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ORIGINAL PAPER

# Attachment, A Matter of Substance: The Potential of Attachment Theory in the Treatment of Addictions

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**Abstract** In North America, substance abuse is a public health crisis with annual costs in the billions. Individuals suffer from substance use disorders for multiple years throughout their lifespan. This suggests that neither historical, community-based interventions, nor current, evidence-based behavioral modalities are successful in healing the causes of addiction. A growing corpus of research has established that traumatic early-childhood experiences and insecure attachments are both independent and interrelated risk factors for developing substance abuse disorders. An impressive literature is emerging exploring potential applications of attachment theory-informed intervention. There has yet to be widespread adoption of such techniques. By examining the scholarly literature, this paper synthesizes existing work on attachment theory in the treatment of substance use disorders. A clinical case application is provided to highlight the potential for attachment-informed therapy. Recommendations for using attachment-informed approaches in the treatment of substance use disorders with various groups are offered.

**Keywords** Attachment · Substance use disorder · Addiction · Self-regulation · Treatment · Self-medication

## Introduction

Substance abuse is a public health crisis in North America. It occurs with and exacerbates numerous social problems, such as poverty, crime, and conjugal violence (Cunradi et al. 2012; Stone et al. 2012; Weegmann and Khantzian 2011). In the 2011 survey on drug and alcohol use in Canada, 14.4 % of Canadians age 15 and older were identified as having a chronic risk for alcohol use, and 10.1 % were seen as having an acute risk (Health Canada 2011). Approximately one in six users of illicit drugs reported experiencing some harm as a result of their drug use (Health Canada 2011). Substance abuse in Canada costs an estimated $39.8 billion in direct costs, health care, and indirect costs (productivity losses) (Rehm et al. 2006). In the United States, 8.5 % of adults meet criteria for an alcohol disorder, 2 % meet criteria for a drug use disorder and 1.1 % meet criteria for both (Falk et al. 2008). The cost of substance use disorders in the United States is estimated at $600 billion, annually (National Drug Intelligence Center 2010; Rehm et al. 2009).

Disagreements persist around whether addiction is a disease or a mental health issue that can be individually controlled. Some researchers argue that not enough is known about addiction to define it as a disease. They posit that research provides evidence about what addiction is *like* (signs and symptoms), as opposed to what it actually *is* (a disease or brain disorder) (Larkin et al. 2006). Others question whether addiction is merely a choice, a myth or a social construction (see Heyman 2009; Vrecko 2010). Despite this controversy, treatment models and research alike overwhelmingly define addictive disorders as a brain disease (Glantz 2010; McKay and Hiller-Sturmhoefel 2011; Volkow et al. 2011). The American National Institute on Drug Abuse (NIDA), which funds research on addiction, globally, describes addiction as a brain disease caused by potentially long-term changes in the brain's structure and function (2007).

Addiction is a "complex and multidimensional phenomenon" (Larkin et al. 2006, p. 210). Individuals with

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substance disorders seek out and use drugs with impaired control, at the expense of other aspects of their lives, and negative consequences arise from this behavior (Durrant et al. 2009; Saha et al. 2012). While many individuals (40–60 %) eventually recover from substance addiction and maintain abstinence (McLellan et al. 2000), many factors can persist and interfere with sustained recovery. Some of these factors include pre-existing genetic traits, psychiatric risk factors, peer culture and parental care (Menicucci and Wermuth 1989; Zeinali et al. 2011). It is within these factors that the potential usefulness of attachment emerges. It is directly related to early experiences with caregivers and mediates psychiatric risk factors, throughout an individual's life span. The following case study is presented to ground attachment within substance abuse treatment. How this case was approached does not represent a prescriptive method for applying an attachment based focus to addiction treatment, but an example of how these concepts can be illuminated to a client, in an effort to promote change.

## Case

Jason,[1] a 35-year-old Caucasian, Italian-Canadian salesman, had been married to Angela for 2 years. Together, they had a daughter who was 6-months old. Jason sought treatment at an outpatient clinic for individual therapy for an addiction to crack cocaine. He described having struggled with his addiction since his early twenties. He had completed two 3-month residential treatment programs in the past 10 years, and had attended day programs "countless times." Although he reported being sober for 8 months, he described an almost daily struggle with thoughts of relapse. At the time of therapy, it was the longest period Jason had maintained sobriety in 10 years.

Jason reported he had longstanding relationship issues with his wife. He felt frustrated with Angela constantly questioning his whereabouts and sending him frequent text messages at work. Jason reported he was worried that Angela's persistence would lose him his job. Jason highlighted that on days when he was unable to respond immediately to Angela's requests for contact, he dreaded going home, as inevitably, the couple would have a fight. He stated that he was fearful that Angela would leave him if he relapsed, which had often occurred after a fight with Angela. Jason also described having trouble with other relationships and felt as though he had "no friends" he could "count on." When asked about this, Jason explained his old friends were all drug users and he reported feeling as though he had "no time" to make new friendships. Crack cocaine, Jason conveyed, was a "release" for him, and something to which he had turned since adolescence to manage stress and to "feel better." Jason reported that he was particularly interested in maintaining abstinence because he wanted to be able to be a "present and good" father to his daughter.

