PART 1 & 2

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ATTACHMENT at the Center of Chemical Dependency

Attachment-based Psychotherapy *for* Addicted Behavior

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Lecture Outline:

- Function of Addiction
- Disorganized Attachment and Addiction
- Internal Working Models
- Dissociation
- Affect Regulation
- Disorder of Self
- Stages of Treatment

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Function of the Addiction

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A Love Story. YES… It IS a LOVE Story

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- It's about passion, sensual pleasure, deep pulls, lust fears, yearning hungers. It's about saying good-bye to something you can't live without.
- *"I loved the way drink made me feel, and I loved its special power of deflection, its ability to shift my focus away from my own awareness of self and onto something else, something less painful than my own feelings. I loved the sounds of drink: the slide of a cork as it eased out of a wine bottle, the distinctive "glug-glug" of booze pouring into a glass, the clatter if ice cubes in a tumbler. I loved the rituals, the camaraderie of drinking with others, the warming, the melting feelings of ease and courage it gave me."*

FLORES, P. J. (2020). "ADDICTION AS AN ATTACHMENT DISORDER" (p. 60). essay, ROWMAN & LITTLEFIELD.

- Narcissism, like addiction, is a retreat into a grandiose-self or false-self personality organization as a way of avoiding the need for attachment. Addiction from this perspective is the result of unmet development needs, which leaves certain individuals with an injured, enfeebled, un-cohesive, or fragmented self. Vulnerable individuals are unable to regulate affect and in many cases are even unable to identify what it is they feel. Unable to draw on their own internal resources because there aren't any, they remain in constant need (object hunger) of self-regulating resources provided externally "out there." Since painful, rejecting, and shaming relationships are the cause of their deficits in self, they cannot turn to others to ger what they need or have never received. Deprivation of needs and object hunger leave them with unrealistic and intolerable affects that are not only disturbing to others, but also shameful to themselves. With few other options open to them, substance abusers turn to alcohol, drugs, and other external sources of regulation (e.g., food, sex, work, gambling, etc.
- Consequently, addicted and alcoholic patients are always vulnerable to compulsive, obsessive and addictive behavior, constantly substituting one addiction for another until the vulnerabilities in the self structure are repaired and restored.

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Secure Base

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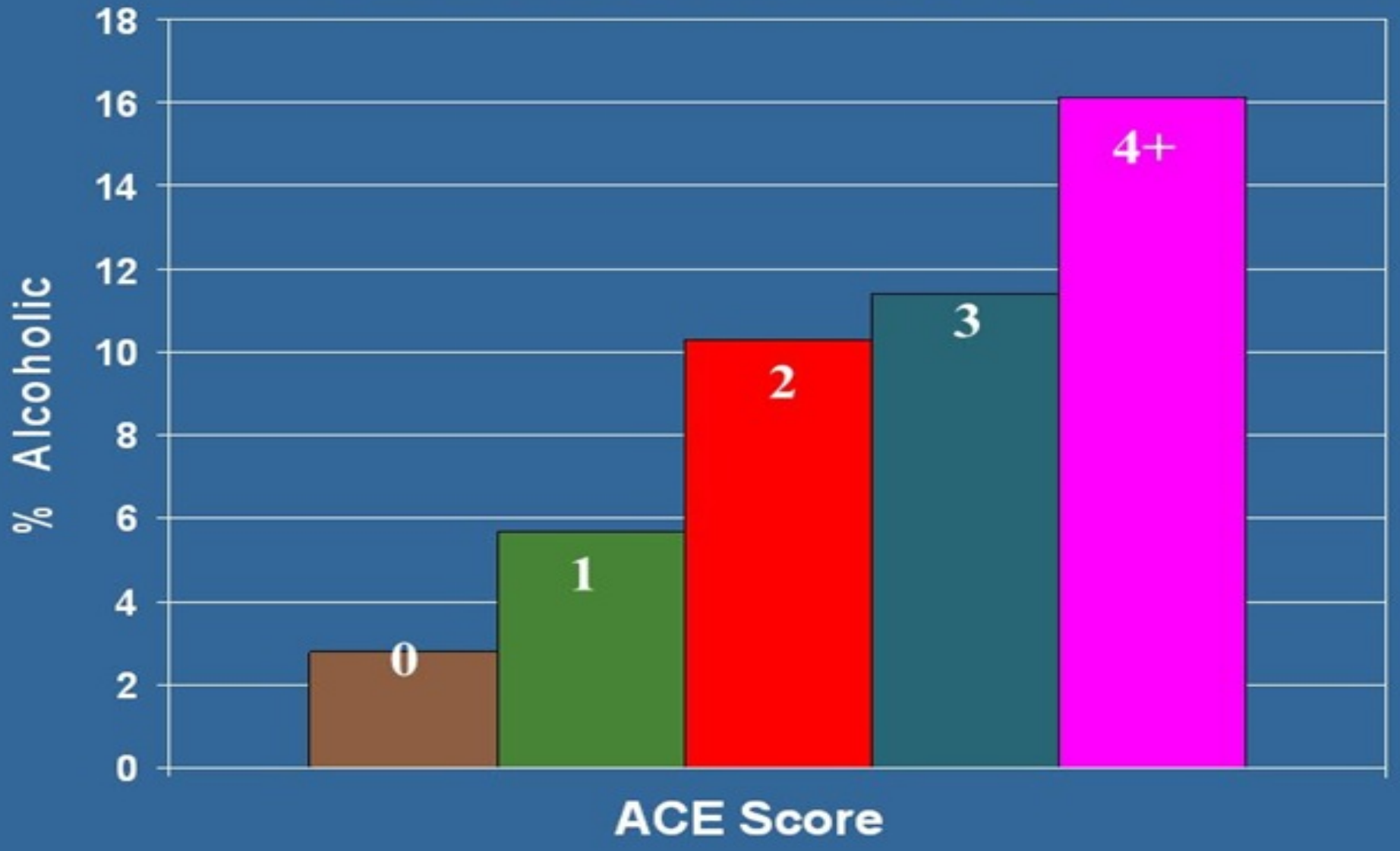
The affective attachment between infant and caretaker established during the first year of life evolves into a capacity for object permanence and evocative constancy during the second year that provides a "secure base" – enabling the child to explore and master. These cognitive-affective schema provide templates that maintain continuity of inter-personal behavior beyond infancy.

