (2008). Clinical Interventions for Children With Attachment Problems. *Journal of Child and Adolescent Psychiatric Nursing*, *21*(1), 35–47. https://doi.org/10.1111/j.1744-6171.2008.00127.x

Eguiluz Romo, L. de L. (2004). *Dinámica de la familia: un enfoque psicológico sistémico*. México, D.F.: Editorial Pax México.

Fields, R. (2013). *Drugs in perspective: causes, assessment, family, prevention, intervention, and treatment* (8th ed). New York, NY: McGraw-Hill.

Flores, P. J. (2004). *Addiction as an Attachment Disorder*. Jason Aronson.

Garbarino, S., Holland, J., University of Birmingham, & Governance and Social Development Resource Centre. (2009). *Quantitative and qualitative methods in impact evaluation and measuring results*. Birmingham? GSDRC.

Guadalupe, C. (2017). Consume de drogas, cifras que todo padre debe saber. *El Universo*. Obtained from https://www.eluniverso.com/vida/2017/09/13/nota/6378178/cifras-que-todo-padre-debe-saber

Hasin, D. S., Fenton, M. C., Beseler, C., Park, J. Y., & Wall, M. M. (2012). Analyses related to the development of DSM-5 criteria for substance use related disorders: 2. Proposed DSM-5 criteria for alcohol, cannabis, cocaine and heroin disorders in 663 substance

abuse patients. *Drug and Alcohol Dependence*, *122*(1–2), 28–37. https://doi.org/10.1016/j.drugalcdep.2011.09.005

Hedden, S. L., Kennet, J., Lipari, R., Medley, G., Tice, P., Copello, E. A. P., & Kroutil, L. A. (2014). *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*. 64.

Holmes, J. (2011). *Teoría del apego y psicoterapia: en busca de la base segura*. Sevilla: Desclée de Brouwer.

Humeniuk, R., & World Health Organization. (2010). *The Alcohol, smoking and substance involvement screening test (ASSIST): manual for use in primary care*. Geneva: World Health Organization.

Kvist, L., & Moraes R., M. (2006). *Plantas psicoactivas*.

Leshner, A. I. (1997). Drug Abuse and Addiction Treatment Research: The Next Generation. *Archives of General Psychiatry*, *54*(8), 691. https://doi.org/10.1001/archpsyc.1997.01830200015002

Lorenzo, P., Ladero, J.M., Leza, J.C. y Lizasoain, I. (2009). *Drogodependencias*. Madrid: Editorial Medica Panamericana. (3ª ed.)

Miller, S. G., September 8, S. W. |, & ET, 2016 04:34pm. (n.d.). Drug Use in America: What the Numbers Say. Retrieved April 9, 2019, from Live Science website: https://www.livescience.com/56026-drug-use-america-2015-report.html

Nora D. Volkow, M.D. (2013). Dangerous Synthetic Drugs. National Institute on Drug Abuse. Obtained from https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2013/dangerous-synthetic-drugs

Newcomb, M. D., Maddahian, E., & Bentler, P. M. (1986). Risk factors for drug use among adolescents: concurrent and longitudinal analyses. *American Journal of Public Health*, *76*(5), 525–531. https://doi.org/10.2105/AJPH.76.5.525

Shaffer, D., & Kipp, K. (2010). *Psicología del desarrollo: infancia y adolescencia*. México [etc.: Cengage Learning.

Smith, D. E., Seymour, R., & Ebrary, I. (2001). *Clinician's guide to substance abuse.* New York: McGraw-Hill, Health Professions Division.

Substance Abuse Psychoeducation - Education in Treatment. (n.d.). Retrieved April 20, 2019, from Cirque Lodge website: https://www.cirquelodge.com/treatment/lectures/

Waisman Campos, M., & Benabarre Hernández, A. (2017). *Adicciones: uso de sustancias psicoactivas y presentaciones clínicas de la enfermedad adictiva*.