[1] Names are pseudonyms and case example is a composite of multiple cases.

## Addiction Treatments

Addiction treatment in North America for clients like Jason is currently dominated by short-term, symptom-focused approaches. Among these therapeutic models, Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI) are two of the most evidence-based treatment methods used in outpatient and inpatient addiction treatment centers (McHugh et al. 2010). CBT focuses on altering cognitive distortions that lead an individual back to substance use, has been well validated in comparison to other controls, and is seen to produce relatively stable improvements (decreased substance use or abstinence) over time (McHugh et al. 2010). MI is a technique that targets an individual's ambivalence around changing their substance use behavior and attending substance use treatment. MI is often used in conjunction with CBT (McHugh et al. 2010). While both of these treatments have been validated, substance abuse rates continue to increase in North America. Kazdin (2011) states, "no single model of delivery of treatment will reach most people in need" (p. 691), and it does appear that these treatment approaches are not working for everyone.

Treatment modalities like CBT and MI focus on short-term, behaviorally-focused interventions. These approaches are directed at clinical productiveness and cost-effectiveness. This can be problematic, especially because treatment can last for many years with multiple episodes of care (SAMHSA 2011). Time-limited treatment options may not adequately address the reality of chronic, relapsing episodes in the life of an individual with an addiction (Dennis et al. 2005; McKay and Hiller-Sturmhoefel 2011). Further, these approaches appear to be cost-effective given their short duration, but once appraised longitudinally, it becomes clear they reoccur, making them lengthy and costly, in practice. If substance use disorders are truly chronic disorders, treatment approaches that target or integrate the underlying mechanisms behind the client's behaviors could be useful.

Peer support models continue to be popular methods for addiction treatment. These include 12-Step programs such as Alcoholics Anonymous and more behaviorally-focused peer groups such as SMART recovery. At the core of 12-step programs is anonymity, which allows newcomers to the program the freedom to share without judgment,

thereby building trust within a peer group and within a relationship with an individual sponsor (Spiegel and Fewell 2004). Newcomers are encouraged to rely heavily, 100 % of the time at the beginning, on the support of the group and their sponsor, to attend meetings regularly and commit to the 12-step program (Spiegel and Fewell 2004). Twelve-step groups can act as a secure environment that fosters unconditional acceptance and support among group members. This is promoted through nurturing and consistent relationships, which in turn facilitates a strong bond and attachment to the group (Spiegel and Fewell 2004).

When Jason presented for treatment for his crack cocaine addiction, it quickly became apparent that he linked his problem to early experiences. He described his childhood home life as lacking in emotional comfort and as being an unreliable place to find support. He began experimenting with drugs in high school; he reported loving the feeling of escape it gave him from his home life. Jason described feeling low, restless, and unable to enjoy anything "normal" as a teenager. He admitted he had found a welcome security in his relationship with drugs. When using, he felt "free from the burdens of his family," and, as he described, "it became my normal." During a session early in treatment, I highlighted for Jason that drugs became a comfortable mechanism for him to avoid the realities of day-to-day life. As his drug use increased, crack cocaine became Jason's "safe haven," where little was expected of him, but comfort was found. Crack cocaine satiated Jason's restlessness and provided temporary relief from his anhedonia.

For Jason, this powerful connection with substances was reinforced physically and psychologically over time as a powerful and effective (albeit problematic) relief from pain. It became clearer treatment to help Jason find a new "normal" would likely not be a short-term investment and would require a broader framework than solely possible via a behavioral approach. Continued research on what constitutes effective treatment for substance abuse is needed (Watson et al. 2013). High relapse rates, despite the inundation of cognitive and behaviorally-focused programs, merit the testing of a more relationally-based theory like attachment theory.

## Attachment Theory

Attachment theory is primarily concerned with how the self develops in relation to others (Bowlby 1979). It posits that from infancy, physical and emotional proximity to a loved one is biologically necessary: being physically separated or emotionally distant causes loneliness, anxiety and sadness (Bowlby 1988). Attachment behavior is present throughout an individual's life cycle, and the attachment between a primary caregiver and their child has determining effects for later relationships and functioning (Bowlby 1988; Fonagy et al. 2002; Stevenson-Hinde 1990).

Bowlby's internal working models (IWMs) describe the way a child interprets themselves and understands the world around them (Anda et al. 2002; Padykula and Horwitz 2012; Thompson 2008). Functionally, an IWM encompasses a child's capacity to maintain close relationships, regulate emotions, and manage early, negative experiences (Main 1995; Wallin 2007). IWMs are present throughout an individual's life and influence how an individual attaches to others interpersonally.

