Addiction as an Attachment Disorder

WHAT COUPLE & FAMILY THERAPIES TAUGHT ME ABOUT TREATING ADDICTION

RYAN BUNDREN, M. DIV., PHD(C), LADAC II, CAADC

Outline & Goals

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- About the Presenter & Presentation
- History of the Couple/Family Therapy Movement
- Introduction to Systems Theory
- History of Attachment Theory
- Addiction as an Attachment Disorder
- Attachment to God
- Integration of Couple/Family Therapy skills & Addiction as an Attachment Disorder in SUD Treatment
- Conclusion
- Q&A

Goals

- Develop further understanding about Couple/Family Therapies, Systems Theory, and Attachment Theory.
- Identify how addiction may function as an attachment disorder
- Participants leave the session as an "attachment-informed" clinician able to begin to integrate how couple/family therapy skills and understanding addiction as an attachment disorder may be used in SUD treatment.
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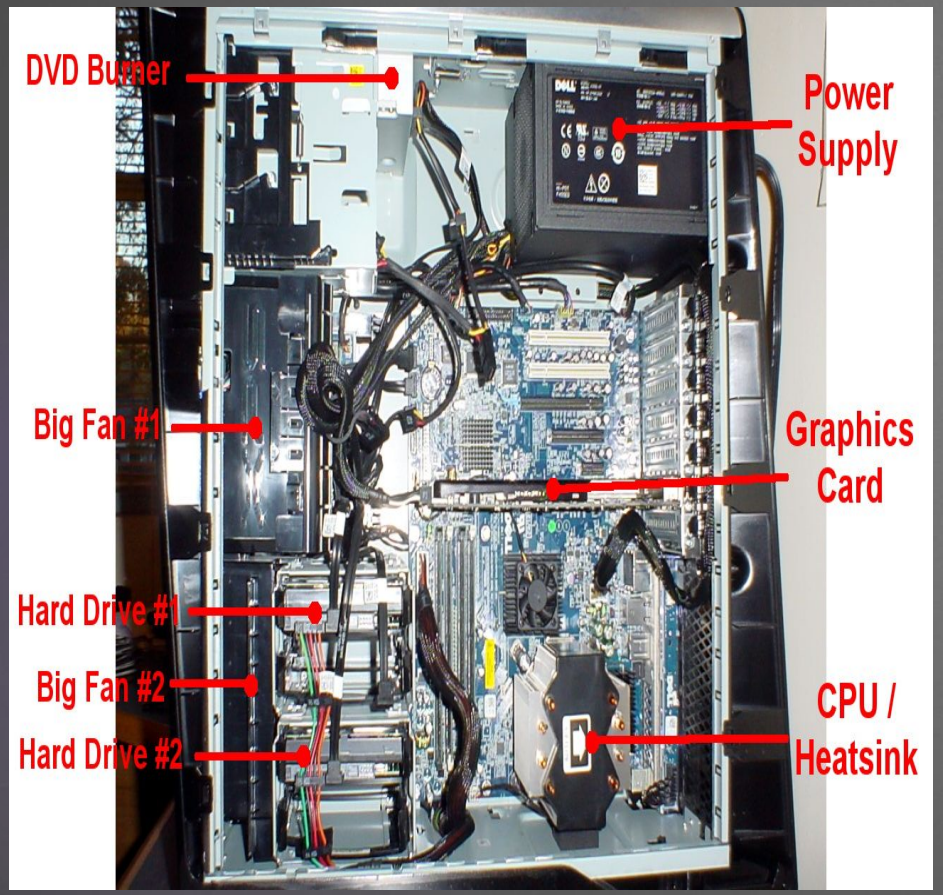
The Presenter & Presentation

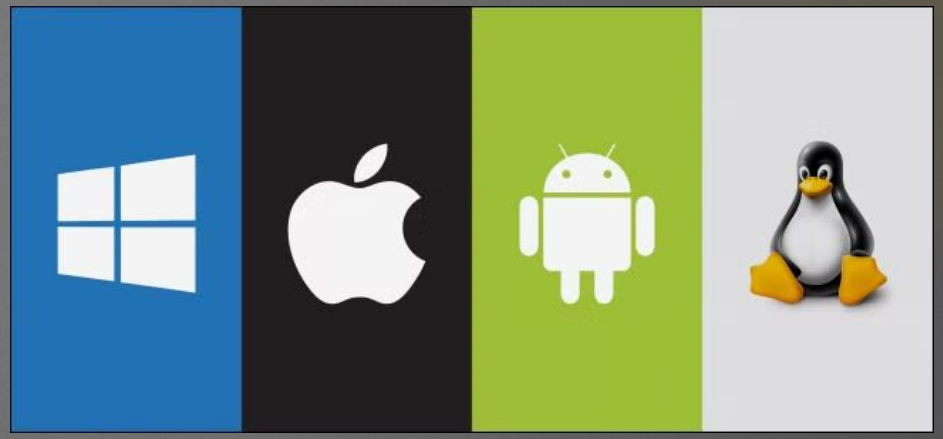
- Ryan is
  - LADAC II.
  - Graduated in 2019 with a Master's of Divinity with an concentration in counseling.
  - Currently a doctoral candidate in a PhD in Marriage and Family Therapy Program.
- Began working in the field in 2015.
- Served in various roles: primary counselor in residential and IOP, case manager, outpatient MAT clinician, SUD Treatment Program Director.
- Became convinced that one of the areas we fail as SUD treatment providers is working with couples and families.
- Decided to further my education and sought a degree in MFT, historically a field of behavioral sciences often unaffiliated with substance use disorder.
- My experiences as both LADAC II and MFT student shaped transformed me and contributed to my passion for this topic.

