Oral Speech Errors In Adult Attachment Interviews: A Pilot Study

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Summary

Aims

In oral speech everybody makes grammatical and stylistic mistakes which are against the rules of their mother tongue. However, clinicians agree that some patients (not only psychotic) make many more mistakes than others. Some people notice their own failures and show an emotional reaction (amusement or embarrassment). Qualitative research on speech errors on a Russian clinical sample led us to suggest that such an awareness of one's own grammar was connected not only with the severity of psychic pathology but with the type of the error. Errors fitting the classical concept of repression ("Freudian slips" - Freud 1901, 1905) were more noticeable for the speaker, as well as for the listener. However, such slips of the tongue appeared to be less frequent, while with most of the errors it was not possible to determine a psychic conflict underlying the mistake. Such errors usually remained unnoticed by the speaker.

They mostly included syntactic incorrectness, queer lexical usage or stylistically peculiar phrases conveying a vague feeling of something "wrong" or "uncertain". Exact registration and further investigation of these errors helped to determine what was grammatically or stylistically wrong with them. However, linguistic analysis was not of much help to classify these errors.

Based on clinical and developmental studies (e.g. differentiation between animate and inanimate in psychotic and borderline patients as described by Searles, 1962, 1989; particular speech features of patients in the state of grandiose self as observed by Kohut, 1971, 1977; development of mentalisation and syntactic skills as conceptualised by Fonagy, 1991, 1995; acquiring verbal skills as investigated by Piaget 1954; development of verbal causation as reviewed by Clark & Clark, 1977) we worked out a psychological classification of errors into three levels that hypothetically corresponded to successive stages of speech development in the child: level I mistakes (causality, or self-object mixture); level II (intentionality, or failures to describe human self, making proper use of grammatical and stylistic means, idioms, metaphors inherent in the language); level III (conflict of intentions, or classical 'Freudian' slips).

Classification of Speech Errors

Our first general hypothesis derived from clinical impressions was that patients with pronounced narcissistic features or those who were discussing their narcissistic problems during particular periods of psychotherapy and analysis had more inclination to deflect from correct grammar of the language. While in traditional linguistics (Mehringer 1895, 1908; Ellis 1980; Fromkin 1980, 1988) speech errors were mainly explained by phonetic or lexical proximity of the intended and actual utterances, it was natural for psychoanalysts to look for motivational conflicts. However, a large amount of speech errors apparently did not fit the Freudian concept of repression.

During several years of registration of grammatical and stylistic speech errors of Russian patients the analyst (A.K.) collected a sample of more than 400 speech errors and worked out a system of psychological classification of such errors based on psychoanalytic and developmental studies. Here is a brief review of this classification with some examples translated from Russian.

Level I errors

The situation was hardly tolerating for me.
Our mother studied us Russian language.
The punishment did not consist of my not having asked.

Level I errors are in fact false accounts of subject-object interaction or causality. According to developmental studies, these are typical mistakes of children around 3 years old (the English examples were taken from Clark & Clark, "Psychology and language" 1977):

I'm gonna just fall it on her. (instead of drop)
Mommy, can you stay this open? (instead of leave)
She came it over there (instead of brought)

Psychoanalytically it would be logical to suppose that verbal mastering of subject-object construction by the child should depend upon the relations with primary objects. Thus, Level I speech errors made by adults may be reflective of an early disturbance or a deep regression.

Level II errors

I have experienced an erotic couple interaction.
Sexual relations started to happen with me.
At school I was often captains of the team.

Such errors can be understood psychologically as queer 'mechanical' descriptions of human self and one's intentional stance. According to Fonagy (1991), the capacity to verbalize mental states appears after 3.5 years old. Self-representation is based upon this ability. For instance, a person is alive (see erroneous utterances of borderline patients cited by Searles, 1989) and has only one life. Correct usage of singular-plural forms (see the example about captains above), verbal tenses, definite and indefinite articles, specific idioms and metaphors etc. might be linked with self-representation and human identity as a whole. Comparing examples of mistakes in Russian, English, German it is interesting to observe how a similar psychological content can be conveyed through different grammatical forms.

Level III errors

These represent classical 'Freudian' slips of the tongue revealing a previously repressed intention. As Fonagy (1991) argues, the mechanism of repression is always based upon fully articulated thoughts that need verbal representation of mental states. These considerations enable us to formulate a basis for further research in the field of defense mechanisms utilizing methods of investigation of speech peculiarities, particularly oral speech errors.

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Supposing that a psychological classification of errors should work irrespective of the language spoken, we attempted to replicate the Russian study with German speaking subjects.