Working with Jason, I wanted to know more about his early relationships because of his description of his adolescence. His strained relationship with his wife made me wonder about his attachment to his parents. In particular, I was curious whether Jason had experienced early attachment traumas (abandonment, violence, etc.). I asked him about his early home life, and he reported he grew up as an only child in a divorced family and spent little time with his father (some birthdays and holidays). He recalled feeling helpless and alone and, his mother stayed in her room all day, crying, the day his father left. Jason described how he had always felt responsible for his mother who suffered from multiple sclerosis. He claimed he was isolated as a child, was expected to stay quiet when his mother needed to rest, and was not allowed to go out and play with friends very often. Given his infrequent contact with his father and his caregiving role with his mother, I learned Jason did not have a secure base from which to explore the world.

Ainsworth classified insecure attachment styles as "ambivalent" or "avoidant." As observed in the Strange Situation, insecure children would either not react to their mother's absence or return (avoidant), or exhibit an exaggerated, prolonged behavioral reaction to the experiment (ambivalent) (Bretherton 1992). Jason presented with an insecure attachment style consistent with normative abuse (subtle neglect, inconsistent responsiveness, etc.) (Walant 1995). Specifically, I assessed Jason as having a fearful avoidant attachment as evidenced by his need to protect himself by avoiding close relationships and being fearful of intimacy in his romantic relationship and even our therapeutic relationship (Brennan et al. 1991). As children, fearful-avoidant individuals learned that caregiver comfort and regulation were unsafe or inconsistent. As a result, they were not provided with coping strategies to manage emotional distress. As adults, interpersonal relationships are frightening and unpredictable, and as a result they may favor the immediate gratification of substance use (Lende and Smith 2002). Recent studies have found fearful-avoidant attachment to be linked with addictive disorders (Fonagy et al. 1996; Piehler et al. 2012; Schindler et al.

2007). As attachment styles do not necessarily remain static throughout the lifespan, our therapeutic process had the potential to address Jason's relational difficulties and what I assessed as substance abuse, used to cope with the resulting pain of relational problems. Security, for which he turned to drugs, could be developed through comforting and reliable relationships.

## Attachment Applied to Clinical Treatment

Attachment theory has been used in various clinical models to treat a variety of problems. Attachment-focused therapy (alternately called attachment-oriented or attachment-informed therapy) has been used with individuals, couples, families, and groups (Bettmann and Jasperson 2007). Examples of attachment-focused therapy include: Daniel Hughes' Attachment-Focused Family Therapy, Emotionally Focused Couple Therapy (EFT), and Mentalization-Based Therapy (MBT), an emerging approach, which focuses both on attachment relationships and affect regulation difficulties (see Bateman and Fonagy 2010; Hughes 2007; Landau-North et al. 2011). Whether with individuals, couples, families, or through applying the lens of mentalization, attachment-focused treatments highlight the importance of understanding the underlying developmental mechanisms that contribute to the presenting problem.

Attachment interventions are useful and well validated in other contexts; however, there is a paucity of literature on the effectiveness of addiction treatment using an attachment lens. Frank (2009) applied attachment theory to the addiction treatment of nine mothers living in a residential program. All participants were found to be insecure in their attachment (Frank 2009). Frank's (2009) study measured the effects of an attachment-focused treatment over the course of 6 months. While change in attachment classification was not supported during this time period, the author found that working with attachment information identified inter-individual variations and areas where treatment effectiveness was impeded. Frank (2009) concluded that expecting change in attachment style in only 6 months was premature; however, incorporating attachment theory into practice is "innovative and overdue" (Frank 2009, p. 101). Applying these concepts to treatment with an individual who abuses substances is promising and warrants testing.

## Addiction as an Attachment Disorder

Edward Khantzian was one of the first theorists to examine this relationship between attachment and substance use. Drawing on ideas of self-regulation and attachment, in the 1970s, Khantzian and David Duncan co-founded the theory of addiction as a self-medication process, naming it the Self-Medication Hypothesis (SMH). According to this conceptualization, addictive vulnerability is a result of exposure to drugs, in combination with the inability to tolerate or understand one's own feelings (Khantzian 1997). Within this hypothesis, addiction is not about pleasure seeking, but instead, seeking comfort and contact. Khantzian later expanded on these ideas to define addiction as a self-regulation disorder wherein individuals self-medicate to manage their self-regulation issues. Substances relieve psychological suffering and compensate for an alienated sense of self (Khantzian 2011). Because these individuals have an inability to recognize and regulate their own feelings and sense of self, they act as though they do not need close interpersonal relationships (Khantzian 2012). This disengagement and alienation from self and others produces immense distress and creates a further reliance on addictive drugs (Khantzian 2011).

