

NAADAC

Dying to Connect:

Addiction as an Attachment Disorder

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>> Hello, everyone. And welcome to today's webinar, Dying to Connect: Addiction as an Attachment Disorder by Ellen Elliott.

Thank you for being with us today, I'm Jessie O'Brien and I'm the training and professional development content manager here at NAADAC and I'll be your organizer for this training experience.

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you need to know about that particular webinar. Immediately following this event you'll find the online CE quiz on the same web page you used for this webinar. It will be hosted at NAADAC.org/attachment-disorder-webinar.

We are using Go To Webinar for today's event. You can use the orange arrow any time to minimum or maximum the control panel. If you have any questions for the presenter, just type them into the questions box. We're going to gather all the questions and give them to our presenter during the live Q&A towards the end of the presentation. Any questions that we do not get to, we will collect directly from the presenter and post the questions and answers on our website on that web page I just showed you earlier.

You'll see another tab that handouts, you can download the Powerpoint slides from the handout tab and a using friendly instructional guide on how to access our online CE quiz and earn your CE certificate. Please make sure to use the instructions in our handout tab when you're ready to take the quiz.

I'd like to introduce you to our presenter, Ellen Elliott, a psychotherapist and director of Four Directions Counseling and Recovery center. She is nationally certified as a sex addiction therapist. She covers sexual issues, trauma, childhood abuse, attachment with relationships with a goal in assisting people and creating the live and connections they long for.

She's is currently pursuing a doctorate in counseling and human development and completing research in south Asia related to intergenerational trauma. NAADAC is so delighted to provide this webinar presented by such an amazing leader in our field. Ellen, if you're ready, turn on your mic and I'm going to hand this over to you.

>> Thank you, Jessie. That was an incredible introduction. And I'm very happy to be here. Welcome to everyone. We're

going to talk a little bit about attachment today so let's get started.

What can you expect to learn during this webinar? The significance of attachment in the addictions treatment field, something we don't talk about enough in this field. Types of attachment styles, the meaning and impact of attachment and treatment modalities that go along with healing attachment.

To start with, I assume that many of you most of you are in the addictions field in some way, and we've come a long way in this field, beginning with locking people up in asylums to finally coming up with a disease model since I've been in this deal for about 30 years. That was a new concept many years ago and it's well-known and we have embraced that concept.

Go back one. To the current definition of addiction, which the addiction set out by ASAM has finally included also process addiction so that we have expanded our view of addiction to include not only chemicals now, but also things such as food, sex, shopping, gambling, and, of course, the ones that are forthcoming at this time are internet and gaming addictions that have sort of exploded in recent years.

Even with those definitions, there is a treatment deficit in this field. And that deficit has a lot to do with trauma. We're talking certainly more and more about trauma in recent years. But there still isn't a complete understanding of trauma or how addiction impacts attachment and connection. We're going to talk a little bit about that and how it impacts connection and attachment.

People with addiction use behaviors and substances to escape the discomfort of life and relationships. I apologize for that being on there, this -- I know that the language is changing in this field. For those of us that have been in the field for long time it's sometimes slow to do that. I think

this slide may have been a little older.

I think we're starting or have for some time focused primarily on psychological needs or physiological needs and safety needs without considering the other -- the hierarchy of needs gives us a road map so to speak for dealing with needs. We have historically in this field dealt with lower level basic needs. And there's a lot of reasons for stopping there. One is that we have been historically in the field sort of focused on abstinence and/or harm reduction. So stabilizing people and in that vein, then we really are focusing on making sure that people have what they need and then that they're able to feel some sense of security in order to stay sober or reduce their use.

Higher level needs require more attention. Our field has historically been prepared to provide. It was a grassroots field when I came into the field and many of us came into the field I would imagine. So starting to dive into higher order needs means focusing on how people attach and how people connect. It can be really scary which is some of the reasons why people attach to behaviors rather than people.

Many people avoid connection through those addictive behaviors and adopt their own stories and support that disconnection. So if we think about growing up in traumatic -- with traumatic childhoods or in chaotic environments -- sometimes people are messy, people have beliefs, and opinions and all of those things that make connection difficult. And so attaching to behaviors or substances can sometimes feel much safer than trying to attach to people.

The stories can be self, life, relationships, success, satisfaction, all of the parts of our lives we all adopt narratives that support what we tend to believe and what we feel like keeps us safe. As clinicians, they tell us what a client

believes about those things. Whether it be sex or relationships or money. The core beliefs that we all have about things that happen in our life or the various areas of our life.

To support the belief that human connection or attachment can be really unsafe. So some of those intimacy blocking cognitions include things like other people will not care for me, so if my needs were -- if I learned early on my needs were not going to be met, then I may adopt a narrative that other people can never meet my needs. There's no need to ask. That's an interesting one. I had an opportunity to go to a clinician's professionals weekend at a treatment program. One of the really wonderful treatment programs that does include trauma treatment for a weekend of engaging in a lot of their activities, treatment activities and introduction to their program. For any of you have done this exercise, it was incredible and I'll tell on myself a little bit while I'm talking about that.