Brief History of the Couple/Family Therapy Movement

- The Family Systems Therapy movement began in the 1950s-1960s as a counter therapy movement to traditional Freudian Psychoanalysis and emerging Cognitive/Behavioral psychology.
- Family Therapists conceptualized symptoms, dysfunction, problems, etc. as existing in between family members and couples
- They began to consider how symptoms may be perpetuated by the unwritten rules, values, codes, and other interpersonal dynamics that exist within couple and family relationships.
- This gave rise to viewing the family as a "system" and treating while families or couples as the "client" instead of one "problematic" member of the family or couple.
- This movement believes that treating the one "client" is often not enough to produce lasting change, which can only be produced by change within the entire couple or family system.

Where is the system?





Family Systems Theory

- Psychological framework that views the family as an interconnected emotional unit rather than a collection of independent individuals that is deeply shaped by the network of family relationships and intergenerational patterns.
- Tracks patterns within the system and across generations rather than identifying individual symptoms.
- Interventions address the system as a whole.
- The therapist uses intervention to address the system as a whole and later evaluates the family to see how the intervention changed the whole system and whether this results in:
  - First-order change: changes in specific behaviors that reduce the immediate problem.
  - Second-order change: transformational changes in underlying family dynamics, resulting in changes in how the entire family functions.
- Process > Content
  - Systemic therapy seeks to address the processes of dysfunction rather than the content of the dysfunction.
- Here-and-now Focus
  - Focuses on what is happening in the therapy room through experiencing and processing enactments with the couple and family, rather than focusing on problematic issues that have occurred prior to therapy.

Common patterns in Family Systems Theory

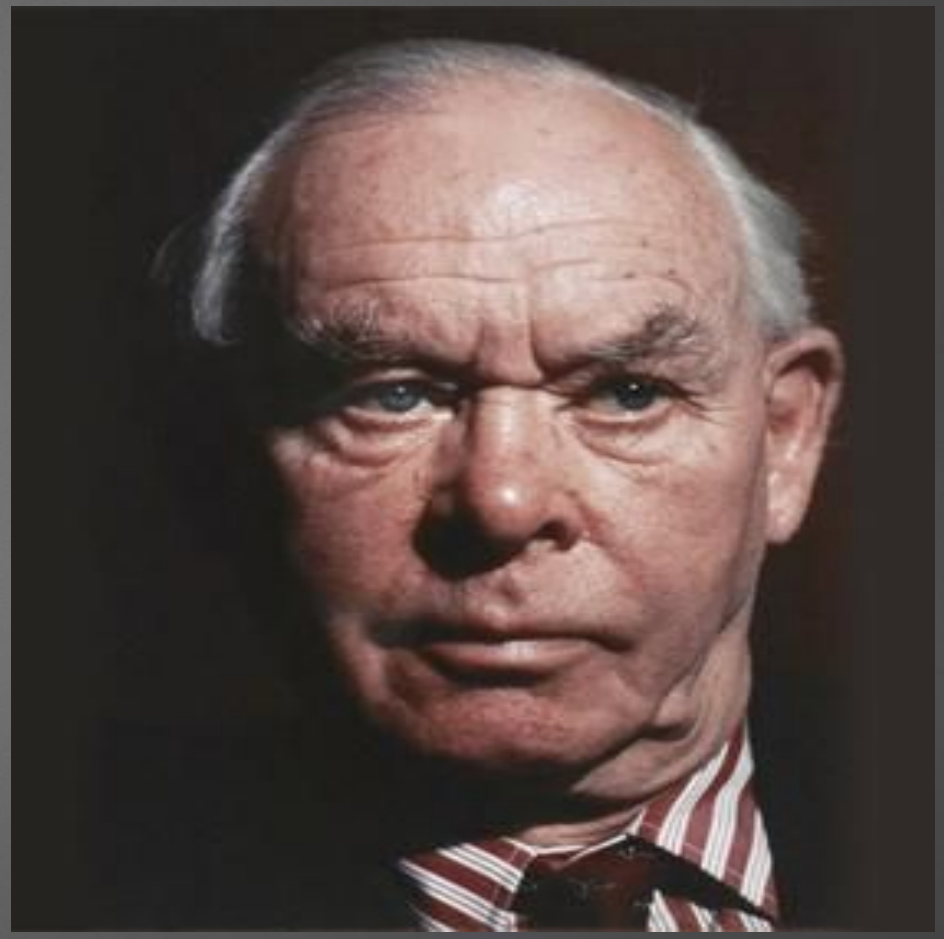
- Pursuer-Distancer dynamic:
  - One member wants connection with an emotionally unavailable member who is frightened of connection.
- "Top-down" authoritarian dynamic:
  - "You mess with the bull, you get the horns"
- Codependency:
  - "I need to be needed"
- Counterdepedency:
  - "I don't need anything. I can take care of myself"
- Emotional Cutoff:
  - "We don't talk about ***them*** anymore"
- Triangulation:
  - "I need **YOU** to help me fix **THEM**"
- Family Projection Process:
  - A parent sees the child's ordinary behavior as confirmation of the parent's fear. As a result, the child internalizes the fear response of the parent and become afraid of the behavior.