The second major hypothesis within the SMH was that an individual's drug preference was based on their individual characteristics and psychological suffering (Khantzian 1997). According to this hypothesis, particular drugs are chosen by substance users to address a particular impairment in affect regulation (Flores 2004). Suh et al.'s (2008) study confirmed Khantzian's (1997) clinical observations that emotional repression was associated with alcoholism, restlessness predicted cocaine preference, and more angry or negative behavior was predictive of heroin use. Thus, the etiology of addictive behavior could arguably begin with an unmet need that fuels an individual's attraction to a particular substance.

Höfler and Kooyman (1996) argued that an individual might choose a substance as an attachment alternative to relationships. They linked this use of substances-as-relationships to attachment ruptures in childhood, manifesting during the life-transition stage in adolescence (Höfler and Kooyman 1996). Flores (2004, 2006) built on Höfler and Kooyman's idea of substances as an alternative attachment relationship. Using this idea, Flores (2004, 2006) referred to addiction as an attachment disorder. Flores (2004, 2006) suggests that individuals who struggle with developing intimacy and closeness with others may seek out a method in which to self-soothe, in times of distress. This relationship with substances can arguably become an attachment, which acts as both an obstacle to and a substitute for interpersonal relationships (Flores 2006). A drug can create the feeling of having a secure base and, within this framework; addictive behaviors can be understood as misguided attempts at self-repair (Flores 2004; Schindler et al. 2005). Substance abuse then becomes the solution, and the consequence of an individual's impaired ability to develop and maintain healthy attachments, effectively "protecting" the individual from relational vulnerability.

Padykula and Conklin (2010) advocated for substance abuse treatment that addresses attachment traumas. They argued the treating therapist should work with the client to develop new working models, and cultivate alternative strategies for self-regulation. An attachment trauma can be any rupture in one's primary attachment relationship, such as the experience of neglect, abuse, or loss. Trauma survivors may abuse substances and avoid close interpersonal relationships in attempts to cope with and manage negative memories (Feld 2004; MacIntosh and Johnson 2008). The experience of attachment trauma can create deficits in an individual's capacity for emotional regulation (Padykula and Conklin 2010). This can cause an individual to attempt to self-regulate by using substances (Basham 2005; Padykula and Conklin 2010).

As a therapist using an attachment lens, I was interested in helping Jason create the capacity for healthy relationships, beginning with our therapeutic relationship. I was clear with Jason about the structure of our therapy: I provided basic psychoeducation about attachment styles and about the impact early childhood experiences can have on later relationships and experiences. Jason had difficulty, at first, attaching to me as a therapist; this was evidenced by his reluctance to open up in initial sessions and in ongoing questions about whether the therapy would continue if he weren't "cured" in a few months. He also expressed some concern that I would end the therapy if he relapsed, or I was to move away, as had done his last therapist. Jason shared he had ongoing fears of abandonment he struggled to manage in the midst of drug cravings and difficulties with his wife. These fears were expressed as so powerful that perhaps they triggered his old feelings of needing to escape. Insecurities can enact defensive distortions and feelings of being threatened, which can then propel ineffective responses to stress (McNally et al. 2003). While Jason was in a relationship with Angela, his closest attachment relationship had continued to be crack cocaine and the assurance that he could always return to it, if needed. Crack cocaine appeared to be a deactivating coping tool for Jason that allowed him to manage insecurity and regulate his interpersonal relationships.

## Attachment-Focused Therapy for Addictions

Flores (2004) posits that attachment-oriented therapy within the context of addiction should center on the therapeutic relationship and the transformative potential of human relationships. In particular, attachment-focused therapy can work to develop empathic attachment relationships, while simultaneously helping the substance-dependent individual become acquainted with their own emotional self (Flores 2006). "Addicts and alcoholics are best treated by helping them to develop a capacity for healthy relationships" (Flores 2006, p. 6).

Identifying some of Jason's challenges as related to attachment insecurity was a helpful place to start in working together. Initially, sessions focused on reassuring Jason that therapy was an ongoing process and that I, as his therapist, could provide a safe place to begin examining his relationship with crack cocaine.

As therapy progressed, my therapeutic relationship with Jason developed. By remaining consistent, soft, reliable, and supportive, I worked to demonstrate that therapy could be a safe-haven and a beginning secure attachment for Jason. Slowly, Jason moved from seeing crack cocaine as his only safe exit or escape, to expressing relief and safety in being able to share his experiences and story in therapy and forming a strong attachment between us. This was evident when Jason said things like, "It's such a relief to be able to tell you this," or "I trust you to hear this story, even if I am ashamed." I also noticed that Jason began smiling in therapy and making more frequent eye contact. Therapy provided a space for Jason to discuss his insecurities and understand better how they were related to his early attachment.