Winnicott, D. W. (1990). *The maturational processes and the facilitating environment: studies in the theory of emotional development* (Repr). London: Karnac [u.a.].

ANNEXED A: Application for approval of the study and informed consent form

Comité de Ética de Investigación en Seres Humanos
Universidad San Francisco de Quito
El Comité de Revisión Institucional de la USFQ
The Institutional Review Board of the USFQ

Formulario Consentimiento Informado

Título de la investigación: *Group psychoeducation for repairing attachment and achieving abstinence in addicted populations*
Organización del investigador: *Universidad San Francisco de Quito*
Nombre del investigador principal: *Laura M. Puerta Correal*
Datos de localización del investigador principal: *0990000000, lmpuerta@estud.usfq.edu.ec*
Co-investigadores: *n/a.*

DESCRIPCIÓN DEL ESTUDIO
Introducción *(Se incluye un ejemplo de texto. Debe tomarse en cuenta que el lenguaje que se utilice en este documento no puede ser subjetivo; debe ser lo más claro, conciso y sencillo posible; deben evitarse términos técnicos y en lo posible se los debe reemplazar con una explicación)*
Este formulario incluye un resumen del propósito de este estudio. Usted puede hacer todas las preguntas que quiera para entender claramente su participación y despejar sus dudas. Para participar puede tomarse el tiempo que necesite para consultar con su familia y/o amigos si desea participar o no. Usted ha sido invitado a participar en un investigación sobre la efectividad de la psicoeducación para reparar el apego con el fin de prevenir y el contunio abuso de sustancias.
Propósito del estudio (incluir una breve descripción del estudio, incluyendo el número de participantes, evitando términos técnicos e incluyendo solo información que el participante necesita conocer para decidirse a participar o no en el estudio)
Se reclutarán 40 participantes con el objetivo de determinar cómo, y en qué medida, la psicoeducación grupal puede lograr la abstinencia y reparar los vínculos inadecuados.
Descripción de los procedimientos (breve descripción de los pasos a seguir en cada etapa y el tiempo que tomará cada intervención en que participará el sujeto)
1. Reclutar voluntarios que cumplan con los criterios requeridos para la investigación. 2. Diagnosticar a los participantes y determinan si efectivamente tienen un problema de adiccion. Simultaneamente se evaluará el apego de la persona. 3. Comenzar programa de intervención. - Las primeras seis semanas serán principalmente un proceso de enseñanza, donde se enseñará información práctica relacionada con los archivos adjuntos seguros, la adicción y la recuperación. - Durante la semana siete y ocho, los terapeutas ayudarán a los padres a implementar todo lo que han aprendido y lo aplicarán con sus hijos. 4. Al culminar, evaluar nuevamente a los partipantes. 5. Analizar datos y sacar conclusiones.

Riesgos y beneficios (explicar los riesgos para los participantes en detalle, aunque sean mínimos, incluyendo riesgos físicos, emocionales y/o sicológicos a corto y/o largo plazo, detallando cómo el investigador minimizará estos riesgos; incluir además los beneficios tanto para los participantes como para la sociedad, siendo explícito en cuanto a cómo y cuándo recibirán estos beneficios)
Existe el riesgo de que como resultado de la intervencion, los participantes experimenten sentimientos adversos e indeseados. Inclusive, pordria occurrir que dichos sentimientos ocasionen fuertes respuestas de abstinencia por tanto aumentando el riesgo de recaida.

Los participantes se beneficiarían ya que la intervención los ayudará a reconocer el problema y reparar sus apegos. El buen apego es fundamental para manetener relaciones interpersonales sanas y por ende evitar conductas adictivas. Ademas, se espera que al reparar el apego de los participantes, los mismo puedan crear vinculos seguros con sus hijos por lo tanto disminuyendo la prevalencia y frecuencia de consumo de sustacias psicoactivas.