One of the things that they did was blindfold us and take us into a room and put us in a maze. So but there were probably about 15 to 20 of us overall through the weekend, so we were all in this maze. The only thing -- we could raise our hand if we needed help and ask a yes or no question. So, of course, many of those questions, the questions I asked was should I go left, should I go right. I continued to get no. If I asked should I go left and they said no, then I went right.

What we discovered at the end -- I'll tell on myself in that I was one of the clinicians that did not get out of the maze. At least until the very end with lots of help and basically it was over by then. So the only way out was -- they took our blindfolds off at the end of this and some people had gotten out. What we found was the maze was a circle with no exit. So the exit was you had to ask can you help me get out, or will you help me. Not can, but will you help me get out. So

that was the only way out.

The amazing part of that was clinicians -- we may expect that from clients, but as clinicians, we think we know the answers and there were probably about half of the people in the room who did not ask the question. Did not ask for help. So growing up with the idea that others will never meet my needs means that sometimes our clients, as well as ourselves, have trouble asking for help. Those narratives follow people and direct their behavior and choices throughout life that are all based on attachment.

>> All right. We have a poll question here. I am going to go ahead and launch the first poll that you will see pop up soon on your screen. If it's not showing up at first, just press escape and get out of full screen mode. It should be popping up. Got some votes coming in. According to the information presented in the training, addiction can be viewed at what type of disorder? Behavioral disorder, intimacy disorder, personality disorder, learning disorder. If you have any questions for the presenter, put them in the questions box in the menu. We'll get to as many of those as we can at the end of the webinar in the Q&A.

I'm going to give the poll about five more seconds. Get your vote in and then I will show the results. All right. Closing the poll now. I will share the results. Ellen, you can go ahead if you want to comment on the results?

>> Okay, yes it looks like a lot of you already have a good idea about this. That addiction is considered at this point an intimacy disorder, which again is based on attachment. Very good. Intimacy order, exactly.

What we're going to talk about is how attachment -- there we go. How attachment impacts people -- the addictions field and clients who have addiction.

What is attachment? The first question is. It's an emotional bond between infant and caregiver originally. And it's a means by which helpless infants get primary needs met. If those needs don't get met early on then people do start to adopt those narratives that my needs can never be met, no one will ever help me get those needs met so there's no need to ask.

It then becomes an engine of subsequent emotional and cognitive development that stays with us forever. Those experiences stimulate growth of the brain and can have an enduring influence on the ability to form stable relationships.

Viewing addiction from an attachment lens means to acknowledge that addiction -- an attachment to behaviors is a maladaptive way of trying to connect when people are scary. When relationships with other people are uncertain and feel impossible in a lot of cases.

So if conditions support an emotional bond, a secure attachment is created with caregivers. But if those conditions are not there, then a secure attachment is never formed. Bonding is not possible and insecure attachment develops rather than secure attachment. There's a lot of situations which prohibit the development of secure attachment.

So some of the causes of insecure attachment are those listed on the screen. Many of those we already know about. There were a few that in the beginning of this was a little surprising to me. Things that we had not written -- maternal depression I think certainly. Traumatic experiences, illnesses, accidents, but also -- so Jessie mentioned at the beginning of this session that I am currently doing research in Nepal and South Asia that was focused on intergenerational trauma or historical trauma.

Sometimes that also can be one of the reasons for insecure attachment. Trauma that seems to be passed through generations.

Separation from a primary caregiver, particularly early on. If something happens to a mother where they may end up in a hospital for a period of time -- and there was a wonderful documentary done about that and I cannot -- it was actually in the 60s. It was way ahead of its time. But it was about a couple of really young children who were separated from their mother because their mother had a pregnancy issue while she was still in the hospital and it was so interesting to watch the child -- apparently that long ago, rather than sending the child home with father, there was a place in the hospital where the children could stay while their mother was in the hospital. And watching them fail to bond and -- more and more become hypervigilant and afraid of the caregivers, who of course changed with every shift. It was a really -- it's a wonderful documentary. I wish I could remember the name of it, but I can't right now. It was very interesting.

So physical or sexual abuse, of course. Other traumas that happen are causes for insecure attachment. The reasons why people fail to bond or attach to their primary caregivers. Certainly maternal addictions, alcohol or other drugs, but also -- and this isn't in that slide, but certainly paternal addiction when mother is the other parent is involved in one parent's addiction, then they're still not present and not able to connect. So children very much are impacted by that.