Methods

As a source of data we used AAI tape recordings and verbatim protocols of 8 patients who had been in treatment in the Department of Psychotherapy and Psychosomatics of the University of Ulm and 8 control AAI protocols. Speech deviations caused by dialect or low level of education were thoroughly checked out and excluded from investigation. It seems, however, doubtful that level I mistakes (self-object mixtures) should depend upon these parameters.
The treating analyst (H.K.) provided a clinical account including ICD diagnoses. The AAIs were conducted and evaluated by a certified specialist (A.B.). The grammatical and stylistic evaluation of records and protocols was done by a specialist in germanistics (E.G.). All the researchers worked independently until the last stage of the study, when psychological classification was carried out and all the data was put together (A.K.).

Results

The amount of speech errors confirmed that AAI transcripts were a suitable source of data. The psychological background of the registered mistakes in German appeared to be comparable with those in the Russian sample.

Discussion of a German patient diagnosed with borderline personality organisation whose mistakes were comparable to a BPO patient in the Russian sample

Speech Errors and the Psychotherapeutic Process

One patient (female) in our German clinical sample diagnosed with borderline personality organization had a much larger number of level I and II errors than all other subjects of the study. It is interesting to note that in the Russian clinical study of speech errors there had been a case of a female patient diagnosed with BPO who had also made a great number of errors. This gave us an opportunity to compare the corresponding grammatical constructions and stylistic features of German and Russian utterances with similar psychological background.

The German patient was attributed an U/E2 (unresolved trauma, unresolved loss/angry preoccupied) attachment classification. It was stressed in the AAI report that the patient experienced, since her childhood and up to present time, a sense of mixed roles, in which she had to take responsibility for her mother. This might have contributed to her difficulties in verbally describing self and object (level I and II mistakes).

After two years of psychoanalytic treatment the patient was interviewed for her attachment status once more. Her attachment classification shifted from U-E2 to E2, thus showing that the unresolved trauma and loss had been elaborated in analysis.

In the second AAI the patient continued to make many mistakes, however the quality of these mistakes changed. In the first AAI the patient made 25 errors (12 of the level I, 12 of the level II, and 1 of the level III). In the second AAI 22 errors were registered (correspondingly, 3, 17, 2). We can see that the amount of level I errors considerably diminished, while the number of Levels II and III errors increased. We know from developmental evidence that a bigger amount of self definition mistakes (level II) are typical for a later developmental period than subject-object mixtures (level I).

The account of the treating analyst corresponds with the psycholinguistic findings in a meaningful way. According to this account, the main themes (and their transference implications) introduced by the patient shifted from the maternal to the paternal object that had been previously almost absent from the discourse.

In the second AAI some erroneous utterances of an intermediate type appeared that were difficult to ascribe to the level I (incorrect description of subject-object interaction) as they became more understandable from the point of view of motivational conflict (level III). However, these errors lacked a clear sense of appearance of the conflictual motive - an important feature of a Freudian slip. This did not allow to classify them as level III errors. For example:

Dann hat sie mir alles getan…
(Then she did everything to me…)

In the sense of taking care such a phrase should have been formulated as "sie hat alles fuer mich getan" (she did everything for me). The way the patient formulated it the utterance acquired a vague tint of aggression that corresponded with an earlier paradoxical phrase of the patient "aggressive Fuersorge" (aggressive care). Such examples allow to suggest a possible mechanism of gradual becoming aware of one's emotional ambivalence in terms of psychic conflict, which might be similar to a developmental movement characteristic for a particular age period.

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From the two tables below it can be seen that the rate of speech errors of levels I and II was significantly higher in the clinical sample than in the control group. Patients with narcissistic psychopathology and insecure attachment status showed a tendency towards a

bigger amount of level I and II speech errors and a smaller amount of level III errors (slips of the tongue) than the other patients and the subjects in the control group.

TABLE 1. Distribution of speech errors in AAIs of 8 patients

Sex	Diagnosis, ICD-10	Attachment status	Speech errors-whole	Levels of speech errors		
				I	**II**	**III**
f	F60.31 Borderline personality organisation; F33 recurrent suicidality	U/E2	25	12	12	1
m	F33 recurrent sucidal episodes F60.8 Narcissistic character disorder	E2	4	3	1	0
m	F48.1 Depersonalisation syndrome, mixed personality disorder; F61.0 depressive syndrome	U/Ds1	10	3	5	2
m	Narcissistic character	E1	15	2	7	6
m	Narcissistic character	E1	6	0	4	2
f	F34.1 Dysthymia, misuse by the husband	U/F2	11	0	8	3
f	F45…32 Psychogenes colon irritabile; F34.1 dysthymia	E2/Ds2/CC	8	0	7	1
f	F43,21 PTSD after suicide of the husband	U/E2	3	0	0	3

TABLE 2. Distribution of speech errors in the AAIs of control group.