Childhood Experiences and Adult Alcoholism



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2nd Stage of Emotional Recovery: Relationships

- Dependency — addiction to chaos, abandonment, pain, and rejection
- Use of Denial/Dissociation
- Strong need to be in control
- Tendency to be oversensitive and take things personally
- Difficulty trusting others
- Distorted sense of responsibility
- Difficulty being assertive and dealing with anger
- Unusual thinking and behavior
- Self-defeating behavior patterns
- Sexual/Somatic problems
- Alienation from others
- Blackouts
- Life Problems — social, familial, legal
- Loss of control — moderating and limiting is impossible; although, they can stop using for a while
- Other issues of control — manipulating people and circumstances
- Making rules and breaking them
- Denial — minimal insight and distorted thinking patterns

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Other Disorders Often Concomitant with PTSD

- Mood Disorders
  - Major Depressive Disorder
  - Dysthymic Disorder
  - Mania
- Anxiety Disorders
  - GAD
  - Agoraphobia
  - Social Phobia
- Alcohol Abuse/Dependence
- Drug Abuse/Dependence

(Kessler et al, 1995)

MEN	WOMEN
47.9%	48.5%
21.4%	23.3%
11.7%	5.7%
16.8%	15.0%
16.1%	22.4%
7.3%	12.6%
27.6%	28.94%
51.9%	27.9%
34.5%	26.9%

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Main

Cecilia displays distress immediately upon finding herself in the unfamiliar laboratory environment, even though her mother – a slightly disheveled, overwhelmed-appearing woman – is present. When the stranger enters, Cecilia looks suspicious and ill-at-ease, and refuses to engage in interactive play. Immediately upon separation, she begins to cry, while angrily resisting the stranger's attempts to comfort her.

Reunited with her mother, Cecilia cries loudly; when picked up, she does not settle but continues crying and wriggling uncomfortably in her mother's lap. She does not calm even after the mother has held her for a full minute. As her mother attempts to interest her in toys, she looks momentarily out into the room, then turns back to cling again to her mother, crying and apparently still uncomfortable. The mother repeats, "calm down, calm down, you're OK," but Cecilia refuses to get off her lap and doesn't engage in play.

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Main *(cont…)*

When the mother leaves again, Cecilia begins crying loudly and crawls toward the door. The stranger enters at once, but Cecilia angrily resists her advances.

The mother is sent in almost immediately and after a lengthy pause in which she watches as Cecilia continues to cry, she picks her up and holds her. However, when she tries to put her down, Cecilia throws herself backward in a tantrum movement. When the mother reaches out to comfort her, her crying increases and she closes her eyes, throwing herself about.

Two minutes later, Cecilia remains focused on her mother, clinging to her knees and fussing in a petulant, dissatisfied way. She has never engaged with the toys.

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Table 1. Core Characteristics of DSM-IV Borderline Personality

Unstable Intense Relationships	- "splitting" - "object hunger" - "abandonment depression"
Affective Instability	- mercurial moods - reactive dysphoria - irritability - binge eating - suicidality
Chronic Emptiness	- boredom
Unstable Sense of Self	- identity disturbances
Polarized Contradicting Internal Shifts	- dissociation