History of Attachment Theory

- Attachment theory is a **"biopsychosocial"** framework rooted in mammalian biology that suggests children require an "attachment" relationship with a caregiver for survival, protection, and growth.
  - Attachment Theory argues that the caregiver serves as a "secure base" from which children can experience the world.
  - Researchers believe that Attachment Theory is a biological fact of human existence.
  - Children are born "hardwired" to seek attachment from caregivers.
  - Whether attachment needs are met or not as well as how those attachment needs are met affect a child's development and contribute to the development of a child's "attachment style"
- Attachment theory is of clinical significance when working with adults because an individual's "attachment system" is shaped by the relationship model that was presented to them by their caregivers.
  - The relationship with our parents becomes the relationship we enact with others, particularly spouses and children.

John Bowlby

- John Bowlby pioneered attachment theory by integrating his experiences as a child psychiatrist and psychoanalyst, the study of mammalian behavior with their young, and evolutionary psychology.
- Bowlby believed humans have the same hardwired attachment system for survival and protection.
- Worked with London's children and their families in various capacities from 1937 to 1957.
- First articulated "Attachment theory" in a presentation to the British Psychoanalytic Society in 1957.



Harry Harlow's Monkeys

- In the 1950s, Harry Harlow conducted experiments proving that monkeys seek contact comfort as an attachment need, validating Bowlby's research that mammals have a biological need for attachment.
- Key aspects of Harlow's experiments are the cloth mother, wire mother, milk and Freud Drive theory, mechanical monster, and the "secure base"

Mary Ainsworth's "*Strange Situation*"

- In 1965, Mary Ainsworth conducted the "Strange Situation" experiment, which expanded Attachment Theory into Attachment Styles, theorizing that "attachment injuries" over time contribute to different types of insecure attachment.
- The experiment revolves around a mother and infant playing alone, a stranger entering, the mother exiting, and then the mother briefly returning and reuniting with the infant. The researchers observe the infant's reaction upon reunion with the mother to theorize "attachment styles".

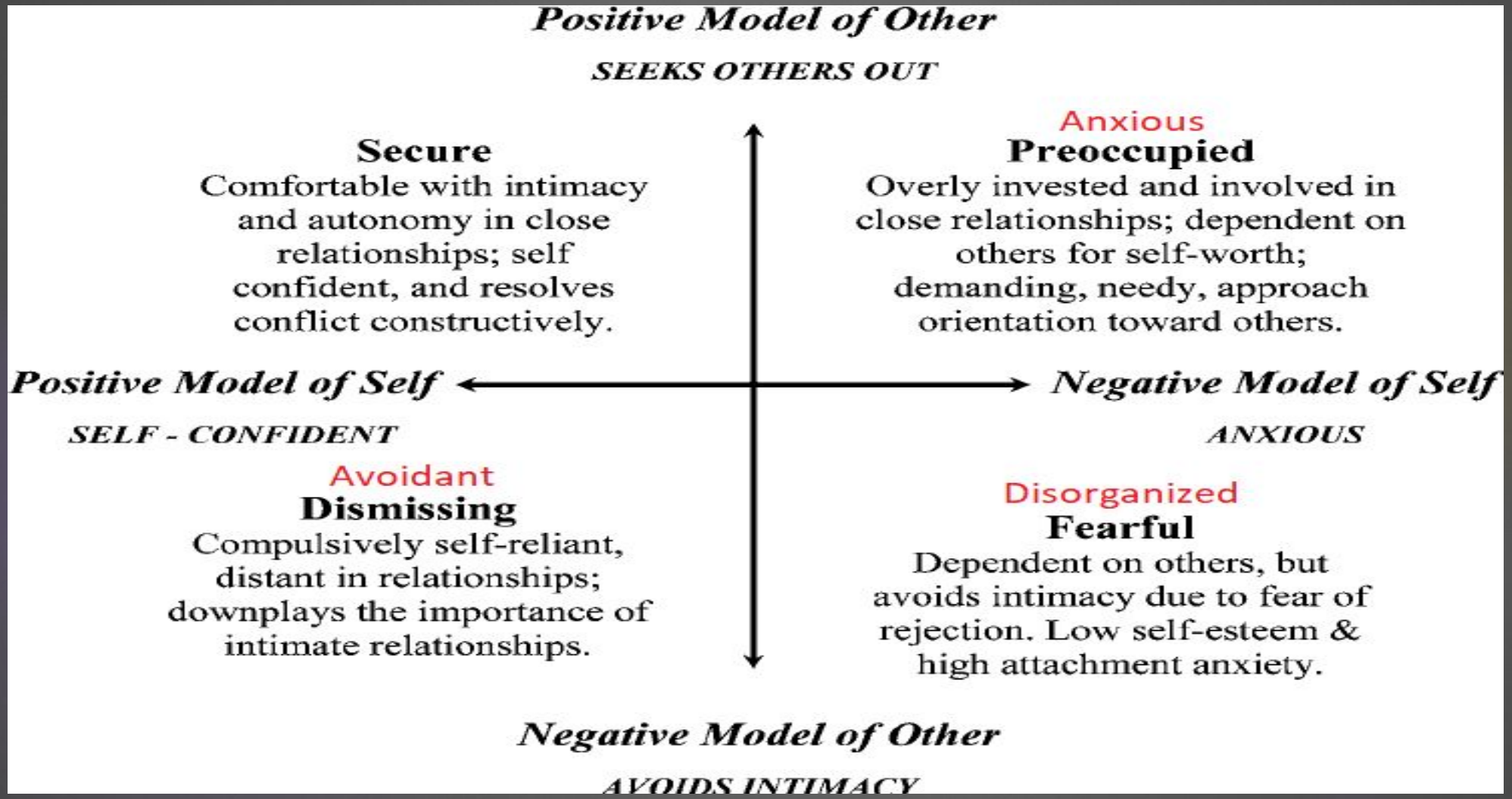
Edward Tronick's "Still Face"