So trauma causes disorganized attachment. We'll talk a little bit more about that later. The question is, is it safe to be attached? A lot of times it doesn't feel safe for attachment to happen. Particularly for people with trauma histories, it does not feel safe to attach. We in this country have the DSM-V and trauma has been recognized more in this edition of the DSM. We have several different diagnoses we didn't have before, especially that deal with bereavement and

stress. But there are still a lot of room for improvement in the DSM.

Some of the limitations of the PTSD diagnosis have to do with the fact it's a single event. PTSD was really started from the concept of shell shock and with veterans in mind, so it seems to be focused on single event traumas like war or an accident. Vietnam and World War II vets is where the diagnosis originated.

Rape victims. The criteria for PTSD certainly is focused on single events more than anything else. Traumatized children don't always meet the conditions, the criteria. So one of the reasons that I got really interested in this was when I went to South Asia where the infrastructure is very much lacking. You know, just getting from one place to the other is traumatic more for westerners who go there and don't know how to navigate through the landscape.

But it is. It's a hard life living in developing countries. But the -- when I looked at the studies about trauma among populations in South Asia, what I found was that the percentage of people who met the PTSD diagnosis was lower than in the U.S. Which makes no sense. The PTSD diagnosis definitely has some limitations and doesn't always apply. Certainly not to other cultures, populations, other populations. But also for people who have experienced developmental trauma or childhood trauma.

So lucky for us, the ICD-11 code will include complex trauma. Now, the ICD-11 was presented last year, but we don't have access to it yet and will not have access to it until 2022. And at that point it will replace ICD-10, which is the global DSM, the global diagnosis for mental health overall.

That will include complex trauma, which includes multiple forms of violence and other traumatic stressors. It's not based

on a single event trauma but rather on cumulative trauma in the developmental context. So childhood trauma usually meets the diagnosis for complex trauma much easier than it meets the criteria for PTSD.

Childhood trauma including abuse and neglect is probably the single most important public health challenge. A challenge that has the potential to be largely resolved by appropriate prevention healing and that's by -- written by Van de Kolk who is the leading trauma expert, certainly on developmental trauma. He has developed a diagnosis of developmental trauma with criteria that was not put into the last DSM. But hopefully at some point will be included.

Complex trauma better addresses underlying attachment issues that go along with that. I don't know how many of you may be familiar with the ACE study. I think many of us are now in this field. It's a little more commonly known and recognized in this field. The ACE Study is one of the greatest things that's happened for us, I believe. It was a 50-year study and now it keeps going. It studied traumatic experiences in childhood and compared those to -- followed a group of people for 50 years. Compared those to diseases that developed in adulthood.

The original ACE Study followed a group of people from childhood who were involved in the system in childhood to adulthood. So any time those people came up in the hospitals as having some diseases, they were flagged. As it stands now, anyone in the system, any child who goes into the system, any family services, the children's home, any of those services people automatically are given an Ace questionnaire. If they end up in the hospital later, then that is compared to the Ace's questionnaire so they can get the data. They have been now collecting this data for many, many years.

We've found incredible information from these. So it's the largest study of its kind. It looks at the health and social aspects, effects of adverse childhood experiences over a lifespan. The ACE study is the adverse childhood experiences study. It looks at different things that children experience and then connect those to adulthood. Or diseases in adulthood.

Some of the adverse childhood experiences that are asked the questions are focused on some of these things in the questionnaire. Are things like physical, emotional and sexual abuse. Alcohol and drug abuse in the household. Imprisonment by a caregiver or household member. Domestic violence, and that includes being a witness of domestic violence. Loss of a parent. Emotional or physical neglect and exposure to someone who has mental illness. Some of the things that we don't always ask in our own intakes have been asked of the ACE study and some information has been collected from that.

So neglect, as you see in here -- so the most prevalent form of child mistreatment is neglect. And that's really important because a lot of times people come in and we ask questions about abuse and the answer is no, I have never experienced abuse. People automatically go to sexual abuse and answer that way. Or even physical abuse and so the answer is no. What we don't ask, because a lot of our clients don't have a way to conceptualize what neglect is, are questions about neglect and being able to help them understand how much neglect impacts their adulthood. But also just what neglect is.

I think if we ask clients, a lot of times they have no idea what we're really asking. I hear so often clients say things like -- but they -- but if we ask them five minutes later were you neglected as a child that would say no, I had food, I had shelter, I had clothes to eat -- food to eat and clothes on my back. They don't think of that as neglect.

So as the ACE score increases, the risk of health problems increases. Including alcoholism, alcohol abuse, drug abuse. And the table at the side, you can see that with the more adverse childhood experiences, the more adverse childhood experiences that someone has experienced, the lower their percentage of being disease free. So this is -- so with zero at the end of life, 35% and 38% of men have never experienced any of these health problems. But with four or more, only 15% or 9% of people have not experienced these health problems.