Together, Jason and I explored how he had developed a fearful-avoidant attachment in his early childhood years, and how that had informed his substance use. I worked with Jason to help him connect the relationship between his feelings of abandonment and the sense of relief and comfort he found in his relationship with drugs. When I asked Jason questions about his relationships with his caregivers, he was able to identify how he began to avoid close relationships at a young age. The thought of being abandoned, like he had been by his father, was too threatening. He did not want to get close to others and would often "shove off" his mother's attempts to get close when he was a teenager. Jason shared that at first, he saw his coping mechanism of drug use as being independent, resilient, and "not needing anyone else," but was also able to share how alone and scared he had felt. Having explained attachment styles to Jason, he was able to identify his attachment to his parents as fearful and avoidant.

We then moved to looking at Jason's current attachment relationships. Jason's mother had died when he was twenty-one and he had had infrequent contact with his father. As the therapist, I highlighted the similarities between Jason's attachment with his parents and his relationship with Angela. Jason was able to see that he had replicated his insecure attachment style in his current romantic relationship. When Angela pressured Jason, he withdrew and found a reliable escape and feeling of security in crack cocaine. Jason admitted, "Sometimes, she just gets too close, and I want to hide". As his therapist, I found that Jason's relationship with the drug served as a

defense against forming other close, affiliative relationships. Again, this mirrored a fearful-avoidant way of relating.

Recently, Landau-North et al. (2011) provided a theoretical extension of Emotionally Focused Therapy (EFT) for couples with addiction. Within this extension, they view addiction as an attachment issue, arguing therapists should help couples create healthy dependency within their relationships as an alternative to addictive regulation strategies (Landau-North et al. 2011). They argue that substance use behaviors are inevitably connected to the attachment relationship between romantic partners.

Drawing from Landau-North et al.'s (2011) EFT extension, I opted to invite Angela to some of the sessions. Couple therapy with Angela and Jason focused on strengthening the bond within the couple relationship, healing pre-existing attachment traumas in the couple, addressing attachment insecurities, and acknowledging fears of abandonment. Both partners were encouraged to use the relationship as a place to begin to develop a secure and effective dependency on one another. In creating this framework, the couple was able to seek support and security inside of the relationship, as opposed to seeking external soothing (e.g. Jason's drug use). Jason's increased trust and security with Angela improved his ability to mentalize within the relationship, which allowed him to "stay with it" when the couple had disagreements or arguments. Angela was able to learn about Jason's fears of getting close, and worked to find different ways to soothe him when she noticed he was triggered by a conversation they were having, or when he withdrew unexpectedly.

In arguing for attachment-focused therapy for addictions, 12-step programs also provide promise and create an important foundation for future dialogue around attachment-based interventions. For some substance abusers who are insecurely attached, a drug can become the only attachment object in their lives (Spiegel and Fewell 2004). Twelve-step programs therefore can be understood as a less destructive transitional space, i.e., instead of being attached to a drug and the harmful effects that come with addiction, programs like AA provide substance abusers with a healthier object in which to become attached.

Jason did not have a support system outside of his marriage. Working with Jason on the possibility of developing interpersonal relationships became an important part of moving his main attachment away from crack cocaine, and towards a wider support network. I recommended that Jason join a peer support group like Narcotics Anonymous in order to engage in affiliative relationships with other individuals who were trying to maintain abstinence.

Therapy provides an opportunity to begin to activate an individual's capacity for secure attachment (Lipton and Fosha 2011). Within the therapeutic context, an attachment-informed therapist can help clients like Jason acknowledge how their substance use is inextricably linked to their attachment traumas. Jason learned from an early age that attachment figures were not trustworthy and inconsistent, and began using substances as a means of momentary regulation and security. Jason's internal working models were distorted and as a result he had difficulty regulating negative affect in his interpersonal relationships. In Jason's case, alternative self-regulatory strategies included ongoing therapy, developing new friendships, attending a meditation and mindfulness course, and slowly opening up to Angela about his day-to-day challenges.

## Conclusion

Given the large empirical body of work supporting the validity of attachment theory as an intervention, there is a need for researchers and clinicians to continue to act as proponents for relationally-based, theory-grounded clinical practice. While some treatment models such as Emotionally Focused Therapy (Johnson et al. 1999) incorporate attachment concepts, attachment-focused therapy for addictions treatment is rare. While altering an individual's attachment style may involve longer-term treatment, longitudinal studies of current short-term substance abuse treatments suggest longer-term treatment may be necessary. Additionally, the costs associated with healing attachment wounding may well be outweighed by the sustained, global benefits experienced by individuals, their loved ones and shared communities.