Delitto (et al): 44% of clients with Borderline overlap with Bipolar 1 or 2

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Disorganized Attachment

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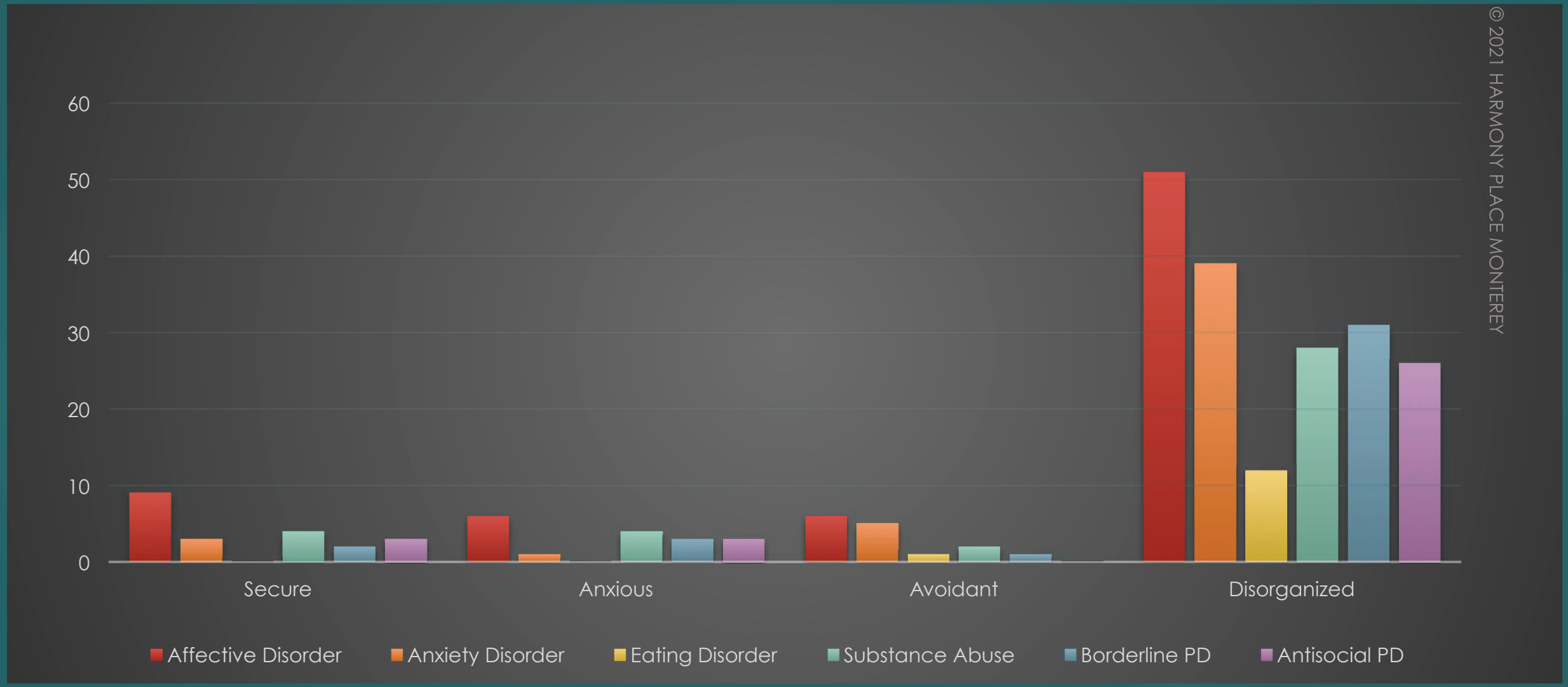
AAI Classification and Psychiatric Diagnoses



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Clinical Manifestations: *Disorganized*

- Affect Dysregulation
- Lapses In Self-Monitoring
- Discontinuous Self- and Mood-State
- Dissociated 'PARTS'
- Impaired Self-Agency *and* Goal-Directed Behavior
- Inhibited Exploratory Behavior
- Contradictory Attachment Strategies
- Controlling versus Submissive
- 'Stable Instability' In Relationships
- Source of Attachment Is Also Source of Fear

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Rupture in Attachment Impingement

Greenburg & Mitchell

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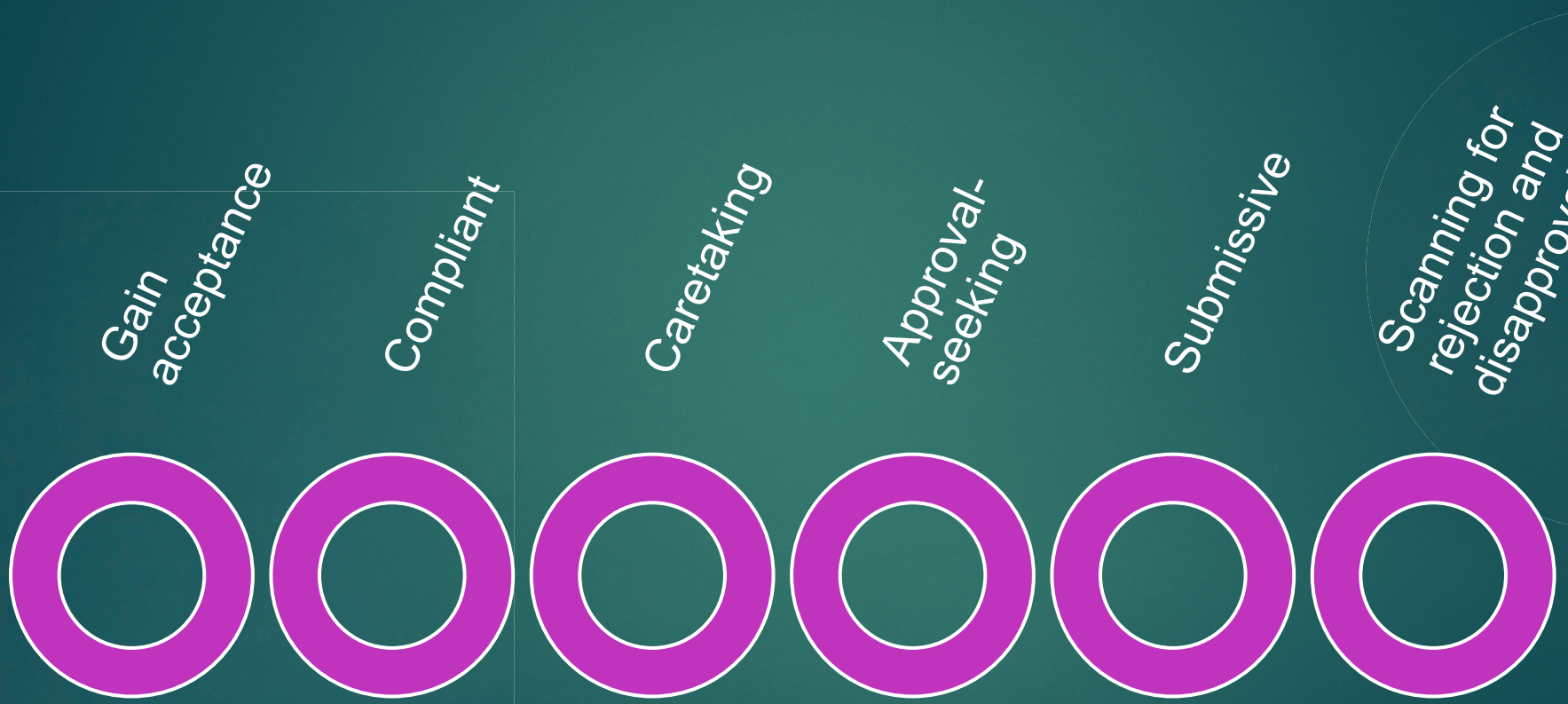
- **The child's psychological survival must not depend upon meeting the mother's needs.** The major consequence of prolonged impingement is fragmentation of the infant's experience. Out of necessity, he/she becomes at the request of others. The child's "true self,"— and source of spontaneous needs, images and gestures — goes into hiding and becomes detached and atrophied. **The "false self" provides an illustration of personal existence whose content is fashioned out of maternal expectation. The child becomes the mother's image of him/her.**