So it's a significant number. I've seen other studies where seven or more the number has greatly increased. So it really depends on how much exposure someone has had, but certainly the more exposure to adverse childhood experiences, the more risk of addiction and other diseases. So ACE, the ACE study is not focused only on addiction, but also on heart disease was one of the most prevalent diseases that were experienced by people with higher ACE scores.

So I thought I had skipped one. Adverse childhood experiences, these are the numbers. Sexual abuse certainly is close to the top and then impaired caregiver. The reason I wanted to include this slide was because I thought that was really important. The most frequently identified adverse childhood experiences in the ACE study were sexual abuse and an impaired caregiver. And they almost are at the same percentage, which I thought was really interesting.

There are also unresolved trauma history in the caregiver, that's the intergenerational trauma we were talking about. And then other things that happen in people's lives, even motor vehicle accidents, things like that. Burns, fires, different accidents in addition to the emotional impacts. Placement in foster care is really high, also, and witnessing domestic violence is way up there. So all of those are really

significant.

When those numbers were separated and people with addictions were asked about their trauma, 97% of people with addictions identified as having emotional trauma. 81% with sexual abuse or trauma which I thought was also actually significant. And physical trauma or abuse 72%.

So children learn that they can get their needs met early on. When we're talking about attachment issues, we're really talking about early, early, early particularly right in this area one month to one and a half years. So in the trauma field, we talk about preverbal trauma. And that is trauma that happens usually before the age of two or three. And you see how much is impacted before two or three. So people do decide or learn early in their lives whether or not that are able to get their needs met. If their primary caregivers are not available and not able to be present, then it's really difficult to develop attachment and that doesn't happen. Instead people develop an insecure attachment style.

Eight months to two and a half years are when people develop the ability to be autonomous. And we're going to talk a little bit about that in a minute. Children learn they can get their needs met by a year to year and a half years of age. If that doesn't happen then children do not learn to trust and don't learn to rely on other people. They don't learn the concept of interdependence. That's what creates insecure attachment styles.

So secure attachment -- first of all, we're going to revisit this. But secure attachment is when someone is able to bond with their caregiver and they do trust that their needs are going to be met. They're okay exploring the world and being dependent. So there is an ability to be interdependent, to feel like they are independent enough to go and explore, but knowing

that they have a place to come back to that they're safe to do that. So it really has so much to do with safety. And we get to a treatment portion of this, you're going to see that safety is such an important part of this.

I want to show you a quick video that will help -- we pay a lot of the attention to the expressions that this baby goes through.

>> All right. I'm going to go ahead and launch the video.

[No audio]

>> Okay, so I think it's really I can watch that 20 times and it's still really difficult to watch. I don't know if it was difficult for any of the rest of you to watch, but it can sometimes be difficult to watch.

And you saw all the different sort of phases the baby goes through in that length of time. The reason I like this one and if you Google still face experiment you'll find that there were several -- this is the first that always comes up. It's a classic. The reason I like it so much is because you see every attachment style this baby goes through every attachment style through this process. So it's really, really fascinating to watch. But it's also difficult to watch.

So we're going to -- okay. And just in case we couldn't show the film, I had put up -- you will have -- no, you don't. Okay. Sorry, that slide was taken out.

Here are the attachment styles. There are essentially four attachment styles. The DSM included only one and called it something different. So we'll talk about that in a little bit. First of all, it's secure attachment. And so when parents are aligned as you saw in the video, when parents are aligned with the child, when they can mirror and -- you know, when the child points, the mother looked. When children know that they are seen and heard and someone is in tune with their needs, they

are -- the caregiver is present and able to be there.

The child learns how to create relationships, they're able to set boundaries because they have the confidence to do that and know what those boundaries are. Know that they deserve and are able to get their needs met. It's interesting to me when you read studies or statistics on attachment and they will say that secure attachment is like 50% to 70%. I'm not sure I agree with that number. I think most people or many people I would say it's probably more like 25% of people who have two caregivers who are able to be present. And certainly many of us learn through the years how to have secure relationships. But that doesn't always happen and certainly for our clients it has not.

So the two -- if some of you do couples or marriage counseling, you'll know -- some of you may be trained in EFT. I see there are many of you out there, so I would imagine there are several of you who may be trained in EFT, which is Emotionally focused therapy for couples, which is now being used for individuals as well. A lot of times people couple with these two disorders. Or attachment styles. Avoiding attachment style is I can do it on my own. I don't want to be close to people because I couldn't get my needs met so I learned how to do this on my own.

You see the baby -- so the baby first, as you go through that video, the first thing that that -- the first reaction is that the baby becomes very anxious. Starts squealing. So you see the anxious attachment style first thing. And then eventually the baby gives up and turns their head. At that point, you see the avoidant attachment style as well. By the end, the baby is just everywhere, which is the disorganized attachment.

Avoidant is -- avoidant people tend to reject close

relationships or emotional connection. Stay really distant in relationships. They will often disappear. When things get close, they go away. And not very tolerant of close relationships.