- The "still face" experiment was conducted across the 1970s. It involved a parent visibly interacting with their infant and then at a certain point the parent would hold a "still face" for two minutes. Researchers studied the child's behavior during the "still face" and how the child soothed with the parent afterwards.
- Reinforced previous findings that attachment is a biological need met through human interaction.
- New findings were that infants do not possess the ability to "self-soothe" and only soothe through connection with their caregiver.
- Implications for further research were that children learn "soothing strategies" by soothing interactions with their caregivers.

Attachment Styles

- Bowlby argued that attachment experiences contribute to a child's development of an "internal working model" based on the child's view of self, others, and the world.
- Bowlby's collaboration with Ainsworth confirmed the attachment system and that internal working models of the attachment system vary based on attachment experiences, resulting in "attachment styles"
- Secure – Caregivers who are consistently available, responsive, and engaged show their children they are worthy of love, their needs will be met, others value them and will help, and the world is a safe and secure place.
- Anxious – Caregivers who are inconsistent cause their children to believe something is wrong with them, and they must "do something" in order to be loved and have their needs met. These children believe they are flawed, others will love them if they perform correctly, and the world is safe as long as they are "good".
- Avoidant – Caregivers who are unavailable cause children to believe that the world is unsafe and that others will abandon them, leading them to believe they must take care of themselves so their needs are met.
- Disorganized – Children who experience complex developmental trauma want the help of others, but are too fearful of others hurting them further, so they actively push others away. The world looks painful and hopeless to these individuals
- The key difference between securely attached and insecurely attached children are that insecurely attached children lack a secure base or lack a secure attachment relationship with their caregiver.
  - Remember this, it will be important later.

Attachment Styles



Attachment to God/higher power/"The Divine"

- The application of attachment theory to spirituality/religion by assessing one's relationship with God as an emotional attachment relationship.
- Originally conceptualized by Richard Beck, who developed the *Attachment to God Inventory* to assess the quality and style of one's attachment to God.
- This is a psychological concept that has gained a lot of traction in Christian circles.
- Attachment to God is distinct from cognition. It is not based on what one knows about God but rather what one feels about God.
- It is clinically significant because one's relationship with God is a reflection of their internal working model of attachment.
- Individuals often project their experiences with human caregivers on to their relationship with God.

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- Attachment Styles in Attachment to God
  - Secure - views God as loving, consistent, and compassionate, particularly when experiencing distress
  - Anxious - fears being abandoned because they are "bad". Displays perfectionism in spiritual performance and chronic worry that they'll never be "good enough".
  - Avoidant - keep emotional distance from God, struggles to accept God's love for them, relying strictly on themselves to accomplish things. May display an intellectual closeness to God that feigns spiritual intimacy.
  - Disorganized - craves closeness with God but withdraws with experiencing intimacy. Experiences God as frightening despite professing a desire to a relationship with God. Regards their relationship with God with constant vigilance and can never rest in it.
- Research indicates that one with an insecure attachment to God can develop a more secure attachment to God, through corrective emotional experiences with God and spiritual community.
- Furthermore, one's attachment to God also serve as a secure base through which individual may approach other attachment relationships.

Attachment in therapy

- Identify the patient's internal working model/attachment style by tracking patterns in views of self, others, and the world.
- Process past and current attachment injuries while working in the "here-and-now"
- Address patterns that are core to the patient's insecure attachment style.
- Process attachment needs and develop more adaptive patterns to obtain and maintain a secure attachment style.
- The patient's relationship with the clinician serves as a "secure base" in and outside of therapy through which the patient may approach other relationships and process traumatic experiences.
- When the patient has a "secure base" they can work from an insecure attachment style towards a secure attachment style through the secure base providing a "corrective emotional experience".
- While there are specific "attachment-based" therapies, any therapy may be "attachment-informed" by using these concepts.

