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TREATING SUBSTANCE USE DISORDERS THROUGH AN ATTACHMENT LENS:

A CASE EXAMPLE

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Abstract

Substance use treatment addresses addiction behaviors, increasing coping skills, and sobriety but current modalities do not address the insecure attachment styles that may contribute to substance use for many individuals. Insecure attachment styles seemingly have a bidirectional relationship with substance use and are therefore are likely an important aspect of treatment. This case example focuses on an attachment therapist's work with a young man with a substance use disorder and attachment insecurity. Attachment theory interventions are proposed to address potential contributors of continued substance use. This paper proposes that using attachment theory in combination with existing treatment modalities for substance use would likely increase the efficacy of current treatment models and decrease treatment drop out and relapse rates.

Keywords: attachment theory, substance use, insecure attachment

Introduction

There are many treatment modalities that address substance use in the current literature and yet relapse remains a significant concern for individuals with substance use disorders. For instance, a longitudinal study found that individuals struggling with substance use attended treatment three to four times over a nine-year period before maintaining sobriety for a one-year period (Dennis, Scott, Funk, & Foss, 2005). One possible consideration is that relapse rates may be elevated due to the short-term nature of many substance use treatment modalities, not allowing for a long-term therapeutic relationship to develop. Addressing the role that attachment insecurity plays in sustained substance use could significantly enhance current treatment modalities.

Attachment theory addresses how one's attachment style to early caregivers impacts relational functioning and experience of safety and security in the world. The therapeutic alliance, which is a well-known factor of psychotherapy effectiveness, has been shown to account for approximately one-third of positive treatment outcomes (Bordin, 1979). The therapeutic alliance, then, may serve as a template for secure attachment and increase abilities for emotional regulation and interpersonal functioning. Addressing attachment insecurity through the therapeutic alliance may lead to increases in an individual's abilities to tolerate frustration, regulate emotions, and engage in positive coping strategies.

Utilizing attachment theory interventions to increase an individual's ability to self-regulate and recognize the function of their maladaptive relationship patterns may increase the efficacy of current treatment models and decrease drop out and relapse rates. Integrating attachment theory into current behavioral models of substance use disorder treatment addresses the emotional mechanisms of the substance use (Fletcher, Nutton, & Brend, 2015).

Literature Review

Substance Use Disorder

Overview. According to the American Psychiatric Association (2013), substance-related disorders cover ten classes of drugs: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants, tobacco, and other (unknown) substances. They further specify that these categories are not distinct from each other and all classes of substances activate the brain reward system in a similar way. The activation of the brain reward system is involved in memory production and behavioral reinforcement. The manner in which each substance activates the reward system differ, but the side effects are similar (e.g., feeling “high”). Individuals with lower levels of self-control may be more highly predisposed to develop substance use disorders, possibly indicating impairments of the brain’s inhibitory functioning (American Psychiatric Association, 2013). The American Psychiatric Association (2013) identifies the essential feature of a substance use disorder as a combination of cognitive, behavioral, and psychological symptoms.

Attachment Disorders

Attachment Theory. Attachment theory was born from the work of John Bowlby and then further expanded upon by the research of Mary Ainsworth, specifically her studies of the Strange Situation Procedure (Ainsworth & Bell, 1970). Bowlby’s work described the attachment behavioral system, in which infants learn ways to behave from responses that are provided from caregivers. The attachment behavior system is an inborn system that drives individuals to search for closeness to caregivers when in need (Mikulincer, 2019). The main purpose of the attachment behavioral system is to improve the chances that vulnerable individuals survive the dangers of childhood (Simpson & Rholes, 2012). According to Bowlby’s work, attachment theory posits

that internal working models are formed based on the caregiver's fashion of responding to the emotional needs of their child. Internal working models are mental representations of 'self' and 'other' that are carried on from these earlier experiences. They represent one's expectations of others and way of behaving in relationships that may help to reduce anxiety by achieving connection and security. These earlier experiences with caretakers generate these mental representations (Bowlby, 1969, 1980). According to attachment theory, an attachment style is defined as "a pattern of relational expectations, emotions, and behaviors" that are formed in early experiences with caregivers and may continue forward throughout one's life (Brenning and Braet, 2013, pg. 107).

Early childhood experiences with available, responsive caregivers create secure attachment relationships where caregivers have responded predictably and with care. Early experiences with caregivers who are unavailable, dismissive, or inaccessible increase the likelihood of developing an insecure attachment style. An insecure style of attachment is a response to caregivers who have provided care in ways that are unpredictable and fail to promote feelings of security and decrease anxiety. Such experiences may lead to self-perceptions of being less worthy of care and seeing others as unreliable, unsupportive, and non-responsive during times of crisis (Bowlby, 1969, 1980). Furthermore, early experiences with primary caregivers or attachment figures create the foundation for skills of emotion regulation later in life. Emotion regulation is characterized as the processes one utilizes to manage internal experiences and external emotional expression (Gratz & Tull, 2010). The soothing that is provided by caregivers during infancy and childhood serves as a template for building subsequent self-soothing strategies in adulthood (Brenning & Braet, 2013).

In Ainsworth's laboratory studies involving the Strange Situation Procedure (SSP), attachment behavior is prompted by the caregiver leaving, and particular attention is given to behavior that occurs after separation and upon reunion with the caregiver. Particularly of note are the infant's behavior upon return of the caregiver and the length of time it takes the child to return to exploration of their environment. The manner the child approaches their caregiver is also indicative of attachment style. There are four classifications of attachment style for the SSP: secure, insecure avoidant, insecure ambivalent, and disorganized (Van Rosmalen, Van Der Veer, & Van Der Horst, 2015). Secure attachment is characterized by utilization of the caregiver as a safe base from which to explore the environment and to which return for comfort and security when distressed (Ainsworth, 1989). Insecure, avoidantly-attached individuals are characterized by being self-reliant in distressing situations in order to maintain connection with the caregiver who becomes withdrawn and rejecting of the child when the child expresses negative affect. In an ambivalent attachment style, attachment behaviors are fearful to draw the attention of their caregiver who is inconsistent in their response to the child's attachment behaviors (Cassidy, 1994). Disorganized attachment is characterized by apprehension, disorientation, and/or conflict responses when with their caregiver in a distressing situation. These infants have often experienced a caregiver who has displayed frightened, frightening, or other unusual behaviors (Lyons-Ruth & Jacobvitz, 2016).