Anxious attachment in this field for many years we have called that codependency. Or at least many times have called that codependency. So the thing that creates anxious attachment is when parents are sometimes there and sometimes not. So it's inconsistent. Sometimes they're available, but a lot of times the child doesn't know when they're going to be available, so they're always wanting the availability of their parents. Parent or parents. So it's inconsistent parenting rather than with avoidant it's unavailable parenting. People become anxious and secure and sometimes controlling, blaming they may have erratic moods, unpredictable is sometimes charming as well. Tend to take care of other people in order to get -- so anxious attachment -- people with anxious attachment tend to try to please to be able to get connection.

Avoidant people really want connection, but just have trouble doing it. Dig organized or fearful avoidant attachment. It's called a lot of different things. Is when people were ignored or not really -- their needs were never met and the parents' behavior was frightening.

So when households are really violent, when there's a lot of alcohol and drug use, when things are extremely chaotic, particularly witnesses of domestic violence often develop disorganized attachment. Disorganized attachment is don't leave, go away. There's been many books written. Please do not leave me no matter what, but don't get close to me. So the minute things get close, they go away. But then constantly are trying to get -- seeking attachment but just aren't able to sustain it.

The DSM recognizes only one of those, and usually for children. And the word in the DSM is reactive attachment, which is extreme disorganized attachment. It's when the parent style was extremely unattached and not healthy at all. And reactive attachment can't establish positive relationships or are often misdiagnosed as other things. But also reactive tends to be really explosive, abusive to other people. We sometimes -- lest talk about some of the things that they are misdiagnosed as.

For children, a lot of these attachment styles have been misdiagnosed and we sometimes call trauma or attachment issues ADHD. So many of these disorders -- when trauma is not considered, get diagnosed because it's easier, it's what it looks like. We've come up with a lot of different things rather than understanding trauma and the attachment deficits that go along with that.

Oppositional defiant disorder and reactive attachment is -- you know, if the same behavioral issue child is diagnosed by ten people, it may be oppositional defiant five times and reactive attachment five times. So you see conduct disorder, a lot of these things are just used when it is disorganized attachment then a lot of times people are diagnosed as a lot of different things that may or may not be accurate.

I did the supervision at a children's facility for a long time. The -- not understanding attachment -- a lot of times children come in already with a list of diagnoses that made by a medical personnel who has no understanding of attachment or trauma or what children may go through. And the fact that -- really, these may be normal reactions and need to be treated rather than diagnosed and medicated. But that's a whole other training.

So adults are often misdiagnosed as well. When adults come in with attachment issues -- because that isn't a diagnosis. If

you are using Medicaid or insurance to pay for expenses, then Medicaid or insurance isn't going to pay for attachment disorders. So instead, people often are given diagnoses of lots of different things. My personal bias is borderline personality disorder, which is absolutely disorganized attachment. There is no -- borderline and disorganized attachment are one and the same in many instances. There -- I think if you really work with people through an attachment lens, you find out that borderline attachment is -- borderline personality disorder is often an attachment disorder.

Narcissism, narcissistic personality disorder, avoidant attachment maybe. Looking it through an attachment lens makes it look very different. Substance abuse disorders and attachment are -- is addiction and attachment disorder. Absolutely. Addiction is an attachment to behaviors and processes because attaching with people is more difficult. Whether that's eating disorders, gambling, sexual disorders, all of those fall under the -- if looking at those through an attachment lens they all could fall under an attachment disorder.

I'm a fan if you notice some of the quotes in here are van der Kolk. Many people since him -- certainly he was on the cutting edge and has been for a long time. One of the things that he says in one of his books, body keeps the score, it's when you have a persistent sense of heartbreak and gut wrench. The physical sensations become intolerable. You'll do anything to make those feelings disappear. That is what is really the origin of what happens in human pathology. People take drugs to make it disappear, they cut themselves to make it disappear. They starve themselves to make it disappear. And they have sex with anyone who comes along to make it disappear. Once you have these horrible sensations in your body, you'll do anything to

make it go away.

And I think that is an incredible quote that explains addiction and certainly through an attachment lens. People, rather than attaching to people, all of these other things become way to make that disappear. And sometimes people use relationships for that, but not in a connected sort of way. More in a -- I just want to feel better kind of way. We call that love addiction most of the time in the sex addition field.

>> All right. I'm going to go ahead and launch the second poll. Should be showing up on your screen now. Yep, I see some votes coming in. We've gotten a lot of questions in the questions box, you guys, so thank you, keep them coming and we'll get to as many as we can at the end of the webinar.

All right. I'll give about five more seconds and then I'll launch the results and hand it back to you, Ellen, to comment. All right. Launching the results, you should see them on your screen now.