What is an attachment disorder?

- Attachment disorder can best be understood as the most extreme end of insecure attachment styles resulting in behavior that is harmful to one's self, others, and/or the environment.
- Attachment disorders are characterized by neglect, abuse, or unstable caregiving during early childhood that interfere with a child's ability to form healthy attachment relationships.
- Complex trauma is often results in the development of attachment disorder, which involves someone seeking comfort, support, and aid from someone who has also been a source of harm, abuse, and neglect.
- Attachment injuries occur when the attachment relationship has been violated by the caregiver.
- Secure attachment may be restored when injuries are repaired by mending the attachment bond.
- Those with attachment disorder:
  1. Never had an attachment relationship with a caregiver that served as a secure base.
  2. Lost an attachment relationship/secure base due to death, divorce, loss of custody, etc.
  3. Had an attachment relationship/secure base that was consistently damaged and unrepaired by the caregiver to the point that the entire relationship deteriorated.

“Balancing the ledger” metaphor from Contextual Therapy

- What is the “ledger balance” in a bank account?
- A healthy relationship runs on deposits and withdrawals into the relationship.
- Deposits are closeness, connection, desire, trustworthiness, etc. these activities build up a relationship.
- Withdrawals are distance, unresolved conflict, apathy, unreliability, etc. these activities damage a relationship.
- What happens when there are more withdrawals than deposits?
- When a parent does not “balance the ledger” with their children insecure attachment and attachment disorder are the outcome.

Addiction as an Attachment Disorder

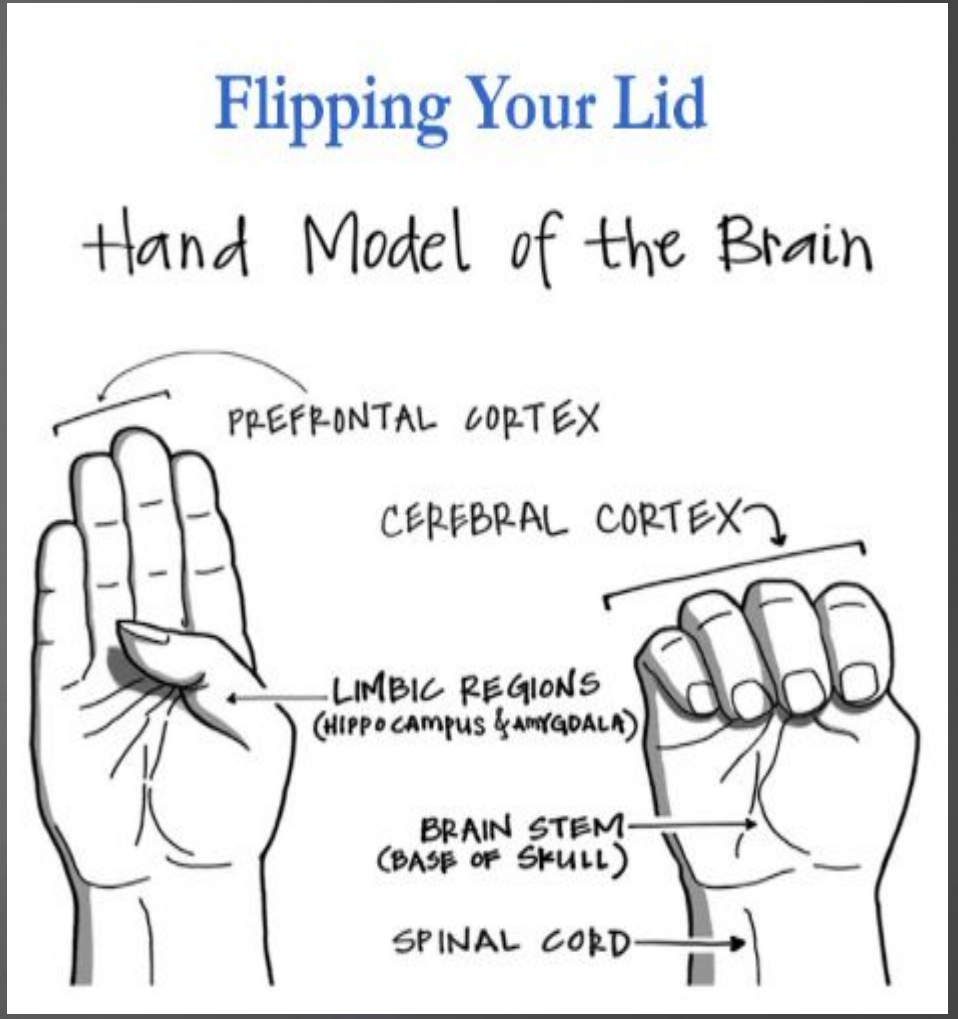
- Before addiction there is an attachment disorder, or at the very least, an insecure attachment style.
- For an addiction to become an attachment disorder, a substance must must first become someone's secure base.
  - They come to substance for comfort, confidence, security. It helps them feel better, do better, and be better version of themselves.
  - Whatever conflict is causing them distress, the substance as the secure base, alleviates the conflict.
  - As the person continues using the substance, they believe they have found the solution to their problems and resolved the issues that they have within themselves.
- The person enacts a relationship with addiction that presents initially as a corrective experience for their insecure attachment style.
- This continues until what happens? Addiction.
  - Urges and cravings, loss of control over substance use, continued use despite negative consequences, tolerance, withdrawal