Bartholomew and Horowitz (1991) proposed four attachment patterns in adulthood: secure, preoccupied, fearful, and dismissing. These attachment styles are similar to the attachment styles of childhood but have their own descriptions. Individuals with a secure attachment typically feel worthy of being loved and are able to trust others. Individuals with a preoccupied (anxious-ambivalent) attachment style feel unworthy of love but are trusting of

others. Dismissively (avoidant) attached individuals feel worthy of love but are untrusting of others. Individuals with a fearful attachment style feel unworthy of love and untrusting of others (Blalock, Franzese, Machell, & Strauman, 2015). There is a possible correlation between adult attachment and an individual being able to form relationships that are satisfying and connected to others (Baumeister & Leary, 1995).

Brennan, Clark, and Shaver (1998) classify adult attachment in two subsets: attachment anxiety and attachment avoidance. According to the authors, attachment anxiety is the fear of being rejected or abandoned while attachment avoidance is a fear of intimacy and feelings of discomfort with dependency or closeness. Possible consequences of these attachment styles are psychological, emotional, and general distress (Wei, Vogel, Tsun-Yao, & Zakalik, 2005). There have also been links found between these attachment styles and interpersonal difficulties (Bartholomew & Horowitz, 1991). Affect regulation is an important mediator that impacts the relationship between attachment and distress (Wei, Vogel, Tsun-Yao, & Zakalik, 2005). When an individual's attachment system is activated, affect regulation can decrease the stress response that is triggered.

Neurobiology of Attachment. Early attachment experiences with a primary caregiver shape the neurobiological development of an infant, supporting the growth of the autonomic nervous system, limbic system, and other structures when experiencing secure attachment with an attuned caregiver (Kathakis, 2016). When an infant during their first eighteen months of life is met with a caregiver who is not present, inconsistently present, or abusive, these neuronal structures are not able to grow and develop, creating deficits in the regulatory skills of the infant that can persist into adulthood (Kathakis, 2016).

The function of the autonomic nervous system is to regulate the limbic system, which regulates emotion. The autonomic nervous system is comprised of the sympathetic, or excitatory, and parasympathetic, or inhibitory, branches (Kathakis, 2016). Porges' Polyvagal Theory posits that the autonomic nervous system is hierarchical, requiring a balance between the parasympathetic and sympathetic branches; this balance allows the individual to respond appropriately to environmental influences and is a necessary component of secure attachments (Porges, 2011). When the autonomic nervous system experiences increased levels of stress, the sympathetic and parasympathetic systems can uncouple, which can lead to overuse of either the excitatory or inhibitory branch (Kathakis, 2016).

The limbic system transfers information to and from the body as the most connected brain layer. The limbic system supports emotional learning, memory, and feeling states. In addition, through the moderation of affect and emotional needs, the limbic system assists an infant in regulating via their caregiver's attunement (Kathakis, 2016). Attunement is defined as "harmonizing with and responding to the child's feelings in a calming, loving manner" (Kathakis, 2016, pp. 79). Unmodulated affect can alter neural pathways from the prefrontal cortex to the limbic system which impacts affect regulation (Kathakis, 2016).

When an individual initially perceives a threat the brain first calls on the parasympathetic branch to regulate the autonomic nervous system. If the danger is too great the sympathetic branch will engage, triggering the fight or flight response, and if the stressor is still not relieved the dorsal vagus, or freeze response, will prepare the individual for death, making emotions inaccessible, creating a sense of numbness, and reducing the body's experience of pain by releasing opioids (Kathakis, 2016). An infant's early attachment experiences impact these developing capacities for self-regulation via the autonomic nervous system (Kathakis, 2016).

Schore's affect regulation theory posits that an infant's systems for affective control grow based on responses from the "good-enough maternal right brain," which facilitates external regulation. Communication between the infant's and mother's right brains takes place by means of emotional attunement, specifically, eye contact, facial expression, tone of voice, gesture, and touch (Papousek, 2007; Schore, 1994, 2003a, 2003b). Caregivers respond to micro-communications from the infant which facilitates the development of their right hemisphere. This is where future abilities for emotional intelligence, emotional expression, empathy, and self-control are housed (Kathakis, 2016).

When the emotional care circuit and communication between infant's and caregiver's right brains are engaged (Schore, 2003a, 2003b), the caregiver's system enters a response mode. When the caregiver attunes to the infant's affective needs, the infant's autonomic nervous system can downregulate, slowing heart rate and decreasing blood pressure, muscle tension, and breathing rate. Over an extended time period the infant internalizes relational expectations that predict their caregiver's response to the infant's regulatory needs (Hill, 2015). Misattunement with repair following can increase an infant's ability to tolerate stress, teaching the autonomic nervous system to return to a ventral vagal state after a stressor (Kathakis, 2016). Chronic experiences of misattunement from a caregiver deprives a child the experience of interactive affect management that leads to the ability for self-regulation (Kathakis, 2016).

Caregivers with insecure attachment styles prepare an infant's developing system for deficits (Kathakis, 2016). When a primary caregiver is not able to regularly attune to and mirror an infant, thereby regulating the infant, the infant can be overly aroused (Benjamin & Atlas, 2015) or under aroused. Relational trauma during infancy can impact creativity, passion, intuition, and imagination. Additionally, traumatic relational experiences in infancy can conflate

expectancy with frustration, which causes desire to be an intolerable experience that is to be avoided (Benjamin & Atlas, 2015) or can increase desire infinitely in an automatic manner (Hill, 2015) such as with addiction. For example, in the case of addiction, the desire for the substance increases unendingly based on the concept that expectancy of attachment needs is intertwined with the experience of frustration which leads to increasing desire to reduce the distress. Chronic activation of the fear and panic circuits cause a child to feel consistently hyper or hypoaroused (Hill, 2015). Repeated hyperarousal overuses the neuronal circuits causing affect regulation to become more difficult over time. Conversely, repeated hypoarousal causes the child's system to drop into a downregulated state, causing sensations of dissociation and numbness (Solomon & Tatkin, 2011).