Split off 'FALSE SELF'



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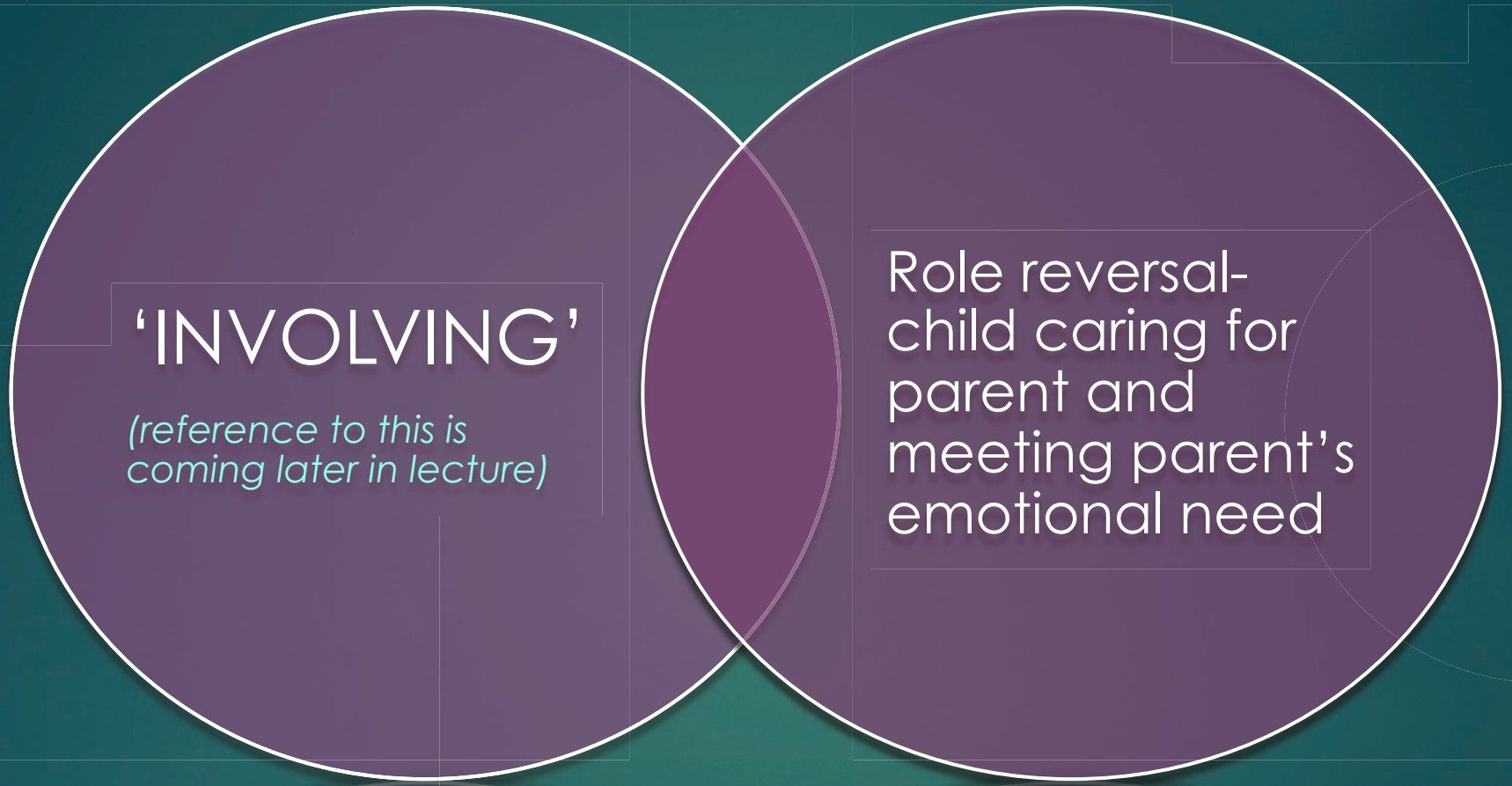

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The Parent's Control Strategies consist of constantly redefining the children's feelings and emotions until they experience them according to The general family pattern.

This injures "Self Differentiation."