Addiction as an Attachment Disorder - Disease Model

- Adaptation
  - Damaged myelin sheath decrease connectivity in the brain, particularly between the prefrontal cortex and other brain regions.
  - Myelin sheath growth increases connectivity and activity in the brain's pleasure centers
- Tolerance
  - Receptor downregulation causes a decrease in available receptors to which substances may bind.
  - Receptor desensitization causes remaining receptors to be less stimulated by substances.
- Withdrawal
  - Endogenous neurotransmitters are depleted meaning that one now uses a substance to feel "normal" and will continue using to avoid withdrawal symptoms.

Disease-Attachment Integration

- Both attachment disorder and addiction are complex trauma
  - Complex trauma occurs when a person seeks comfort from a parent, partner, or in this case, substance, that brings both relief and pain.
    - When this occurs the addiction comes full circle with the attachment disorder because now the addiction has become both a place of comfort and pain.
  - It is also development trauma for many, as both attachment disorder and addiction are often rooted in childhood and adolescence experiences.
- Both attachment disorder and addiction are not just psychological, but also biological and physiological.
  - They are rooted in the limbic area of the brain, which "overrides" the prefrontal context to ensure needs are met.
- See Daniel Siegel's "hand model of the brain" as a reminder on why we "flip our lids"



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- Once addiction has been "stabilized", attachment disorder remains and contributes to the relapse cycle.
  - Urges and cravings change once stabilization is occurs. It is no longer about getting out of withdrawal, but meeting unmet attachment needs and emotional regulation.
- Attachment is a regulatory system for human beings. Addiction becomes an adaptive solution for self-regulation until new "secure base" is established.
  - Without developing new methods for self-regulation within the attachment system, self-regulation is compromised and there is high risk for substance use for self-regulation
- As a person becomes securely "attached to recovery" they are able to use their recovery as a "secure base" from which to explore the world and create new secure attachments.

What substance with which style?

- Anxiously attached individuals are prone to use substances to
  - Distract themselves from self-loathing.
  - Decrease focus on real of perceived failures in relationships with others
- Alcohol, Benzodiazepines, and opioids are most common with anxiously attached individuals.
- Avoidantly attached individuals are prone to use substances to
  - Maintain independence and self-sufficiency
  - Numb unwanted emotions
- Stimulants and opioids are most common with avoidantly attached individuals
  - Opioids are listed with both styles because they tend to be a "wild card".
- Linking one's substance preference with attachment style often reduces the stigma one feels
  - Instead of seeing a selfish junkie, they can see a person with legitimate attachment needs, who addressed those needs through illegitimate methods.
- Clinicians must be attentive when assessing patients to identify how substance use addressed unmet attachment needs.
  - Do not assume all meth users are avoidant and all alcoholics are anxious.

On Becoming a Secure Base - Ethics & Boundaries

- As the clinician becomes their patient's "secure base," that relationship becomes the model relationship through which the patient may experience secure attachment and larger use as a template for other secure attachments.
  - This allows an emotional corrective experience for previous attachment relationships that contributed to insecure attachment styles.
  - Additionally, the patient is able to develop a model of secure attachment with their clinician that upon which they may model future attachment relationships.
- What are the ethical considerations of being your patient's "secure base?"
- Maintain role and relationship clarity.
  - You're not a parent, spouse, sibling, child, or friend. Maintain both clinical boundaries and secure attachment in the therapeutic relationship.
- Prepare for projections from previous attachment relationships that contributed to insecure attachment.
- Anxiously attached individuals will seek porous boundaries, while avoidantly attached individuals will erect rigid walls.
  - Redirect how such behaviors are patterns that are indicative of their attachment style and highlight and process unmet attachment needs behind the attachment style.

Attachment Integration in Specific to SUD Treatment

- The substance is the person's "secure base". Until addiction has been displaced, nothing else can be developed as a secure base.
  - Relapse prevention, promoting stabilization, abstinence, and recovery-oriented lifestyle is key here.
- Track and reframe patterns as legitimate unmet attachment needs while further exploring attachment needs to develop understanding of a patient's emerging attachment style.
  - Anxious attached individuals often use to alleviate externalized anxiety, whereas avoidantly attached individuals often use to alleviate internalized anxiety and promote self-sufficiency.
- Develop and/or repair secure "bases" through treatment that where attachment needs may be further explored and ultimately met.
- Relapse prevention often isn't enough, especially when trauma is involved.
  - Until the person is securely attached to recovery, treatment must continue in some form, as it's goal has not been achieved.
- Attachment to a therapy and/or recovery groups as a "secure base" in treatment are essential to promote long-term secure attachment to recovery.
  - Yalom's 11 Therapeutic Factors tell us why

Yalom's 11 Therapeutic Factors for Group Therapy

1. Instillation of Hope: Believing that recovery and positive change are possible. Seeing others improve gives members faith in the process.
2. Universality: Realizing that one's struggles are not unique. Members discover they share similar thoughts, fears, and life problems with others.
3. Imparting Information: Receiving direct advice, guidance, or educational facts about mental health and coping strategies from the clinician or peers.
4. Altruism: Gaining a sense of self-worth and purpose by helping, supporting, and giving to other group members.
5. Corrective Recapitulation of the Primary Family Group: Experiencing group dynamics that mirror one's early family life, allowing members to identify and resolve childhood-based dysfunctional roles or conflicts.
6. Development of Socializing Techniques: Learning, practicing, and testing new communication and social skills in a safe environment.