Autoregulation will take the place of interactive regulation when a caregiver is not attuned to an infant's regulatory needs which encourages the use of externalized behaviors to achieve a regulated state which can lead to maladaptive coping behaviors over time, such as substance use (Katehakis, 2016). When a child experiences neglect or abuse they cannot seek out their primary caregiver as a source of comfort therefore, autoregulatory behaviors are the only avenue through which they can experience comfort. An infant that is not experiencing interactive regulation with a caregiver will restrict the output of the limbic system that would demonstrate the expression of attachment needs instead favoring autoregulation in lieu of coregulation (Schoore, 2009). Children, as well as adults, who experience affect dysregulation engage in maladaptive methods of autoregulation or dissociation which can solidify into a dependence on external methods of emotional regulation (Katehakis, 2016).

Traumatic stress experienced in childhood can deteriorate a child's capacity for self-regulation and interfere with attentional abilities, processing of pain, and growth of self-concept

(Schore, 2009). Neglectful, insensitive, and abusive caregivers create children who are emotionally deprived whose regulatory systems learn to care for themselves on their own for survival (Katehakis, 2016). These children will separate themselves from their feelings or seek individual methods of managing them, internalizing shameful messages (Hill, 2015). Shame plays a crucial role in addiction and can also be related to posttraumatic stress disorders and anxiety disorders (Budden, 2009).

Individuals with dismissive/avoidant attachment styles infrequently experienced attunement from their caregiver due to rejection or insensitivity to cues. An individual with this attachment style will invalidate their own and other's feelings or avoids engaging in interpersonal relationships. Their parasympathetic branch became the dominant structure for regulation causing the right brain to be overregulated (Katehakis, 2016). Conversely, individuals with a preoccupied attachment style experienced inconsistency from their caregiver causing the child to experience a lack of control. This child would likely upregulate in order to get their needs met by the caregiver and would choose to be near their caregiver to get whatever attention they were able to from the caregiver (Katehakis, 2016). Lastly, individuals with a fearful/avoidant, also known as disorganized, attachment style experience themselves and others negatively. They likely appear to be both avoidantly and ambivalently attached but underlying this presentation have a desire for relationships. These individuals were traumatized or experienced an unsafe caregiver who was unable to regulate the child. Often the caregiver was the cause of the threat and the source of comfort (Katehakis, 2016).

Attachment Insecurity and Substance Use. There is a distinct relationship between insecure attachment styles and substance use disorders (Schindler & Bröning, 2015). Attachment theory highlights the bi-directional relationship between insecure attachment and substance use

disorders; substance use negatively impacts attachment security in relationships just as insecure attachment is a risk factor for substance use (Schindler, 2019). Insecure patterns of attachment may be related to affective, cognitive, and behavioral dysregulation, which may lead to substance use as a way to decrease stress and negative affective states (Schindler & Bröning, 2015).

Individuals with insecure attachment styles may lack coping skills which can contribute to their desire to regulate with substances (Schindler & Bröning, 2015). Individuals with avoidant attachment patterns can be conceptualized as using substances as a method to avoid negative emotions, needs for attachment, and loneliness (Schindler, 2019). More highly insecure patterns of attachment were found in an overview of studies of attachment and substance use. Those with disorganized patterns of attachment may use substances as a way to cope with posttraumatic stress (Schindler, 2019).

Integration of Substance Use Disorder and Attachment Disorder

The Contribution of an Attachment Lens in the Conceptualization of Substance Use.

Individuals with attachment insecurity have higher rates of substance use and greater difficulties with emotional regulation than individuals with secure attachment styles (Caspers et al., 2005). Further, insecure attachment and resulting emotional dysregulation may be significant causal factors in increased risk for various types of substance use and addictions (Liese, Kim, & Hodgins, 2020). Most individuals with substance use disorders exhibit not only difficulty with emotion regulation but also with emotional awareness and clarity. These difficulties with aspects of emotional well-being can lead individuals to feel that it is not socially acceptable to express their negative affective states (Dingle, da Costa Neves, Alhadad, & Hildes, 2018).

When considering addiction as a manifestation of insecure attachments that fuel and sustain substance use, it is also important to highlight the bidirectional and distancing impact that

substance use has on interpersonal relationships in the individual's life. Substances appear to create a strong emotional response that both reinforces substance use while hindering less intense emotional experiences (Flores, 2011). Specifically, there is an "emotional rush" that is induced by substance use that strengthens the relationship to the substance. As a result, the attachment to the substance can become an obstacle to engaging in interpersonal relationships as well as a replacement for these relationships (Flores, 2006). Individuals who struggle to establish secure emotional attachments have a higher predisposition for substance use to substitute for intimacy. It can also be difficult for a person struggling with substance misuse to engage in the requirements of a secure relationship. At the onset of substance use, the substance can provide relief from difficulties in interpersonal attachment relationships. As the substance use progresses, interpersonal skills including positive connection may decline, making relationships significantly more difficult and causing an increased dependence on the substances (Flores, 2011).

As Flores (2011) explained, substance use can become a replacement for the interpersonal relationships that individuals with substance use and insecure attachment struggle to maintain. This dynamic creates a cycle where the substance is replacing the need for human connection which further isolates the individual from their interpersonal relationships and increases their substance use. This further supports the conceptualization of the bond between individual and substance.

When considering the evidence about the interpersonal functioning deficits and insecure attachment style of individuals with substance use treatment it is also important to reflect on how this may impact the therapeutic alliance in treatment. Bordin (1979) proposes that the working alliance is contingent upon the client and clinician agreeing upon the treatment goals. He further describes that the bond between client and clinician is dependent on trust and attachment. Given

the previous outlined impact of attachment insecurity and the relationship with substance use disorders, it may be assumed that establishing a bond in the therapeutic context could prove to be challenging. Flores (2011) further illuminates this concept, stating that for an individual to attach to substance use treatment they must detach from the substance itself.