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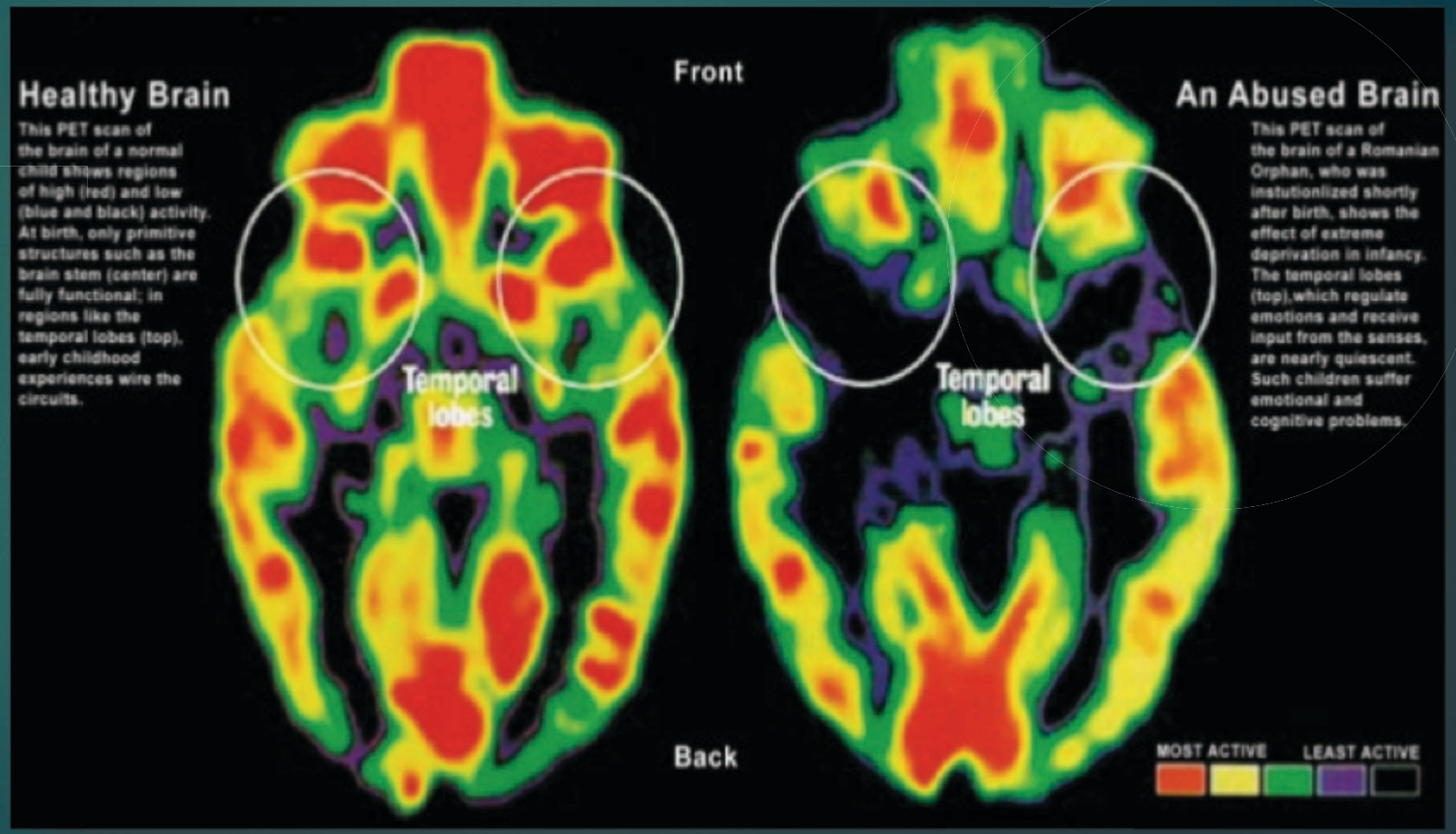
PTSD Complex Trauma

Changes in the Brain

- Neurocircuitry models make references to some important brain areas
- Amygdala, medial prefrontal cortex and anterior cingulate, and hippocampus
- Activity in these areas is markedly different in children with a trauma history than without



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Examples of **Stuck Points**:

- Expressing any emotion means I will lose control of myself. (assimilated)
- I must be on guard at all times. (assimilated)
- I should be able to protect others. (overaccommodated)
- I must control everything that happens to me. (overaccommodated)
- Mistakes are intolerable and cause serious harm or death. (overaccommodated)
- No one can understand me. (overaccommodated)
- If I let myself think about what has happened, I will never get it out of my mind. (overaccommodated)
- I must respond to all threats with force. (overaccommodated)
- I will go to Hell because of the things I have done. (overaccommodated)
- I am unlovable. (overaccommodated)

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Stuck Points *(cont….)*

- If I had done my job better, then other people would have survived. (assimilated)
- Other people were killed because I messed up. (assimilated)
- Because I did not tell anyone, I am to blame for the abuse. (assimilated)
- Because I did not fight against my attacker, the abuse is my fault. (assimilated)
- I should have known he would hurt me. (assimilated)
- It is my fault the accident happened. (assimilated)
- If I had been paying attention, no one would have died. (assimilated)
- If I hadn't been drinking, it would not have happened. (assimilated)
- I don't deserve to live when other people lost their lives. (assimilated)
- If I let other people get close to me, I'll get hurt again. (assimilated)

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‘Talking About’ versus ‘Processing’ Memory

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- **“Talking about” what happened** (i.e., accessing narrative memory) **does not process or metabolize the memories.** It establishes a context for the symptoms, validates the suffering, and increases self-compassion.
- And because **narrative re-telling** activates implicit memories (emotions, body sensations, autonomic arousal), it **risks autonomic dysregulation and re-traumatization.**
- **“Processing” memories refers to interventions that transform or digest the experience** in some way and **do not always include attention to the narrative.** In processing, we seek interventions that promote a sense of mastery, even if they elicit strong emotions.

Dissociation

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Integration versus Dissociation

- **Pathological Dissociation**, which can most often be traced to Disorganized Attachment in infancy, represents a profound distortion of core self-processes, such that development progresses towards greater complexity, without complementing integration. The result can be internalizing a sense of defectiveness, self-criticism, and hostility to protect the idealized image of the caregiver. When dissociation prevails, there is fragmentation of self.
- ***Vulnerability to* dissociative coping mechanisms** is more likely in the absence of experiences of reliable support and self-efficacy. Dissociative processes interfere with the formation of a personal narrative and verbal exchange, undermining the integration of traumatic events with other experiences.