>> Wonderful. Yes. Isolation, secrecy and disassociation and most of you got that right. I hope we had gotten that -- made really clear by now. Absolutely. Is it also genetics and learned behavior? Absolutely. Is it also anger and resentment and shame? Absolutely. Spiritual bankruptcy? Yes. But primarily from an attachment lens, it is a disease of isolation and secrecy and disassociation.

Jessie, do you want to move it back to the slides now? There we go. Okay.

So I want to talk a little bit about the black hole. And this is from Patrick Carnes work. For those of you who don't know who he is, I consider him the BLW of sex addition. He is in many ways the person who made us look at sex addiction and has written many books about sex and love addiction and also what attachment in the addiction world looks like.

So one of the things that -- this is a slide that came from him -- and the black hole addiction interaction. Sort of the way that we -- that addictions interact is really important. Ultimately, the reason I wanted to use this slide is just to show all of the addictive processes and behaviors that people tend to use in lieu of connection with other adults. With other people.

So we all know the substances, the processes, foods, sex, and love, work, money, exercise, and of course again now internet and gambling is exploding. I would say that when the COVID pandemic is settled a bit, we will start to see even more of that as far as from a treatment standpoint.

Core affect states. People can become very, very attached to rage. So for rage in particular, it keeps people away and if someone is avoidant or disorganized attachment style, rage and even misery tend to keep people away. Some of the other -- from an anxious attachment style or disorganized. The self-loathing and despair is sometimes gets to be something else that's attached because it brings people in, woe is me, please come and help me and save me.

So people can become very, very attached to those core affect states, as well as relationships. And certainly in this field, we know about codependency, co-sex addiction. But there's also things -- relationship issue such as traumatic bonding where people bond around their past traumas as opposed to having real connection. Love addiction, romance and, you know, in the 12 step programs one of the suggestions is no relationships for the first year because people can become very attached to the romance in the relationship as a way, again, to dissociate and connect with fantasy rather than the reality of adult connection.

So some of the -- in our field we've begun to recognize

other behaviors or processes as addictive. That was a long time coming, and certainly that has happened. When ASAM finally came out with that definition in 2011, that's really huge for our field because we had never really considered these things an addiction and tried to keep them separate for a long time.

Often first addictions -- one of the reasons why it's so important to understand that these other processes are addictive behaviors is that when we're looking at attachment that starts really early, attachment deficits that start really early, in the addictions field, if people present because of their chemical dependency, if we start to dive in, we may find that other things came first.

So the one thing I've learned since starting to look at addiction on a deeper level is that people often come in with their least difficult addiction. Addictive behavior. So if people present with chemicals, then sexual or eating disorders may be part of that. I have heard since I started in this field about peeling off the layers of the onion. I got that, but not really.

When I see that now from an addiction standpoint, what I recognize is that not many people only have one addictive process. And so after chemical dependency is addressed, then starting to look at financial and work disorders. How many people in groups say, well, what did you do this week that helped you stay sober and they'll say I worked 80 hours. And everybody in the group, particularly men, because men are socialized more toward work sometimes, everybody says yeah. Get that overtime in. When, actually, somebody who is working 80 hours a week is not sober. So thinking about that as more a holistic place and certainly based on connection.

No one who is working 80 hours is connecting with other people. Not really. Not on a deeper level. Not from an

intimacy standpoint.

First addictions are often sex or food. So for people who are ten and living in a chaotic environment or with impaired parents or in the midst of domestic violence and they're doing anything to soothe themselves, like van der Kolk says. They may not have access to drug and alcohol yet, but they do have access to their body or the refrigerator. Based on socialization, a lot of times men gravitate towards sexual disorders first. And women toward eating disorders. And more and more I can tell that what's coming is gaming.

When I started in the sex addiction field, which sort of is more holistic and includes internet issues, there was one treatment program opening up for gaming addiction and now there's about ten. So those gaming addiction inpatient programs are now opening up which is fascinating. Because gaming or internet addiction now can start at six, five. Really early. So I have a feeling that we'll be seeing more and more of that that have been ongoing for many, many years. Already I see clients who started using pornography at 12, 11, and are now in their 20s.

There are websites, so masturbation now is called fapping for those of you who didn't know. There are no fap or no fapping websites. Usually created by young 20 something men who have been using pornography for long time and are suffering from erectile dysfunction already in their 20s because of pornography. And so they have started to develop those in recovery have started to develop websites to help other young men or boys in recovery or who want to be in recovery. So there's some great things happening out there, but it's important to look at those other disorders as well and the layers of addiction that may be out there that -- because when people are not able to attach and are attaching to behaviors or

processes or things, then they often started before they start reporting their substance abuse. It's important to know that.

You'll need to know this. The current largest consumers of internet pornography begins at 12. The 12-17-year-old age group are currently the largest consumers of porn. Studies indicate first exposure to porn as being about ten for boys and 12 for girls currently. And that could of course change as well.