Attachment theory recognizes that human beings are interactional and constantly impacted by our relationships and the environment around us. When the fundamental ability to connect with others is damaged, it is not surprising that some seek external emotional support and regulation from a substance. As the use of substances increases, the individual's ability to interact with others is further impaired, and the cycle of addiction is set in motion. The empirical literature presents strong evidence for a relationship between adverse early-childhood experiences and addiction (Anda et al. 2002; Dube et al. 2003, 2006; Felitti et al. 1998). The more trauma and neglect to which a child is exposed at an early age, the more likely it is he/she will develop a substance abuse problem. As in the case of Jason, early attachment injuries in his family of origin made drug use a safe and reliable respite. Even as Jason developed, interpersonal relationships did not offer the safety that did crack cocaine. The relationship between early attachment experiences and substance abuse highlights the importance of applying attachment theory to substance abuse.

The therapeutic relationship and the recovery environment provide important spaces to begin building secure interpersonal relationships. The therapist can use an

attachment framework to educate the client on the function of their drug of choice (Padykula and Conklin 2010) and work with their client to consider alternative strategies for self-regulation. The therapist offers a foundational attachment relationship, which sets the stage for individuals to become more comfortable and conversant with their own emotional self. The therapist must move slowly and recognize the attachment the individual has to their drug of choice and the risks inherent in losing that attachment. Rather than altering behavior, an attachment-focused approach addresses the emotional processes that *inform* behavior and functioning. Helping an individual like Jason process how their early attachments have contributed to their substance abuse could provide a means to achieve internal regulation and interpersonal emotional support.

Early relationships with primary caregivers set the stage for an individual's developmental trajectory, and the intersection of attachment and addictive disorders highlights the importance of secure bonds throughout the lifespan. Understanding how one's early attachments may have impacted their choices around initiating drug use and the role that the substance plays in their life offers a less pathologizing approach to treatment. This approach addresses the underlying emotional processes around the addiction, as opposed to solely prescribing behavioral interventions. More research is needed to consider the potential benefit of applying attachment theory to the treatment of substance abuse disorders. It is our hope that individuals like Jason could be supported and nurtured to develop secure attachments within themselves and with their loved ones, rather than to their drug of choice.

**Conflict of interest** The authors declare that they have no conflict of interest.

## References


Anda, R. F., Whitfield, C. L., Felitti, V. J., Chapman, D. P., Edwards, V. J., Dube, S. R., et al. (2002). Adverse childhood experiences, alcoholic parents, and later risk of alcoholism and depression. *Psychiatric Services, 53*(8), 1001–1009. doi:10.1176/appi.ps.53.8.1001.

Basham, K. (2005). Transforming the legacies of childhood trauma in couple and family therapy. *Social Work in Health Care, 39*(3–4), 263–285.

Bateman, A. W., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World Psychiatry, 9*(1), 11–15.

Bettmann, J. E., & Jasperson, R. A. (2007). Adults in wilderness treatment: A unique application of attachment theory and research. *Clinical Social Work Journal, 36*(1), 51–61. doi:10.1007/s10615-007-0134-0.

Bowlby, J. (1979). *The making and breaking of affectional bonds*. London: Tavistock.

Bowlby, J. (1988). *A secure base: Parent–child attachment and healthy human development*. London: Routledge.

Brennan, K. A., Shaver, P. R., & Tobey, A. E. (1991). Attachment styles, gender and parental problem drinking. *Journal of Social and Personal Relationships, 8*(4), 451–466. doi:10.1177/0265407591184001.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology, 28*(5), 759–775.

Cunradi, C. B., Mair, C., Todd, M., & Remer, L. (2012). drinking context and intimate partner violence: Evidence from the California Community Health Study of couples. *Journal of Studies on Alcohol and Drugs*, *73*(5), 731. Retrieved from http://www.jsad.com/jsad/article/Drinking_Context_and_Intimate_Partner_Violence_Evidence_From_the_Californi/4730.html.

Dennis, M. L., Scott, C. K., Funk, R., & Foss, M. A. (2005). The duration and correlates of addiction and treatment careers. *Journal of substance abuse treatment*, *28 Suppl 1*(null), S51–62. doi:10.1016/j.jsat.2004.10.013.

Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics, 111*(3), 564–572.

Dube, S. R., Miller, J. W., Brown, D. W., Giles, W. H., Felitti, V. J., Dong, M., & Anda, R. F. (2006). Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, *38*(4), 444.e1–444.e10. doi:10.1016/j.jadohealth.2005.06.006.

Durrant, R., Adamson, S., Todd, F., & Sellman, D. (2009). Drug use and addiction: Evolutionary perspective. *Australian and New Zealand Journal of Psychiatry, 43*, 1049–1056.

Falk, D., Yi, H., & Hiller-Sturmhoefel, S. (2008). An epidemiologic analysis of co-occurring alcohol and drug use and disorders: Findings from the national epidemiologic survey of alcohol and related conditions (NESARC). *Alcohol Research & Health, 31*(2), 100–110.