Yalom's 11 Therapeutic Factors for Group Therapy

7. Imitative Behavior: Modeling positive actions, coping mechanisms, or behaviors observed from the therapist or other peers.
8. Interpersonal Learning: Gaining insight into one's relational patterns by interacting with others, receiving feedback, and experiencing secure emotional connections.
9. Group Cohesiveness: Feeling a deep sense of belonging, trust, solidarity, and mutual acceptance among group members.
10. Catharsis: Releasing pent-up, repressed, or strong emotions, which brings psychological relief.
11. Existential Factors: Accepting ultimate responsibilities for one's life choices, recognizing mortality, and finding meaning despite the inherent pain and unfairness of life.

Successful Treatment: "Running the Secure Bases"

- At bat - issue that forces the person into treatment
- First base - developing a secure base in their primary counselor, physician, treatment program, etc.
- Second base - developing a secure base with their therapy group, recovery group, etc.
- Third base - developing a secure base with their spouse, family, chosen friends
- Home - developing a secure base within God, their higher power, or spirituality that brings meaning to their life and world

“Ideal” Strategic Application of Attachment to SUD Treatment

- Successful treatment is made possible by smooth transitions through ASAM’s levels of care.
- Level 3: Residential and above - relapse prevention, stabilization, attachment theory psychoeducation.
  - Relapse prevention skills are necessary to prevent re-attachment to addiction as a secure base
  - increased physical and mental well-being through a stabilizing environment to promote attachment to recovery.
  - Introduce attachment theory, alongside ACEs, trauma-informed care, etc.
- Level 2: PHP & IOP - integrate attachment alongside building a lifestyle supportive of recovery.
  - Explore attachment experiences, identify attachment style, explore how urges and cravings may have also been attachment needs.
- Level 1: Outpatient interpersonal process group therapy and couple/family therapy
  - Patients obtain new attachment-based experiences through interpersonal learning by being “attached to the group”
  - Patients explore forming new secure attachment relationships with their spouse and/or family based on their emerging attachment system being unoccupied by addiction as a secure base.