So now let's talk about treatment. So we have talked about what addiction -- what attachment means in the addiction field and how important and significant it is. How important it is to address it in treatment. It's something that we haven't historically talked about so much and certainly not addressed in treatment. The one thing that I think it is important to remember is that for years one of the things that I've heard is that 70% of success in substance abuse treatment is the relationship with counselor. And I never really understood why that was. I think the same goes for 12 step programs. That has been studied for as long as I've been in this field and way before and no one has understood why 12 step programs work.

All of those things, we have used lots of modalities and different theories in this field and what works is connection. So in thinking about treatment, what's important is to think about how do we help our clients create secure, safe, positive connections.

Most of us are aware of PESI. And in contrast to 25 years ago, trauma treatment today focuses survivors not on the pain, but on accessing the kinds of feelings they would have experienced if they'd never been traumatized. I say the same is true for attachment. We aren't trying to help people act as if those things had never happened, but how do we help them access reheat the trauma, re-create those trauma bonds that should have been created in infancy or early childhood. How do we to that

in adulthood with people who have spent many, many years finding their way out of attachment. Or out of connection.

In one of the first things to look at is trauma. How do we start to address the trauma that created those attachment deficits to begin with. Particularly in the addictions field, since it isn't a trauma field and certainly knowing -- knowing trauma therapists that you can refer out to is really important. But stabilizing people and containing the trauma.

So setting up therapeutic environments that support stabilization in relationship building. Because we know that relationships are the key to healing and treatment.

Noting the abstinence is not part of containment. One of the first -- our first goals in treatment may not be abstinence, but rather how do we help people with self-regulation so that they can achieve abstinence? How do we help them create structure and attachment so that being -- living without drug and alcohol isn't so intolerable that they immediately go back to it. How do we teach people to regulate their emotions and learn to connect in safe ways?

One of those is body work. And there's another thing that we in this country particularly in western countries have not focused on so much in treatment. But it's happening in some treatment centers, some inpatient treatment centers in particular have used art and yoga, exercise. There are lots of different modalities that help people reconnect with their body and regulate those emotions so that they can connect in a way that doesn't flood them or overwhelm them.

One of the first things is -- one of the first parts of treatment may be to help people reconnect with their body and feel anxiety, learn how to calm down and in doing that yoga certainly has -- yoga is the only thing I have seen where every study with what I've seen has shown results. Addiction, trauma,

particularly trauma -- in the trauma field, yoga is well-known as a great way to treat those feelings.

Okay. So the other is to help people with relationships and regulating their emotions. I put art in capital letters with an exclamation because art helps people get into their right brain, get to the emotion. People really tend to want to stay in their left brain, their cognitive brain and describe -- sometimes talk therapy is not necessarily what people need. They also need to be moving or doing or creating as a way to regulate those emotions and reestablish relationships.

12 step groups, one of the reasons why I absolutely believe they work is if taught how to navigate through 12 step programs, then that can be one of the safest first experiences of connection that our clients may ever have. Having a sponsor, being able to start to connect slowly with people in the group is a way to heal the trauma, heal the attachment deficits.

One of the other really important things to remember is our clinical relationships. Emotions expressed in interpersonal relationships can be extremely painful and can be related to attachment patterns. It's important to remember that. We know about transference and countertransference and how that can be used in a positive way, but also that it is there. It's in the room. And so some of the emotions that we see in our clients are about their previous relationships. We're helping them navigate through that in a way that relationships become safe.

These trauma based emotions anger, fear, hopelessness, sexual arousal that comes up in clinical relationships can be very hard for clinicians to tolerate. So sometimes it isn't just the clients having trouble with these emotions, I have known many, many clinicians who were very uncomfortable with clients' anger. And being able to learn how to not take that personally and not get triggered by other people's anger means

us, you know, seeking our own therapy in some cases and just learning how to navigate through those, help clients through those emotions as opposed to taking them on ourselves.

Clinicians also need to be mindful about their experience of attachment and trauma based emotion. So it is really important that we understand our own attachment style and what that means. And what that means both in our personal lives but also in therapeutic relationships. We take us everywhere we go. We tell clients that. As clinicians we do as well. Our own unresolved emotions aren't reenacted in clinical relationships, which happens way too often. For us to be able to be aware of what those are is really important.

Ultimately, when we're thinking about attachment and the importance of attachment in the addictions field, what's important is that we all remember that we were designed to be relational. Intimacy is an authentic connection first to ourselves and then to other people. It's our birthright to be connected. It's our greatest state is to be interdependent with other people. And it is the cure for addiction and emotional problems in intimacy.

Thank you very much and I will open that up now for questions.

>> All right. I'm going to move forward. So thank you, Ellen for that wonderful presentation. We have quite a few questions, so I'm just going to jump right into them if that's okay.

>> Yes, absolutely.

>> Does the father play any role in insecure attachment?