Feld, B. (2004). Holding and facilitating interactive regulation in couples with trauma histories. *Psychoanalytic Inquiry*, *24*(3), 420–437. doi:10.1080/07351692409349092.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258.

Flores, P. J. (2004). *Addiction as an attachment disorder*. Oxford: Jason Aronson.

Flores, P. J. (2006). Conflict and repair in addiction treatment: An attachment disorder perspective. *Journal of Groups in Addiction & Recovery, 1*(1), 5–26.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York: Other Press.

Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Mattoon, G., et al. (1996). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology, 64*(1), 22–31.

Frank, M. L. (2009). Therapeutic change at project pride: Residential substance abuse treatment from an attachment perspective. *ProQuest Dissertations and Theses*.

Glantz, M. D. (2010). Touchstone issues for theories of substance abuse-dependence etiology. In L. M. Scheier (Ed.), *Handbook of drug use etiology: Theory, methods, and empirical findings* (pp. 51–69). Washington: American Psychological Association.

Health Canada. (2011). *No title*.

Heyman, G. M. (2009). *Addiction: A disorder of choice*. Cambridge, MA: Harvard University Press.

Höfler, D. Z., & Kooyman, M. (1996). Attachment transition, addiction and therapeutic bonding—An integrative approach. *Journal of Substance Abuse Treatment, 13*(6), 511–519. doi:10.1016/S0740-5472(96)00156-0.

Hughes, D. A. (2007). *Attachment-focused family therapy*. New York: W.W. Norton & Company.

Johnson, S. M., Hunsley, J., Greenberg, L., & Schindler, D. (1999). Emotionally focused couple therapy: Status and challenges. *Clinical Psychology and Practice, 6*(1), 67–79.

Kazdin, A. E. (2011). Evidence-based treatment research: Advances, limitations, and next steps. *Violence Against Women and Children, 1–2*, 685–698.

Khantzian, E. J. (1997). The self medication hypothesis of substance use disorders: A reconsideration and recent applications. *Harvard Review of Psychiatry, 4*(5), 231–244.

Khantzian, E. J. (2011). Fine-tuning on painful affect and relapse: A group vignette. *Journal of Groups in Addiction & Recovery, 6*(3), 264–271.

Khantzian, E. J. (2012). Reflections on treating addictive disorders: A psychodynamic perspective. *The American journal on addictions/American Academy of Psychiatrists in Alcoholism and Addictions*, *21*(3), 274–9; discussion 279. doi:10.1111/j.1521-0391.2012.00234.x.

Landau-North, M., Johnson, S. M., & Dalgeish, T. L. (2011). Emotional focused couple therapy and addiction. In J. L. Furrow, S. M. Johnson, & B. A. Bradley (Eds.), *The emotionally focused casebook: New directions in treating couples* (pp. 193–218). New York: Routledge.

Larkin, M., Wood, R. T. A., & Griffiths, M. D. (2006). Towards addiction as relationship. *Addiction Research & Theory, 14*(3), 207–215. doi:10.1080/16066350500151747.

Lende, D. H., & Smith, E. O. (2002). Evolution meets biopsychosociality: An analysis of addictive behavior. *Addiction, 97*, 447–458.

Lipton, B., & Fosha, D. (2011). Attachment as a transformative process in AEDP: Operationalizing the intersection of attachment theory and affective neuroscience. *Journal of Psychotherapy Integration, 21*, 253–279.

MacIntosh, H. B., & Johnson, S. M. (2008). Emotionally focused therapy for couples and childhood sexual abuse survivors. *Journal of marital and family therapy*, *34*(3), 298–315. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/18717921.

Main, M. (1995). Recent studies in attachment: Overview, with selected implications for clinical work. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental, and clinical perspectives* (pp. 407–474). Hillsdale, NJ: The Analytic Press.

McHugh, R. K., Hearon, B. A., & Otto, M. W. (2010). Cognitive-behavioral therapy for substance use disorders. *Psychiatric Clinics of North America, 33*(3), 511–525.

McKay, J. R., & Hiller-Sturmhoefel, S. (2011). Treating alcoholism as a chronic disease. *Alcohol Research & Health, 33*(4), 356–370.

McLellan, A. T., Lewis, R. A., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness. *Journal of the American Medical Association, 284*(13), 1689–1695.

McNally, A. M., Palfai, T. P., Levine, R. V., & Moore, B. M. (2003). Attachment dimensions and drinking-related problems among young adults. *Addictive Behaviors, 28*(6), 1115–1127. doi:10.1016/S0306-4603(02)00224-1.

Menicucci, L. D., & Wermuth, L. (1989). Expanding the family systems approach: Cultural, class, developmental and gender influences in drug abuse. *The American Journal of Family Therapy, 17*(2), 129–142.