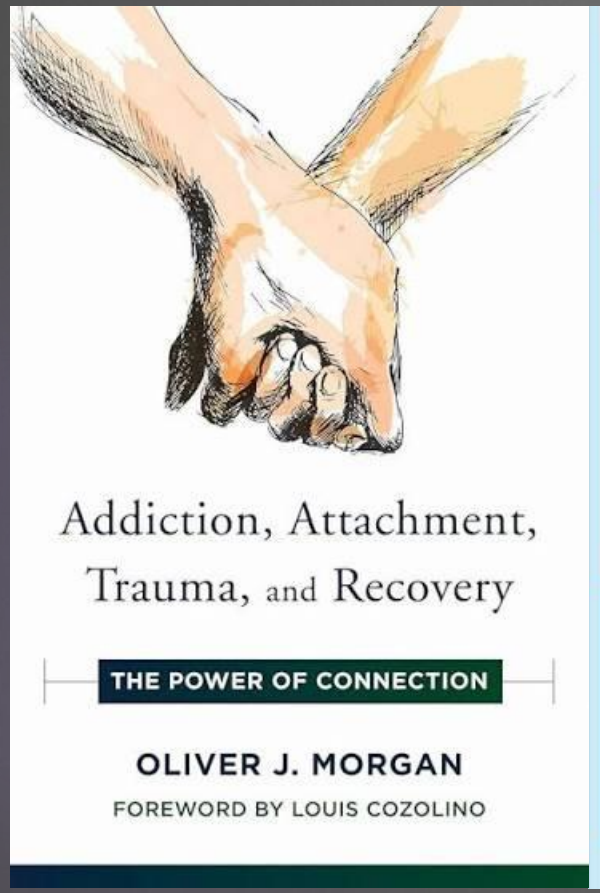
Attachment-based Therapies

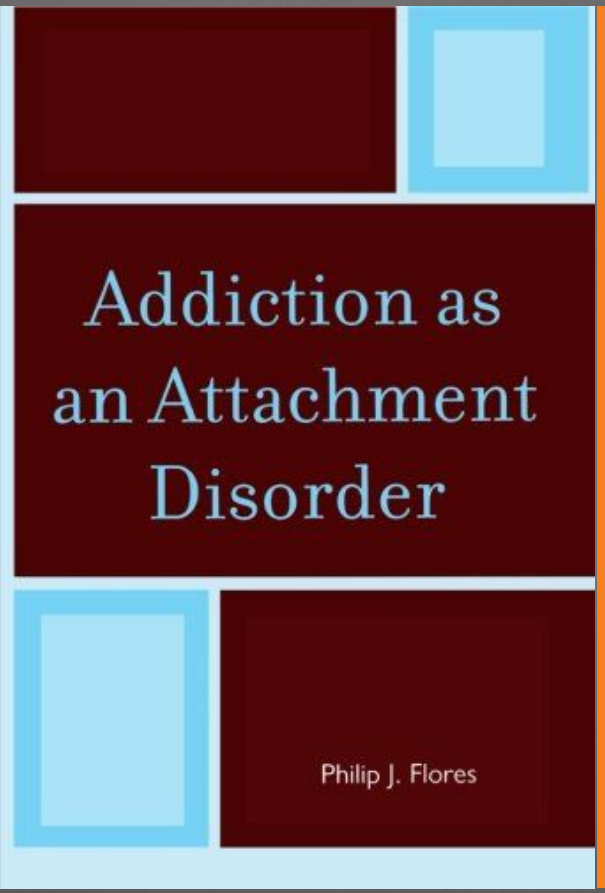
- Attachment-based Therapy was a movement developed by several clinicians as they reflected on the application of attachment research. Focuses on understanding attachment style, processing past and current attachment experiences, and the therapeutic relationship providing a corrective emotional experience for past attachment injuries
- Emotionally-Focused Therapy (i.e., EFT) developed by Sue Johnson. It was originally a couples therapy, but is now also an evidenced-based therapy for families (i.e., EFFT) and individuals (i.e., EFIT). The therapy resolves around processing experiences by focusing on emotions in the here-and-now and integrating them with new experiences.
- Accelerated Experiential Dynamic Psychotherapy (i.e., AEDP) focused on undoing defenses and distress, experiencing core emotions, experiencing breakthrough affect and relief, and reflecting on the transformation experienced in therapy itself.

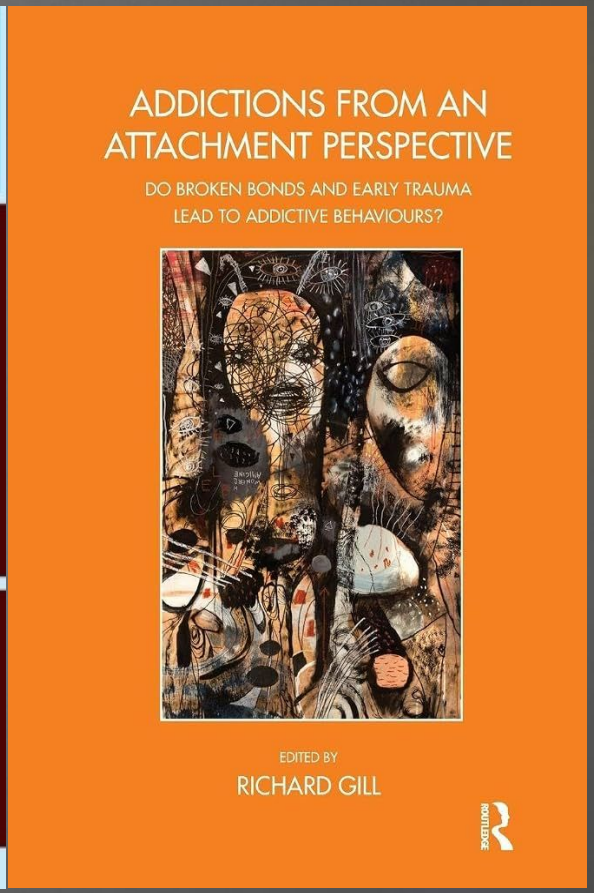
Emotional Attachment Behavior Therapy (i.e., EABT)

- Developed by Doug Smith, a licensed substance use counselor and NAADAC member.
- It is a newly developed attached-based therapy, specifically for SUD.
- Works to understand and process emotional triggers as unmet attachment needs while also develop adaptive coping skills to meet unmet attachment needs.
- Focuses on identifying one's attachment style and restore relationships as a pathway to recovery.
- There is a great NAADAC webinar on this therapy, that I highly recommend you check out.
  - https://www.naadac.org/innovative-behavioral-health-treatment-webinar

For Further Reading







Conclusion

- Session Goals:
  - Develop further understanding about Couple/Family Therapies and Systems Theory
    - Track symptoms as patterns and explore and highlight how they exist not only within an individual but also in between members of a system.
  - Identify how addiction may function as an attachment disorder
    - Addiction develops initially as a solution to an attachment disorder, but leaves a person with both attachment disorder and now substance use disorder.
  - Participants leave the session as an "attachment-informed" clinician able to begin to integrate how couple/family therapy skills and understanding addiction as an attachment disorder may be used in SUD treatment.
- Now that you are "attachment-informed" clinicians, you may go and allow attachment theory to influence your work no matter your treatment modality or therapeutic orientation.

Questions & Answers

Discussion of implications of Attachment for the SUD Treatment field