>> Absolutely. Yes. And ideally you have two parents, two caregivers who are able to connect. The absence of a father makes a huge difference. And, in fact, I would say it's 50% -- even when fathers aren't present, aren't even in the picture at

all, that lack of attachment is meaningful. Children always want the -- want to know who their father is.

You know, so when you deal with adults who never knew their father, there is that real lack, that real absence that continues. So it's -- fathers are very important.

>> Okay. Great. So question two. Hillary from Oregon, does brain development lead to a specific attachment predisposition? She goes on to say, if one area of the brain is developing more quickly/slowly in an infant does this make them more likely to experience dysfunctional attachment and make them more likely to develop a substance abuse disorder?

>> So my first response to that is I can't answer that absolutely. What I do know is attachment disorders slow down and prohibit some of the brain growth or some of the things that happen.

So with trauma, for example, full frontal lobe development doesn't usually happen until about 24. And so it may never happen or certainly not happen for much, much longer than that if trauma happens. So trauma definitely puts people in the fight, flight, freeze mode, which has to do with brain stimulation. And without that connection, some of that normal development never happens.

>> All right, thank you. So Amy, can the attachment disorder occur in the teenage years after sexual trauma as a teen?

>> Yes. So yes, and no. Yes. Particularly if someone already has an insecure attachment style or an attachment deficit, then there is nowhere to turn to. When people have a really secure attachment, then when something bad happens, they're more resilient. They know that their needs can be met. They know thank you ask for help. They can go to therapy. When that hasn't ever happened, when that attachment never happened

then when something happens in adolescence or even later in life then the attachment deficit is even greater and you may see it more prominently, whereas you didn't see it so much before.

Yes, when people already have a really secure attachment, then they know how to get their needs met. In adolescence, that's a challenge anyway. But they know that they can get help and there's someone there -- if that attachment has happened, then their caregivers also make sure that there is counseling. All those resources are available to them. But without that attachment, then it just -- the attachment deficit becomes greater.

>> Okay. So Samuel from Missouri asks if you would clarify with the link of intergenerational attachment issues, do you feel there is a genetic component involved?

>> Yes. Yes. I do in particular. So in some ways that's a really complex question because if it's intergenerational attachment issues, then you already know at least one parent already had attachment issues. Which meant that they probably weren't able to fully bond with their child, which means that -- so you kind of see how that goes.

I am using a theory that was started among native Americans. But the origin of that theory was Holocaust victims' grandchildren. What they found with grandchildren who never knew their grandparents who had been in concentration camps, when trauma happened, in a group of people, if a trauma happened, the grandchildren of Holocaust victims were the first to develop trauma symptoms and a much greater faster and more prevalent than all the other people in the room. Or that the trauma happened to.

So it doesn't mean that they were born with PTSD necessarily or PTSD symptoms, but it doesn't mean that they developed them more quickly and -- so they already had a sort of

history of trauma in their DNA. And there's -- there have been several Native American researchers who have -- doctors who have talked about how trauma can be stored in DNA and how it gets passed down.

So in that case, then, absolutely. When there's trauma, there's attachment issues. And so yes, in that way, it is absolutely intergenerational. Whether it's because the parent couldn't bond or they couldn't bond because of previous trauma, I think that gets really complex. But it's a fact that attachment issues are intergenerational.

>> Okay. I want to squeeze one more one in. Jennifer from Chicago asks there's limited but interesting research indicating adoptees have a higher use of substance abuse disorder. How can the addictions field help to conceptualize -- for faulty early attachments characterized by parental separation.

>> That's an excellent point. Absolutely, when someone comes in and they have been adopted, they have an attachment issue. It's an absolute -- there's no way that they can't. I think that treatment around attachment is even more important at that point because the minute that we know that someone either spent a great amount of their time, particularly in early childhood in group homes or children's homes or whatever that was or were adopted, then we automatically know that working on their ability to be in relationship is really important.

Some people end up with wonderful adopted families who are -- do everything they can to attach and still somewhere in there there is some questions and an impact from not being able to attach really, really early on. And with their actual parents. So there is still a deficit in there. And some people may be fine, but that is -- if they have a substance issue, then that is absolutely something to start off with.

>> All right. That was a big one to give you as your last

question, we apologize. Thank you, Ellen, that's all we have time for guys. Don't worry we have a list of all the questions. We're going to send them to Ellen at the end of this presentation. Give her some time to answer and we'll post her answers back on that web page.

Just a quick reminder about where you can find all the information for this webinar, including the link to the online CE quiz, it's the same website you used to register for this webinar. Everything you need to know is hosted at the website at the top of the slide.

Here is the schedule for our upcoming webinars, take a look and please tune in if you can. There's interesting topics with great presenters. When our annual conference -- we reached out to Aaron Norton and redesigned the post conference one day training to a virtual learning experience. Space is limited but make sure to not miss out on the training on October 21st and 22nd. It's a free webinar.

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