Confidencialidad de los datos *(se incluyen algunos ejemplos de texto)*

Para nosotros es muy importante mantener su privacidad, por lo cual aplicaremos las medidas necesarias para que nadie conozca su identidad ni tenga acceso a sus datos personales:

1) La información que nos proporcione se identificará con un código que reemplazará su nombre y se guardará en un lugar seguro donde solo el investigador tendrá acceso.

2A) Si se toman muestras de su persona estas muestras serán utilizadas solo para esta investigación y destruidas tan pronto termine el estudio *(si aplica) ó*

2B) Si usted está de acuerdo, las muestras que se tomen de su persona serán utilizadas para esta investigación y luego se las guardarán para futuras investigaciones removiendo cualquier información que pueda identificarlo *(si aplica)*

3) Su nombre no será mencionado en los reportes o publicaciones.

4) El Comité de Bioética de la USFQ podrá tener acceso a sus datos en caso de que surgieran problemas en cuando a la seguridad y confidencialidad de la información o de la ética en el estudio.

Derechos y opciones del participante (se incluye un ejemplo de texto)

Usted puede decidir no participar y si decide no participar solo debe decírselo al investigador principal o a la persona que le explica este documento. Además aunque decida participar puede retirarse del estudio cuando lo desee, sin que ello afecte los beneficios de los que goza en este momento.

Usted no recibirá ningún pago ni tendrá que pagar absolutamente nada por participar en este estudio.

Información de contacto

Si usted tiene alguna pregunta sobre el estudio por favor llame al siguiente teléfono 0990000000 que pertenece a Laura Puerta, o envíe un correo electrónico a lmpuerta@estud.usfq.edu.ec

Si usted tiene preguntas sobre este formulario puede contactar al Dr. Iván Sisa, Presidente del Comité de Ética de Investigacion en Seres Humanos de la USFQ, al siguiente correo electrónico: comitebioetica@usfq.edu.ec

<table>
<tr><td colspan="2">Consentimiento informado (Es responsabilidad del investigador verificar que los participantes tengan un nivel de comprensión lectora adecuado para entender este documento. En caso de que no lo tuvieren el documento debe ser leído y explicado frente a un testigo, que corroborará con su firma que lo que se dice de manera oral es lo mismo que dice el documento escrito)</td></tr>
<tr><td colspan="2">Comprendo mi participación en este estudio. Me han explicado los riesgos y beneficios de participar en un lenguaje claro y sencillo. Todas mis preguntas fueron contestadas. Me permitieron contar con tiempo suficiente para tomar la decisión de participar y me entregaron una copia de este formulario de consentimiento informado. Acepto voluntariamente participar en esta investigación.</td></tr>
<tr><td>Firma del participante</td><td>Fecha</td></tr>
<tr><td>Firma del testigo (si aplica)</td><td>Fecha</td></tr>
<tr><td colspan="2">Laura M. Puerta Correal</td></tr>
<tr><td>Firma del investigador</td><td>Fecha</td></tr>
</table>

ANNEXED B: ASSIST Screening Test

Revised Adult Attachment Scale (Collins, 1996)
Please read each of the following statements and rate the extent to which it describes your feelings about romantic relationships. Please think about all your relationships (past and present) and respond in terms of how you generally feel in these relationships. If you have never been involved in a romantic relationship, answer in terms of how you think you would feel.
Please use the scale below by placing a number between 1 and 5 in the space provided to the right of each statement.

1---------------2---------------3---------------4---------------5

Not at all characteristic of me — **Very characteristic of me**

1) I find it relatively easy to get close to people. ________

2) I find it difficult to allow myself to depend on others. ________

3) I often worry that romantic partners don't really love me. ________

4) I find that others are reluctant to get as close as I would like. ________

5) I am comfortable depending on others. ________

6) I don’t worry about people getting too close to me. ________

7) I find that people are never there when you need them. ________

8) I am somewhat uncomfortable being close to others. ________

9) I often worry that romantic partners won’t want to stay with me. ________

10) When I show my feelings for others, I'm afraid they will not feel the same about me. ________