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Multiple Internal Working Models

- Reciprocally incompatible and segregated or dissociated models of self and of the attachment figure are constructed and, thereby, interfere with integrative functions of memory, consciousness, and identity. This suggests that dissociative is more than a defense against trauma. The results are sequential, simultaneous or trance-like contradictory behavioral systems. Disorganized infants are unable to synthesis their overall experiences of their interaction with the care-taker into cohesive mirroring structure.

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If ego states are split off, projected, rejected, indulged or otherwise unassimilated, they become black holes that absorb fear and create the defensive posture of the isolated self — one that is unable to make satisfying contact with one's self or others.

When split-off ego states are made conscious, accepted and tolerated, or integrated, the self can be at one, and compassion can be released.

- Epstein, 1995

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Dissociated States Therapy

- Identify the ambivalence or split
- Contact (polarity questions)
  - What do you want for yourself?
  - How does she/he stop you from getting what you want?
  - Is there any way she/he can be of use to you?
  - What would happen if she/he were to go away completely?
  - Do you know what she/he wants?
  - What would happen if you let him/her get that?
  - Is there any way both of you can get what you want?
- Contract
- Integration or cooperation
- Future pacing

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Disorder of Self

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The Self

- Amalgam of selves, multiple mental systems, each having impulses for action capacity to produce behavior.
- One system can be cut off from another (unconscious)
- Verbal self gives meaning and consistency; language becomes linked with identity and meaning-making
- Defense System serves the self by protecting sense of consistency

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Disorder of the Self: MALE TYPE

- Partial affective/intellectual split
- Anger prominence
  - Walling off vulnerable core self
  - Shame-sensitive, shame-phobic
  - Action blunting of empathetic recognition
  - Incapacity to translate feeling into action
  - Harsh, unconscious self, criticism projected onto others
  - Perfectionistic need to mask
  - Inability to grieve or mourn
  - Vulnerability to substance abuse

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Affect Regulation

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Internal Representations and Affect Regulation

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" In a good-enough child-caregiver system, the child repeatedly experiences the caregiver's soothing affect-modulating responses. As the child's representational capacity matures, he or she is able to sustain an internal representation of the caregiver's soothing function for longer and longer durations. The child intentionally returns to the caregiver as a secure base when necessary. Repeated experiences of the caregiver's soothing coupled with the maturation of representational capacity results in the internalization of the soothing function."

— Daniel Brown, 1993

Internal Working Models

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Structural Deficits

- There is good reason to believe that large segments of the population lack many critical capacities, such as self-observing abilities necessary for mental health, and that even patients who have them, have them only in part. These capacities, which can be called "structural capacities" (Greenspan, 1989), have to do with critical abilities such as self-regulation, relating, pre symbolic-affective communicating, representing and differentializing experience and self-observation. These structural capacities make up the stage upon which our psychological dramas can play out… Using mostly verbal content exploration as a vehicle for psychotherapy, as is indicated, over-utilizes a narrow section of the mind having to do with already represented and differentiated experience. It assumes most patients have abilities which they do not.

From Greenspan, S. (1997). Developmentally Based Psychotherapy, Madison: International Universities Press, Inc.

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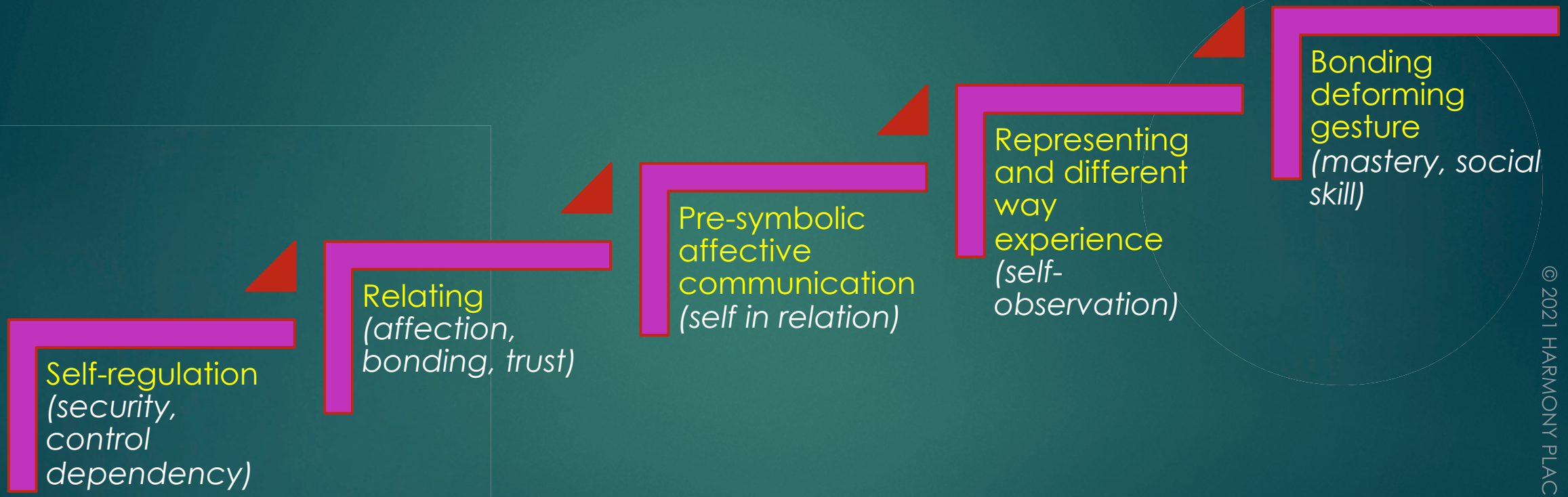
Structural Capacities