What is Lacking in Traditional Substance Use Disorder Treatment. There are a number of empirically supported behavioral therapies for substance use disorders including contingency management therapies, cognitive behavior and skills training therapies, motivational interviewing, and couples and family treatments. Contingency management therapy utilizes a rewards system for meeting goals, such as abstinence from substance use. Similarly, cognitive behavioral approaches are based in social learning theory and the tenets of operant conditioning. This approach is broken down into two steps: a functional analysis of the substance use, looking at antecedents, behaviors, and consequences, and skill building to understand what situations are most likely to trigger substance use (Carroll & Onken, 2005). Motivational Interviewing works to increase the internal motivation a person has to decrease their substance use and effect change (Miller and Rollnick, 2013). Couples and family treatments target the family system in which a person struggling with substance use exists. If an individual's social system participates in treatment this can be a positive indicator of change (Carroll & Onken, 2005). The common theme to these therapeutic approaches is the theoretical grounding in cognitive and behavioral principles which may not fully address the causal, contributing, or maintenance factors of a substance use disorder for all individuals as it relates to insecure attachment.

It may be more difficult for those with insecure attachment styles, particularly avoidant and disorganized attachments, to develop rapport with their therapist. The working alliance between the client and therapist was identified as a variable in treatment outcomes in substance

use disorder treatment (Miller & Moyers, 2015). The alliance is related to treatment engagement, retention, and outcomes. Additionally, specific characteristics of the therapist and client also impact the treatment efficacy with addiction treatment. Therapists who have high expectations of treatment outcomes, allegiance to a specific treatment approach, interpersonal skills (empathy), and fidelity to the treatment method are more likely to have better treatment outcomes (Miller & Moyers, 2015). Client factors that can impact treatment outcomes are, optimism about treatment efficacy, motivation, self-efficacy, and hope (Miller & Moyers, 2015). Many of these factors that can be related to better treatment outcomes are relational in nature, particularly the working alliance.

What is lacking in behavioral treatment methodologies is the understanding of the individual's attachment style to determine what function the substance use is serving in relation to their unmet attachment needs. The behavioral therapies work to develop skills to avoid relapse and analyze the substance use through a behavioral lens. This approach does not address the individual's lack of attunement in childhood, subsequent insecure attachment, and neurobiological impacts that can cause difficulty in interactive, and self, regulation and coping.

Why Attachment is Important to Address in Substance Use Disorder Treatment. When attachment needs are not met in childhood, autoregulation becomes the preferred method for coping and regulation. The autonomic nervous system does not properly develop to respond to stressors and quickly return to a regulated state once the stressor is alleviated (Katchakis, 2016). Adults who experience affect dysregulation engage in maladaptive methods of autoregulation, creating a dependence on external methods of achieving regulation (Katchakis, 2016). Working with clients in treatment to build a therapeutic alliance that creates an attuned environment that

can facilitate co-regulation will help the client's autonomic nervous system to regulate and respond more appropriately over time to signs of threat or danger.

Several of the important considerations in attachment theory for substance use treatment examine both early attachment experiences as well as how attachment needs are a life-long process. Individuals with insecure attachment patterns have beliefs that others will be unreliable or unsafe and also engage in relationships based on these expectations, contributing to the insecure relational dynamics.

In working with insecure attachment styles, thinking of treatment duration in terms of months or years rather than weeks will allow for the development of a therapeutic alliance in a genuine way would be beneficial to treatment outcomes. Treating clinicians would need to work to create a secure environment for clients to process early caregiving experiences and their subsequent relational insecurity. When interacting with individuals with insecure attachment styles, it is likely that there will either be avoidance of relational experiences or reassurance seeking. It would be important to create appropriate boundaries in an empathic manner to avoid creating feelings of rejection or shutting down which would impede the therapeutic process.

It is inevitable that rupture will occur in a therapeutic relationship, however in the process of repairing the rupture expectations of previous relational models are challenged, creating space for a new model to develop. The process of repairing a therapeutic rupture can model how to address conflict and stressors in relationships securely while still maintaining the boundaries of the relationship. Additionally, by creating a space where the client feels understood and validated, the therapist is showing the client through the therapeutic alliance that their emotions can be tolerated and responded to in an empathic manner. In addition to challenging previous relational models, it would be important for the therapist to facilitate the client's understanding

of their dysfunctional patterns and how they have served a function in their life. Once the client is able to understand their patterns, they will likely be more easily able to replace them with more effective regulatory strategies.

The secure relationship created within the therapeutic alliance can support the development of self-regulation abilities and an array of positive coping skills such as mindfulness, meditation, or exercise. The secure base of the relationship with the therapist allows an individual to co-regulate in treatment and then develop the skills to self-regulate over time decreasing their need for autoregulation, such as with substance use. This may decrease the desire for the substance use as a source of addressing unmet attachment needs. The following case presentation illustrates how attachment theory could be integrated into treatment for substance use to increase long-term effects of treatment and decrease the likelihood of relapse.

Case Presentation

Presenting Psychological Problems

Jake, a White male, was 36 years old when he began attending therapy at a university-based mental health training clinic in the Rocky Mountain region. Jake self-referred to the clinic after the ending of his previous romantic relationship. He was struggling with ruminative thoughts about the relationship and significant generalized and social anxiety symptoms. Additionally, Jake was struggling with problematic coping behavior such as isolation, poor relational boundaries, and substance use. Specifically, Jake struggled to assert his needs in a relationship and would ignore “red flags” in his partner. He began therapeutic services in September of 2016.

Psychosocial History and Previous Psychological Services

Family History. Jake was born and raised in the Rocky Mountain region by his biological mother and father along with three brothers, one full brother and two half-brothers. Jake's mother had an alcohol use problem throughout his life; he was not aware of whether there was any substance use during his mother's pregnancy with him. He did not have many memories from his childhood, but the memories he did share involved interpersonal trauma. One memory that was highlighted for him was sitting in the front seat of the car between his mother and father and his mother was attempting to push his father out of the car. Jake recalled feeling so conflicted in this moment of which parent to try to protect. Jake's mother was an inconsistent parent due to her substance use; he indicated when she would become intoxicated she would become angry and volatile. As an adult, two of Jake's brothers overdosed on substances and passed away; one of his brothers died while using substances with their mother. At the beginning of treatment, Jake had not seen his mother in many years and was unaware of whether she was still living. Nearing the end of treatment, Jake found out that his mother had been deceased for approximately one year. Although Jake had not seen his mother in many years this was still highly distressing information for him to learn. As an adult, Jake had a close relationship with his father, stating that his dad was his "best friend" and the most supportive person in his life. During Jake's period of active opioid use, specifically heroin, prior to treatment, his father reportedly severed ties in their relationship. Jake viewed this as an act of "tough love" but identified feeling abandoned by his father when he was in a period of crisis.