Sex	Attachment status	Speech errors-whole	Levels of speech errors		
			I	**II**	**III**
m	Ds	8	3	5	0
m	E	2	0	2	0
m	F	5	0	2	3
f	Ds	4	0	2	2
f	F	3	0	1	2
m	F	3	0	0	3
f	Ds	2	0	0	2
f	F	1	0	0	1

Explanations for the Tables
Attachment classification
U – unresolved trauma/loss
F – secure; F4 – earned secure
E – entangled; E1 – passive entangled; E2 – angry entangled
Ds – dismissive; Ds1 – distanced (idealising); Ds2 – distanced (devaluating)
CC – can't classify


1-3 errors during one interview


more than 3 errors during one interview

Commentary to the Tables
Tables 1 and 2 demonstrate that the amount of speech errors made during AAIs in the clinical sample was significantly higher than in the control group. It can also be seen that in the control group level III errors (conflict of intentions, or Freudian slips of the tongue) prevailed, while errors of the level I (causality) were extremely rare. In contrast, a considerable amount of level I and level II (intentionality) errors was registered in the AAIs of the patients with narcissistic pathology and insecure attachment status.

A large number of level I (self-object interaction) speech errors was characteristic for the subjects with severe narcissistic problems and AAI classifications of unresolved loss and unresolved trauma combined with angry-preoccupied or dismissing attachment strategies. These results fit our hypothesis that severe narcissistic pathology might be connected with difficulties in verbal self and object representation rooted in early relationships with primary objects.

Unexpectedly, acute suicidal crises (not only of the respondent but also of an important attachment figure) corresponded to a low amount of level II (self-representation) speech errors. One may suppose that this does not point to better developed verbal skills of these patients but rather suggests that suicidal experience dismisses the task of self description. On the contrary, attempts to describe and express oneself - to symbolizes - may serve as a barrier against an acted out suicidal attempt. This hypothesis deserves further investigation in terms of the content of the material presented by the interviews.

As a whole, a detailed analysis showed that the individual amount and distribution of speech errors was highly reflective of clinical and attachment status. This conclusion allowed us to try to evaluate certain parameters of psychotherapeutic process by measuring the amount and quality of speech errors in AAI.

Speech Errors and the Psychotherapeutic Process
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subjects of the study. It is interesting to note that in the Russian clinical study of speech errors there had been a case of a female patient diagnosed with BPO who had also made a great number of errors. This gave us an opportunity to compare the corresponding grammatical constructions and stylistic features of German and Russian utterances with similar psychological background.

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Implications for psychoanalysis

Empirical investigation of individual oral speech features on the micro-level and, in particular, the attempt to comprehend the mechanisms of spontaneous speech errors touches upon key problems of psychoanalysis. The Freudian concept of repression developed largely on the basis of understanding parapraxes, including slips of the tongue. Since Freud's time the psychoanalytic understanding of speech errors did not go beyond the mechanism of new appearance of a repressed content (Isay 1977), while linguists were considering only cognitive mechanisms of erroneous utterances (Ellis 1980; Fromkin 1988). In the meanwhile psychoanalytic authors who wrote about symbolization, metaphoric thinking, narcissistic speech, object representation, mentalisation had important insights into earlier phases of speech development (e.g. Klein 1930; Ferenzi 1933; Searles 1962, 1989; Kohut 1971, 1977; Blatt 1974; Fonagy 1991; Corradi-Fiumara 1995 and others). Guided by their views we elaborated a psychological classification of speech errors for our empirically collected examples of erroneous utterances produced by different patients in psychoanalysis.

Speech errors other than 'Freudian' slips occurring in conversations or in analytic process usually do not draw much attention and are difficult to memorise. Their objective registration, where possible based on tape recordings (like in the Adult Attachment Interviews in this study), introduces us directly into the realm of immature defense mechanisms in action, while following psycholinguistic parallels between adult mistakes and the language of the child may help to trace their developmental roots.
Using our classification of speech errors we discovered that quantity and quality of speech errors was a highly individual value. Clinical observations and attachment data allowed us to suggest some connections between psychopathology and speech features. Further research on individual speech peculiarities might be useful for diagnostics and choice of analytic strategy. It may help to distinguish between temporal regression to an earlier developmental stage and underdevelopment of some important verbal skills that might occur due to disturbances of early object relations and attachment to primary objects.

Needless to say, not only the features of the patient's speech but the transference-countertransference interplay in the analytic dyad comes to the fore when speech peculiarities are thoroughly investigated. Considering the technique of analytic interpretation it is worthwhile to have more evidence about how an interpretation is understood (or misunderstood) by the patient. Investigating speech errors at different moments may provide new insights into the process of working through in the analytic couple. Our study showed that speech errors classification can become an instrument to measure therapeutic changes and in some cases to observe how these happen in the therapeutic process.

Mentioning some other advantages that we see in our approach it is interesting to point out that collecting data on grammar is a convenient research method. It involves a procedure that is almost precise (although based on expertise and supported by statistical control) and does not require several independent raters to be reliable. In addition, our

classification of errors applied to different languages can provide evidence concerning psychological background of language acquisition and usage independent of the concrete grammar or conventional styles, thus widening the access to the unconscious.

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Keywords

Attachment, defense mechanisms, narcissism, psychoanalytic process, speech errors

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