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- In therapeutic terms, how does one build the ego structure, including, for example, regulation of attention, mood and behavior; forming, maintaining and negotiating relationships; understanding the intentions and emotions of others; organizing and controlling ones impulses; and learning to delay, pause and tolerate frustration? How does one learn to represent feelings, affect and wishes that have never been represented before? How does one learn to differentiate and build bridges between the past, present and the future, when one's past interactions may have been concrete and grounded in the day-to-day meeting of needs? How does one work on increasing the depth of intimacy and relatedness and overcoming a sense of empty deadness or hollowness, when one doesn't have the ability to represent or deal with affects, feelings and failures of empathy, when there is no ability to represent or put the feelings into words and when the therapist's attempted verbalization has no symbolic reference point? Similarly, how does on deal with issues of merging and separation- individuation for which there are no verbal or representational analogues in the patients personality? How does one deal with proclivities for aggression and fears of annihilation wen these potential conflicts exist as fragmented, pre- representational, behavioral, and somatic tendencies- a series of fragmented, affect and behavioral discharge state.

From Greenspan, D. (1997). Developmentally Based Psychotherapy, Madison: International Universities Press, Inc., pp. 48-49

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The Hallmark of Secure Attachment:

1. The Ability to Reflect on One's Internal Emotional Experience
2. Make Sense of it and at the Same Time…
3. Reflect on the Mind of Another

"Mentalizing" (Fonagy, 2001,2002)

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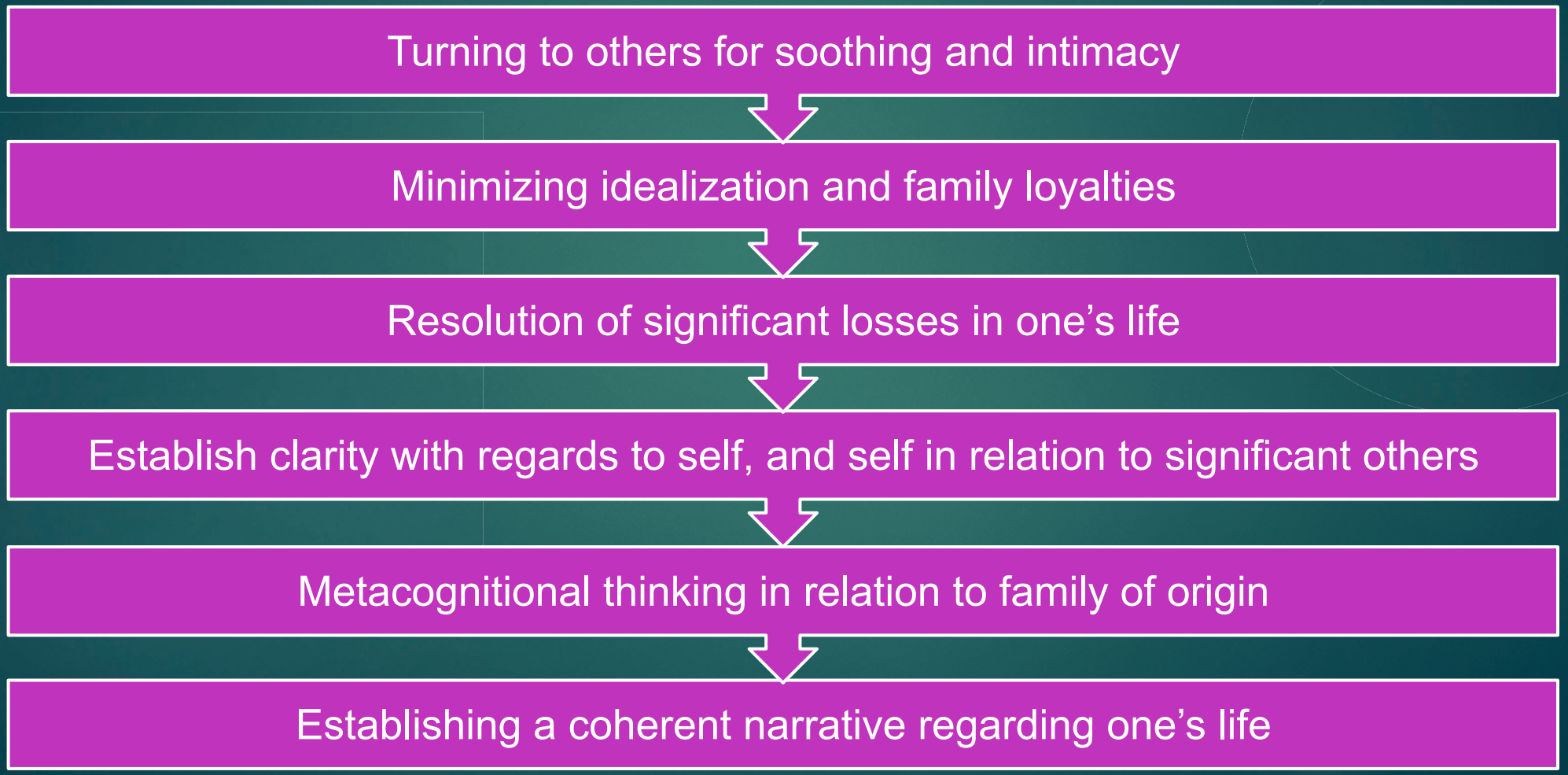
Targets for "Earned Secure Attachment"