Social History. Jake had a number of close friendships but had difficulty engaging in close romantic relationships or trusting people. Despite noting these close friendships, he did not feel that he could discuss his problems with friends, stating that he must always be "the best version of himself" or people would not want to be around him. Jake felt a lot of pressure to perform in

social situations and worried that people would cut him out of their lives if they knew how much he struggled with anxiety. He experienced the death of many friends due to substance use and violence; during the initial session, he shared that he had attended numerous funerals of friends who had overdosed on substances over the previous summer.

At the start of treatment, Jake was having difficulty resolving feelings from the ending of his romantic relationship. He identified that he would become overly emotionally involved in relationships very quickly and choose to ignore warning signs that the relationship may not be going well. Jake was in a new relationship approximately six months into treatment and he felt that this relationship did not follow the pattern of his ignoring “red flags”; he stated that he felt very comfortable with his current partner and was able to have an open line of communication with her. Despite Jake’s belief that there was a two-way line of communication in his relationship, he still felt as if he could not burden her with his stressors and “didn’t want her to feel like she’s got this messed up, stressed out boyfriend.” As Jake’s relationship started to struggle, he had difficulty maintaining an erection in sexual encounters with his partner but was able to achieve orgasm from watching pornography. Jake stated that his partner was making sexual intercourse feel like a “chore”, becoming upset when he would not orgasm. Nearing the end of treatment, this relationship ended, and Jake continued to struggle with the loss of this emotional connection, increasing his substance use and seeking out new romantic connections. Jake indicated that he was spending multiple hours each day on dating sites looking for a new sexual partner and would occasionally have casual sexual encounters with women he met on dating sites with no erectile dysfunction.

Employment History. Jake had a history of homelessness and long periods of unemployment related to his opioid use. His job history included construction work, painting houses, freelance

artist, and tattoo artist. At the time of treatment, Jake worked as a tattoo artist as well as planning construction sites for the city he resided in. He enjoyed his work as a tattoo artist when he was able to focus and get past his “mental block” on being creative. Being a tattoo artist was also a source of anxiety for Jake because he was required to manage his own schedule and to complete tasks in a timely manner. This was anxiety-producing for Jake because he struggled to organize his schedule and prioritize tasks to work efficiently, causing him to often get behind on work. Jake stated that he felt like he was “giving up and selling out” by taking a “9-5 job” working for the city. He identified liking the consistency of a regular paycheck but did not want to feel like his was giving up on being a full-time tattoo artist.

Substance Use History. At the initiation of treatment, Jake had been sober from intravenous heroin use for seven years and alcohol for three years. Jake was using marijuana daily as a sleep aide, to reduce his anxiety, and to increase creativity. He regularly attended mindfulness-based Alcoholics Anonymous (AA) meetings and exercised. Prior to achieving sobriety, Jake had served a jail sentence for substance use and gone to court-mandated substance use treatment. When discussing the treatment program in sessions, Jake indicated that he had been given a lot of coping skills but that he struggled to employ them on a regular basis. At the time of treatment, Jake was using marijuana daily and after approximately six months of treatment resumed consumption of alcohol daily. Jake’s girlfriend had requested that he consume alcohol with her as it made her uncomfortable to drink alcohol alone. Prior to resuming alcohol consumption, Jake stated that he felt he would be able to manage his use of alcohol despite his difficulty decreasing his marijuana use. Jake stopped attending AA meetings because he did not want to have to be dishonest about his substance use. Jake reported drinking a “six pack of beer” every night after work and staying up late, struggling to fall asleep after consuming the alcohol. Jake

started to call out sick to work between one and three times per week or arrive late to work due to difficulty waking up in the morning, feeling hungover and sick from the previous night's alcohol use. Jake stated that he wanted to be able to drink alcohol with his girlfriend and friends as it decreased his anxiety in social situations. After approximately three months of alcohol use, Jake shared that he felt that his alcohol consumption was not under his control and he would repeatedly attempt to reduce his intake, particularly after the ending of his relationship. Nearing the end of treatment, Jake also started consuming benzodiazepines without a prescription to decrease his symptoms of anxiety after he discontinued contact with his ex-girlfriend. He was often taking the benzodiazepines in the morning to reduce his anxiety about attending work.

Treatment History. Jake had received court-mandated substance use treatment at the conclusion of his jail sentence seven years prior to the current outpatient therapy. Jake recalled learning coping skills and engaging in group therapy services but did not receive individual counseling at that time. After the substance use treatment Jake was able to desist his opioid use but continued consuming alcohol. Additionally, Jake had engaged in outpatient treatment at the university-based clinic three years prior but was still actively consuming alcohol and did not attend treatment consistently and after multiple missed appointments was discharged from treatment at that time.

Relevant Treatment

Jake presented to therapy with this therapist on a weekly basis for approximately two years, from Fall 2016 to Summer 2018. Jake vacillated between consistent and inconsistent attendance of treatment, depending on his perceived level of distress. Jake had significant anxiety about the loss of his relationship despite acknowledging that there were a lot of “red flags” and negative characteristics to the relationship such as arguing and mistrust of each other.

Jake also described racing thoughts and dysregulation, for example if a friend took more than a few hours to return a text or phone call Jake would start worrying that they were angry with him or he had upset them in some way. When not at work, Jake would smoke large amounts of marijuana, stating that the effects of the marijuana slowed his racing thoughts and made his symptoms of anxiety more manageable.

At the outset of treatment, this therapist attempted to gather information related to Jake's early attachments with his primary caregivers. Jake shared that he had very few memories from his childhood but that his mother was a very inconsistent parent due to her substance use and that his parents fought frequently and eventually separated. Jake felt a significant sense of loss regarding not knowing his mother's location and whether she was still living. He was not able to share specific memories of his mother from his childhood but did recall that she was a "good mother" when she was sober, but she would get angry and volatile when she would drink alcohol. Jake shared the experiences of losing two of his brothers to substance overdoses and feeling sadness about not being able to locate or contact his living brother. Jake had also lost many friends to substance use during his adult life and shared witnessing his best friend's death due to a physical altercation in a bar. Jake was able to discuss these experiences with little affect as if he was sharing a story about a topic with much less emotionally traumatic content.