National Drug Intelligence Center. (2010). *National threat assessment: The economic impact of illicit drug use on American society*. Washington, DC.

NIDA. (2007). *Drugs, brains and behavior: The science of addiction*. Bethesda, MD.

Padykula, N. L., & Conklin, P. (2010). The self regulation model of attachment trauma and addiction. *Clinical Social Work Journal, 38*, 351–360.

Padykula, N. L., & Horwitz, M. (2012). Using psychodynamic concepts to measure interpersonal competencies during social work training. *International Journal of Applied Psychoanalytic Studies, 9*(1), 48–61.

Piehler, T. F., Veronneau, M.-H., & Dishion, T. J. (2012). Substance use progression from adolescence to early adulthood: Effortful control in the context of friendship influence and early-onset use. *Journal of Abnormal Child Psychology, 40*, 1045–1058.

Rehm, J., Baliunas, D., Brochu, S., Fischer, B., Gnam, W., Patra, J., et al. (2006). *The costs of substance abuse in Canada 2002 highlights* (pp. 1–12). Canadian Centre on Substance Abuse.

Rehm, J., Mathers, C., Popova, S., Thavorncharoensap, M., & Teerawattananon, Y. (2009). Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. *Lancet, 373*(9682), 2223–2233.

Saha, T. D., Harford, T., Goldstein, R. B., Kerridge, B. T., & Hasin, D. (2012). Relationship of substance abuse to dependence in the U.S. general population. *Journal of Studies on Alcohol and Drugs, 73*, 368–378.

SAMHSA. (2011). *National survey of substance abuse treatment services (N-SSATS)* (pp. 1–5). Retrieved from http://wwwdasis.samhsa.gov/webt/state_data/US11.pdf.

Schindler, A., Thomasius, R., Sack, P.-M., Gemeinhardt, B., & Küstner, U. (2007). Insecure family bases and adolescent drug abuse: A new approach to family patterns of attachment. *Attachment & Human Development, 9*(2), 111–126. doi:10.1080/14616730701349689.

Schindler, A., Thomasius, R., Sack, P.-M., Gemeinhardt, B., Küstner, U., & Eckert, J. (2005). Attachment and substance use disorders: A review of the literature and a study in drug dependent adolescents. *Attachment & Human Development, 7*(3), 207–228.

Spiegel, B. R., & Fewell, C. H. (2004). 12-step programs as a treatment modality. *Clinical work with substance-abusing clients, 2*, 125–145.

Stevenson-Hinde, J. (1990). Attachment within family systems: An overview. *Infant Mental Health Journal, 11*(3), 218–227.

Stone, A. L., Becker, L. G., Huber, A. M., & Catalano, R. F. (2012). Review of risk and protective factors of substance use and problem use in emerging adulthood. *Addictive Behaviors, 37*(7), 747–775. doi:10.1016/j.addbeh.2012.02.014.

Suh, J. J., Ruffins, S., Robins, C. E., Albanese, M. J., & Khantzian, E. J. (2008). Self-medication hypothesis. *Psychoanalytic Psychology, 25*(3), 518–532.

Thompson, R. A. (2008). Early attachment and later development: Familiar questions, new answers. In *Handbook of attachment* (2nd ed., pp. 348–368). New York: Guilford Press.

Volkow, N. D., Wang, G.-J., Fowler, J. S., Tomasi, D., & Telang, F. (2011). Addiction: Beyond dopamine reward circuitry. *Proceedings of the National Academy of Science, 108*(37), 15037–15042.

Vrecko, S. (2010). Birth of a brain disease: science, the state and addiction neuropolitics. *History of the Human Sciences, 23*(4), 52–67. doi:10.1177/0952695110371598.

Walant, K. B. (1995). *Creating the capacity for attachment: Treating addictions and the alienated self*. Northvale, New Jersey: Jason Aronson.

Wallin, D. J. (2007). *Attachment in psychotherapy*. New York: The Guilford Press.

Watson, J. M., Fayter, D., Mdege, N., Stirk, L., Sowden, A. J., & Godfrey, C. (2013). Interventions for alcohol and drug problems in outpatient settings: A systematic review. *Drug and Alcohol Review, 32*(4), 356–367. doi:10.1111/dar.12037.

Weegmann, M., & Khantzian, E. J. (2011). Envelopments: Immersion in and Emergence from Drug Misuse. *American Journal of Psychotherapy, 65*(2), 163–177.

Zeinali, A., Sharifi, H., & Enayati, M. (2011). The mediational pathway among parenting styles, attachment styles and self-regulation with addiction susceptibility of adolescents. *Journal of Research in Medical Sciences*, *16*(9), 1105–1121. Retrieved from http://journals.mui.ac.ir/jrms/article/viewFile/7198/2786.

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