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Individuation and Addiction

Differentiation of the Self

- Knowing one's own thoughts, feelings, and desires
- Expressing one's thoughts, feelings, and desires
- Diminishing emotional "contagion"— not getting pulled into having to feel the same feelings as the partner at the same time
- Developing awareness of what works for one's self in solving conflicts
- Handling "alone time," including private thoughts and private physical spaces
- Developing individual goals

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Individuation and Addiction (*cont…*)

Establishing Boundaries

- Developing separate friendships
- Delineating separate areas of family and household responsibilities
- Planning for separate activities
- Delineating separate areas of financial responsibility
- Developing the capacity to handle privacy within the relationship

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Individuation and Addiction cont…

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Differentiating from Others

- Developing more balanced perceptions of the partner and being able to give empathic responses, even at times of disagreement
- Handling discrepancies in desires for closeness
- Developing mechanisms for resolving conflicts with the partner
- Developing mechanisms for “how we do things as a couple”
- Recognizing and handling different value systems

Metacognitional

Metacognition means treatment of one's mental contents as "objects" on which to reflect; or in other words, "**Thinking About One's Thinking**." Distinct skills contribute to its characterization, such as the ability to reflect on one's mental states, elaborating a theory of the other's mind, decentralizing, and the sense of mastery and personal efficacy.

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Enhancing Metacognition in the Disorganized Patient

- Enhancing mentalizing and reflective capacity
- Importance of fostering metacognitive awareness
- Fostering metacognitive mastery
- Metacognitive orientation to pass, present, self/other, child/adult.
- Taking a wider perspective on self to a larger unity, rather than momentary shifting of self-states.

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Stage Approach to Treatment

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Ideal Parent (First Pillar)

Brown & Elliott

Infant Experience	Caregiver Behavior
Felt-sense of safety	Protection
Feeling seen and known	Accurate attunement
Felt comfort	Soothing, comforting, reassuring
Feeling valued	Expressed delight in the child
Supported for exploration	Encouragement

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Maintenance Stage

- Telling our story
- Being a sponsor
- Giving back
- Commitment to continued growth and development
- Progress and not perfection — recognizing stuck points and learning how to deal effectively with the problem
- Learning how to enjoy the journey
- Recognize freedom from the past
- Spiritual growth and improving relationships are the focus
- Finding meaning and purpose

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Crisis Stage - Transition State

- Maintain safety and health
- Description of patient in crisis stage: Flooding, flashbacks, SI/HI, overdoses, work or family crises may present in relapse mode.
- Assess likelihood of maintaining abstinence, absence of significant withdrawal symptoms, high functioning in other areas, belief on client's part to maintain abstinence, and social support.
- Treatment Tactics: structure, limits, education, identify triggers and supports, information on PTSD
- Recognize loss of control over alcohol and drug use
- Recognize that she/he cant control it, because they are addicted
- Make a commitment to a program of recovery that includes the help of others
- Disease concept
- Denial
- Analyzing presenting problems as they relate to abuse of chemicals
- First 3 steps of AA

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Skills Building - Stabilization

- "Being" after safety and health is ensured
- Learn skills to protect and nurture
- Skills provide the basis for more advanced therapy work
- Conflict resolution, boundary-setting, emotional regulation, self-care, relaxation, assertiveness
- Examine underlying beliefs that prohibit use of skills
- Developing a support system and dealing with difficulties of being in a 12-step program
- Physically recover from withdrawal from chemical use
- Stop being preoccupied with chemicals
- Learn to solve problems without using alcohol and drugs
- Develop hope and motivation
- Acute and post-acute withdrawal (PAWS)
- Relapse Cycle: Euphoric recall, positive expectancy, trigger event, obsession, compulsion, craving

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Education Stage/Early Recovery

- Establishing a recovery identity
- Typically, continue flooding and strong emotion, usually use escape and avoidance to manage feelings
- Deal with issues related to shame by telling story openly and honestly
- Honor strengths and coping skills
- Mapping: Addressing parts and their interrelationships. Begin to build alliances with parts. Begin doing "family therapy"
- Rewriting the story: Deal with confusion and shame about arousal. Address power and trust issues and the belief they should have stopped it.
- The major goal is to change the attitudes and beliefs about alcohol and drug use that sets up relapse
- Explore the meaning and purpose of chemical use
- The drinking problem versus the thinking problem (i.e. the irrational thoughts, unmanageable feelings, and resulting self-defeating behaviors that accompany the using)
- The addictive self versus the sober self, putting the sober self in charge
- Reconstructing life history
- Drug and alcohol history, finding the purpose using served

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Integration - Safe, Middle, and Late Recovery

- Resolution of the past and the ability to live in the here-and-now are the goals
- "Burn off" Intense emotions by abreactive work
- Detrancing – less reactivity to dissociation and triggers
- Grief Work – primarily focused on what didn't happen
- Connect past to present
- Defuse triggers by providing the missing experience
- BASK model
- EMDR, letters, past work, telling details, internal dialoguing
- If flooding occurs, move into safety
- Typically after 6–18 months of sobriety begin to see that the internal changes are only the beginning of a fundamental lifestyle change
- Expand the "island of sanity" beyond recovering community
- Repairing the damage of addiction
- Often a period of letdown and depression, high relapse risk
- Late Recovery – Stage 2 Recovery Issues
- Codependency and Family of Origin work

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Grief Work

According to Jonathan Bowlby

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- Numbness-Shock-Denial
- Yearning and Searching: "A loss of the inner world of the sufferer into turmoil" and identification with the lost object
- Disorganization, anger, despair: anger at what's missing; life doesn't feel the way it used to feel; life is unfair and it will never feel good again; constantly questioning
- Reorganization: Begin to see reality and regain hope
- Passing through grief not only strengthens the ego and the inner self, it also increases one's trust in life's ability to repair and renew itself

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