Jake sought out many external sources of regulation such as his Alcoholics Anonymous (AA) meetings, marijuana, and occasionally, benzodiazepines. Jake enjoyed attending AA meetings because if he was able to share an experience in the meeting, often someone would approach him after the meeting and thank him, sharing that his words had been helpful for them to hear. This provided Jake with a sense of temporary gratification and usefulness.

Another avenue of external validation that Jake pursued was sexual partners. Jake spent much of his free time searching dating apps on his phone for women to engage in sexual relationships. After approximately six months, Jake met a woman on a dating app that he developed romantic feelings for very quickly. This therapist reflected with Jake about his previous relationship and his concerns that he had ignored significant “red flags” at the beginning of the relationship due to his desire to have a romantic partner.

Jake developed very strong feelings for his new partner in a short period of time, spending all of his free time with her and occasionally calling in sick to work to spend additional time with her. After two months of being in this new relationship, Jake’s partner started asking him to drink alcohol with her at dinner or on the weekends. Jake experienced significant internal conflict over this decision as he wanted to be able to drink socially, particularly to alleviate his anxiety in social settings but also did not want to forfeit three years of sobriety from alcohol. Jake expressed anxiety that if he was not able to make his partner happy by drinking alcohol with her that she would leave the relationship, based on his own fears, no longer seeing his value. This therapist attempted to utilize Motivational Interviewing techniques in combination with sharing reflections connecting Jake’s early experiences of invalidation from his mother with his strong desire to receive validation from his romantic partner. Jake ultimately made the decision to resume drinking alcohol with his partner, needing his relationship with her to feel secure and validated. Very quickly Jake realized that he did not have the control he believed he would over his alcohol consumption.

As Jake’s relationship progressed, the gains he was making in therapy started to regress. Jake was missing appointments to spend time with his partner or catch up on sleep that he was missing due to staying up consuming alcohol or spending time with his partner. Jake was also

missing work frequently, calling in sick due to lack of sleep or feeling groggy and hungover in the morning. Jake started to feel an immense amount of pressure from the relationship as he felt unable to tell his partner that he needed some time for himself and his hobbies. Jake's alcohol consumption increased as his time alone decreased; he was no longer able to focus energy or attention on art projects, work, meditation, or sleep hygiene. Jake felt as if he was losing his identity in the relationship and no longer had time to engage in activities that were important to him such as art, seeing friends, and meditating. Although he was experiencing a loss of self, his fears of losing his partner were significantly more distressing to him.

This therapist worked to be a secure base for Jake to work through his thoughts, feelings, and behaviors, during this period in therapy providing an attuned and validating environment. This therapist shared her concerns and care for Jake with him regarding his lack of time for self-care, difficulty setting boundaries in his relationship, concerns about losing his partner if he did not acquiesce to her needs for him to drink, and increased level of stress due to struggling to balance the needs of his partner with his own needs. Jake responded that it was difficult for him to hear that his therapist cared so much for his well-being and he was unsure of how his therapist's concern could translate into affecting change in his relationship with his partner. Jake's attachment insecurity also surfaced when the clinic would close for the holidays or this therapist would have to cancel a session due to travel. The session before this therapist would leave Jake would attend the session in crisis, about housing, about his pet, or about his relationship, displaying his fear of abandonment.

A turning point in the therapeutic relationship took place approximately eighteen months into treatment. Jake shared that he was struggling with having his partner sleep over every night as he was too embarrassed to remove his dentures in her presence and would

therefore sleep with his dentures in each night which caused him a significant amount of pain. This admission was surprising to this therapist for multiple reasons. Jake had never shared that he wore dentures in therapy; he proceeded to tell this therapist the story of losing his teeth due to an accident. Jake's father was the only other person with whom Jake had shared the knowledge of his accident and resulting dental problems. This therapist offered an analogy to Jake regarding the physical pain he was experiencing at not being able to remove his dentures in the presence of his partner and the emotional pain he was experiencing at being unable to maintain his autonomy and share his wants, needs, and desires in his romantic relationship.

Jake started to make attempts to set boundaries in his relationship which caused his anxiety symptoms to increase. He was struggling to balance his desire to be authentic and address his needs in the relationship with his anxiety about losing the relationship. When Jake attempted to create a boundary with his partner she would become angry or sad, viewing this as a sign that he did not love her. This caused Jake's anxiety to increase dramatically as he felt that no matter what he did that he was still going to be distressed. As Jake made efforts to regain some autonomy the conflict increased in his relationship. Suddenly, Jake's partner's mother became very ill and she had to abruptly move out of state. Jake was still drinking alcohol nightly, not attending AA meetings, not exercising, and sleeping only a few hours each night. Jake's coffee intake increased to approximately two pots of coffee per day to stay awake which further impacted his ability to sleep at night. Additionally, although Jake was still deciding whether to maintain the relationship with his partner, he was also spending much of his free time on dating apps looking for new sexual partners. With the loss of his girlfriend, Jake needed other partners who could help him achieve regulation through sexual behavior as he was feeling overwhelmed by his feelings of anxiety.

Due to his uncertainty about how to move forward with his partner, his guilt over engaging in sexual encounters outside of the relationship, and his lack of sleep, Jake started taking benzodiazepines (e.g., Xanax) to relax when he would get home from work or when he would try to fall asleep. Jake's father also had a significant health problem arise and Jake was unsure of whether his father would live through this time and be able to return home from the hospital. Jake was now having to take on the responsibility of caretaking and confront his fear about losing the safest relationship in his life on top of his other stressors. Additionally, just before Mother's Day Jake found out that his mother had been deceased for approximately one year and although he had not had any contact with her for a number of years there was still a significant sense of loss and complicated grief over his mother's passing. Now there was no possibility of reconciliation with his mother.

At this time in treatment, Jake started attending sessions irregularly, avoiding discussing transferring to a new therapist due to this therapist moving out of state. Jake's anxiety about termination with this therapist and ongoing sense that others can't be relied upon made it difficult for him to process his feelings of loss about the relationship he had created with therapist over the course of two years of treatment. This caused Jake to engage in avoidant behaviors, missing sessions, and abruptly changing the subject when therapist attempted to address termination.