11) I often wonder whether romantic partners really care about me. ________

12) I am comfortable developing close relationships with others. ________

13) I am uncomfortable when anyone gets too emotionally close to me. ________

14) I know that people will be there when I need them. ________

15) I want to get close to people, but I worry about being hurt. ________

16) I find it difficult to trust others completely. ________

17) Romantic partners often want me to be emotionally closer than I feel comfortable being. ________

18) I am not sure that I can always depend on people to be there when I need them. ________

ANNEXED C: Adult Attachment Scale

A. WHO - ASSIST V3.0

Interviewer ID | Country | Clinic

Patient ID | Date

Introduction ***(Please read to patient)***

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected, or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

Note: Before Asking Questions, Give ASSIST Response Card to Patient

Question 1
(if completing follow-up, please cross-check the patient's answers with the answers given for Q1 at baseline. Any differences on this question should be queried)

In your life, which of the following substances have you ever used? *(NON-MEDICAL USE ONLY)*	**No**	**Yes**
a . Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative:
"Not even when you were in school?"

If "No" to all items, stop interview.
If "Yes" to any of these items, ask Question 2 for each substance ever used.

Question 2

In the <u>past three months</u>, how often have you used the substances you mentioned *(FIRST DRUG, SECOND DRUG, ETC.)?*	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6.

If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4, and 5 for <u>each substance</u> used.

Question 3

During the <u>past three months</u>, how often have you had a strong desire or urge to use *(FIRST DRUG, SECOND DRUG, ETC.)?*	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

Question 4

During the <u>past three months</u>, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC.)* led to health, social, legal, or financial problems?	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the <u>past three months</u>, how often have you failed to do what was normally expected of you because of your use of *(FIRST DRUG, SECOND DRUG, ETC.)*?	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

Ask Questions 6 & 7 for all substances ever used (i.e., those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else <u>ever</u> expressed concern about your use of *(FIRST DRUG, SECOND DRUG, ETC.)?*	**No, Never**	**Yes, in the past 3 months**	**Yes, but not in the past 3 months**
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other - specify:	0	6	3

Question 7

Have you <u>ever</u> tried and failed to control, cut down, or stop using *(FIRST DRUG, SECOND DRUG, ETC.)?*	**No, Never**	**Yes, in the past 3 months**	**Yes, but not in the past 3 months**
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other - specify:	0	6	3

Question 8

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you ever used any drug by injection? ***(NON-MEDICAL USE ONLY)***	0	2	1

IMPORTANT NOTE:

Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

Pattern of Injecting	Interventon Guidelines
Once weekly or less or Fewer than 3 days in a row	Brief intervention including "risks associated with injecting" card
More than once per week or 3 or more days in a row	Further assessment and more intensive treatment*

How to calculate a specific substance involvement score.

For each substance (labelled a. to j.), add up the scores received for Questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: **Q2c + Q3c + Q4c + Q5c + Q6c + Q7c.**

Note that Q5 for tobacco is not coded, and is calculated as **Q2a + Q3a + Q4a + Q6a + Q7a.**

The type of intervention is determined by the patient's specific substance involvement score

	Record specific substance score	no intervention	receive brief intervention	more intensive treatment*
a. tobacco		0 - 3	4 - 26	27 +
b. alcohol		0 - 10	11 - 26	27 +
c. cannabis		0 - 3	4 - 26	27 +
d. cocaine		0 - 3	4 - 26	27 +
e. amphetamine		0 - 3	4 - 26	27 +
f. inhalants		0 - 3	4 - 26	27 +
g. sedatives		0 - 3	4 - 26	27 +
h. hallucinogens		0 - 3	4 - 26	27 +
i. opioids		0 - 3	4 - 26	27 +
j. other drugs		0 - 3	4 - 26	27 +

NOTE: *Further assessment and more intensive treatment may be provided by the health professional(s) within your primary care setting, or by a specialist drug and alcohol treatment service when available