During the termination session with this therapist, Jake shared that over the weekend he had gotten into a verbal altercation that had almost turned physical with another patron at a bar. Jake felt that this was a "wake-up call" for him in that he did not have the control he believed he did over his alcohol consumption. Jake and this therapist were able to process his feelings of grief over losing his connection with this therapist and his feelings of anxiety about starting

therapy with a new clinician and addressing his substance use. Jake was tearful during the last session and expressed how significant the impact this therapist had on him had been over the previous two years. Jake shared that he appreciated how safe this therapist had made him feel to share his feelings without fear of judgment or negative repercussion. He felt that his ability to end his romantic relationship was because of the support he had from this therapist and that despite his relapse that he was managing this break up more effectively than the one he was struggling with when he initially entered treatment. Occasionally after a session where this therapist would encourage Jake to attend an AA meeting or exercise and he would engage in the suggested coping mechanism he would share that he had left the session feeling at peace and after exercising and attending the meeting that he was feeling a sense of acceptance and calm. Jake expressed feelings of grief over the loss of the therapeutic relationship and this therapist reflected her own feelings of sadness and loss over having to terminate work with Jake.

Case Conceptualization. Jake is a 36-year-old, Caucasian, heterosexual, cisgendered male who presented for treatment with self-identified anxiety, relationship concerns following the ending of his romantic relationship, and substance use. Jake has a disorganized style of attachment which causes him to have difficulty with self-regulation and interpersonal relationships, although he desperately desires connection from others. Jake experienced attachment insecurity in the form of his mother's substance use and inconsistent caregiving. Jake's mother was volatile while under the influence of alcohol, creating the experience of fear for Jake. Jake was not able to establish a reliable strategy to obtain benevolent care from a caregiver, creating his disorganized attachment style. Jake is hyper-aroused and struggles significantly to regulate in an effective way. He utilizes substances and sexual relationships as a way to manage his emotions which feel intolerable to him. This enables him to dissociate from his painful childhood memories, current

painful experiences, and profound insecurity. Jake's excessive substance use hinders his ability to engage in meaningful relationships and function in social environments. He tends to choose relationship partners that continue to fail to meet his needs for security, including ones that involve supporting and reinforcing his functioning with sobriety.

Jake's early childhood was marked by pervasive instability and chaos. Jake's mother struggled with substance use issues and failed to consistently meet Jake's emotional and physical needs. Additionally, Jake's mother and father were engaged in a very tumultuous relationship, often fighting in front of Jake. As a child, Jake was surrounded by toxic levels of stress and uncertainty. He was desperate for connection from his mother for a sense of safety and regulation. However, her substance use prevented her from attuning to Jake and comforting his distress. Jake's mother was a source of fear for him, becoming angry and volatile when she would consume alcohol. Jake had to learn to autoregulate to manage his feelings of anxiety, distress, and fear. The toxic levels of stress that Jake experienced in childhood resulted in the overactivation of Jake's stress response systems and led to his hyperarousal. During this time, Jake likely learned that it was not safe to seek attunement and connection from his mother. The neglect, inconsistency, and misattunement Jake experienced throughout his childhood culminated in the development of Jake's disorganized attachment.

Jake's fear of abandonment and rejection prevented him from creating intimacy within his relationships. Jake was able to have casual sexual relationships with women but shied away from any topic of discussion that led into emotional intimacy. Further, Jake learned from his early attachment experiences that he needed to hide parts of himself from the world in order to maintain relationships. Jake's alcohol use allowed him to release his feelings of anxiety and worry about how he would be perceived in social situations. Jake felt that he had to "be his best

self” in his relationship or his partner would leave him. Without having a secure attachment with a female caregiver, Jake did not learn how to trust female partners and expected chaos in his romantic relationships. Additionally, he frequently chose partners that would confirm his mistrust that his needs would reliably be met.

Jake spends a significant amount of his time avoiding his emotional experiences. Instead of attempting to regulate, he navigates the world by using substances to manage his insecurity and pain. The effort required to subdue Jake’s hyper-aroused state is exhaustive. Thus, Jake frequently turns to alcohol as a means to release his control of his emotions and hyperreactivity. Jake’s experience of social anxiety is temporarily reduced when consuming alcohol but then he feels intense shame for how he may have behaved while intoxicated the following day. Following his alcohol use, Jake is flooded with feelings of guilt and shame as he is quickly brought back to his early childhood memories of rejection and abandonment.

Interpersonally, Jake’s disorganized attachment style has led to a cycle of desperately needing reassurance but anticipating withdrawal. Thus, Jake’s interpersonal relationships would be best described as inconsistent and anxiety-provoking. Jake frequently experiences distress over his interpersonal relationships and desperately desires a sense of connection but avoids any feelings of true closeness and intimacy.

Treating Substance Use Disorder with an Attachment Lens. Jake was able to identify and verbalize positive coping skills such as exercising, meditating, and walking his dog, that he had been taught in his residential substance use treatment program and yet when dysregulated was not able to effectively utilize these skills to manage difficult emotions. Arguably, this is because a critical element of Jake’s substance use had not been addressed, i.e. his disorganized attachment style. Jake exhibited attachment disorganization stemming from his early caregiving

experiences with his mother's substance use and parental discord. The experience of disorganization in his attachments included struggles with self-esteem, low frustration tolerance, difficulty with emotional regulation, and limited development of successful and positive coping strategies. Additionally, Jake had difficulty in interpersonal relationships, struggling with feelings of aloneness, fear of abandonment, and insecurity.

In his adult life, Jake was not able to successfully navigate interpersonal relationships with friends or romantic partners. This furthered Jake's sense of isolation and misattunement from those in his life. Jake's substance use became the primary attachment figure that was consistently available to him in times of need. These substances provided Jake with a desired sense of relief from his feelings of anxiety and worthlessness, a relief that he was not able to access in his interpersonal relationships due to his disorganized attachment, but ultimately increased his anxiety because of the guilt and shame that followed. Although Jake and this therapist developed a strong therapeutic alliance, his disorganized attachment style proved difficult to overcome in the span of this treatment. Jake was highly resistant to any connection being made between his early attachment experiences and his current substance use and interpersonal distress, stating that he did not see how his relationship with his parents was relevant to his current relationship difficulties and substance use.

To successfully address Jake's attachment disorganization and consequent struggles to form successful intimate adult relationships, long-term therapy would be required to counter Jake's early caregiving experiences and address his working model of relationships in therapy. Developing trust and security often requires an extended period of time that short-term therapy does not allow for. By creating a secure attachment in therapy, Jake would be able to develop skills to increase his frustration tolerance, emotional regulation, and positive coping skills. By

creating a secure attachment, Jake's brain pathways will rewire, creating a new template for relationships and new self-regulation skills. Additionally, the secure attachment formed in the context of therapy would serve as a space to practice boundary setting and effective communication.

Jake's substance use as a form of autoregulation would need to be addressed, supporting Jake in learning to co-regulate with the therapist. Jake's lack of early caregiving experiences with attunement and validation did not allow him to develop a stress response system based on interactive regulation with an available caregiver. Jake's therapist would need to attune to his emotional state and validate his feelings, showing Jake that his feelings are safe to share with others and will not cause him to be abandoned. For example, using body language (e.g., leaning in) and a soft tone of voice to make the observation of Jake's behaviors and then validate him for being able to receive the feedback and process the emotions and feelings of anxiety that came up in the moment. Through co-regulation with the therapist, Jake will learn to self-regulate, decreasing his reliance on external methods of stress reduction. Additionally, the clinician should support Jake in recognizing his own attachment behaviors, such as coming to sessions before a break in treatment in a state of crisis.

Due to the difficulty Jake has in tolerating genuine expressions of care and support, it would be essential that rapport be built slowly over time. Jake would benefit from exploring his early childhood experiences and understanding how they are currently impacting him. Over time and with consistency of the therapeutic relationship, Jake would likely become more open to exploring this relationship between his attachment style and current distress. Further, Jake would also benefit from identifying his maladaptive coping strategies and the function they have served for him in his life. Once Jake is able to understand how his substance use and avoidance of

emotional expression was adaptive to his survival he will be more able to replace them with regulating strategies that are more effective for his current needs.

Additionally, it would be important for Jake to be in therapy with his partner, or for his partner to be in her own individual therapy. The relationship that Jake was engaged in did not promote positive coping skills but actively encouraged negative coping strategies (e.g., relapsing on alcohol). Jake being involved in a romantic partnership with a woman who appeared to have attachment insecurity and substance use further encouraged his own psychological struggles. The treating therapist would need to address the enmeshment in Jake's relationship and create a space that Jake felt safe sharing his feelings with his partner and also assist his partner in responding in a validating way. This would allow Jake to share his thoughts and feelings about issues with his partner without experiencing fear or rejection. Helping Jake and his partner establish boundaries in their relationship and increasing their direct communication would support Jake in feeling that he could share his thoughts and needs with his partner and maintain the time and space he desired for his own interests, hobbies, and self-care.

Through the experiences of attunement, validation, and safety within the therapeutic relationship, Jake would experience co-regulation. This experience of co-regulation and understanding the function of his substance use and disorganized attachment would allow Jake to self-regulate with more effective strategies. Further, using the therapeutic relationship as a template for secure attachment, Jake would then be able to go practice his new skills in his personal relationships while in treatment with the support of the therapist to generalize the skills to these relationships. Jake would benefit from attending group therapy sessions or support groups in order to practice and generalize the skills learned in the therapeutic relationship as well as establishing a supportive network with other individuals who are sober.

Applicability

While this case study highlights one individual's presentation and possible treatment approach, it also demonstrates that early attachment experiences shaped the presentation in therapy and impacted ability to maintain sobriety. Therapy to address attachment insecurity and substance use treatment should not be two separate entities but should instead be integrated to improve treatment outcomes for many individuals with similar presentations. The purpose of this case example is to illustrate what is lacking in current approaches to substance use treatment with the hopes of prompting the development of an integrated approach to treatment.

Limitations

While this case study aims to exhibit an area of substance use treatment that requires further development, there are several limitations to consider. This is a subjective account of treatment and the gaps in substance use treatment with one individual client. Additionally, attachment theory and treating attachment align with my own values as a clinician. It is important to consider the individual factors of both the therapist and the client that impacted the treatment. While Jake benefitted from developing an attuned relationship with this therapist, he also continued to struggle with substance use and was in an active relapse for a significant portion of the treatment. To fully address Jake's disorganized attachment and related substance use Jake's relationship needed to be in treatment and Jake needed to develop a therapeutic relationship that he could have maintained for a significant length of time. Further, this therapist was in the first few years of clinical training when working with Jake and was still developing a clinical orientation and had little training in the treatment of substance use. It is important to consider how a clinician with more experience and familiarity with treating substance use might have approached this case differently or more effectively have intervened during the active

relapse. Furthermore, there is a high acuity of relapse needs that is not congruent with the length of time required to develop a strong therapeutic alliance. This treatment approach may not be appropriate for clients in an active relapse. Jake was also resistant to engage in substance use treatment and this impacted his attendance nearing the end of treatment as this therapist was working to engage Jake in services with a new provider. Additionally, the time-limited nature of providing therapy likely had an impact on the therapeutic relationship and there may have been a different outcome to treatment had therapy been able to continue.

Conclusion

Treating substance use disorders by addressing attachment insecurity would likely be beneficial for a significant number of individuals seeking substance use treatment. Although Jake had received treatment for his opioid use in the past and learned coping skills, he was unable to successfully employ them when in distress. If attachment theory was integrated into current substance use treatment modalities, such as behavioral therapies, it is likely that the treatment outcomes would improve and relapse rates would decrease. Additionally, by addressing early attachment experiences and providing a positive and secure therapeutic relationship, individuals may be more able to develop self-regulation skills and not require the external sources of stress reduction. Fostering a secure attachment with the therapist is beneficial to address physiological hyperarousal and dysregulation. Through the therapeutic alliance, individuals will experience co-regulation which then allows them to learn self-regulation, rewiring the brain pathways that can lead to emotional dysregulation.

A consideration for future research would be to develop and research a treatment protocol that provides integrated treatment to address both attachment insecurity as well as the attachment to the substance. Additionally, it would be beneficial to research integrating attachment theory

interventions into current treatment models to determine whether there is increased efficacy of previously established modalities.

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