AIAT.CARE

Attachment Infused Addiction Treatment Theory and Case Review

Connections Counseling Associates

Mary Crocker Cook
Ph.D., D.Min., LMFT, LAADC
Clinical Director,
AIAT Outpatient in San Jose, CA

Context

The AIAT model was designed to provide treatment to people who had already completed several traditional treatment programs and could not maintain long-term recovery.

I was particularly focused on people who avoided groups or struggled utilizing the support recovery offers.

Basically Feral People!

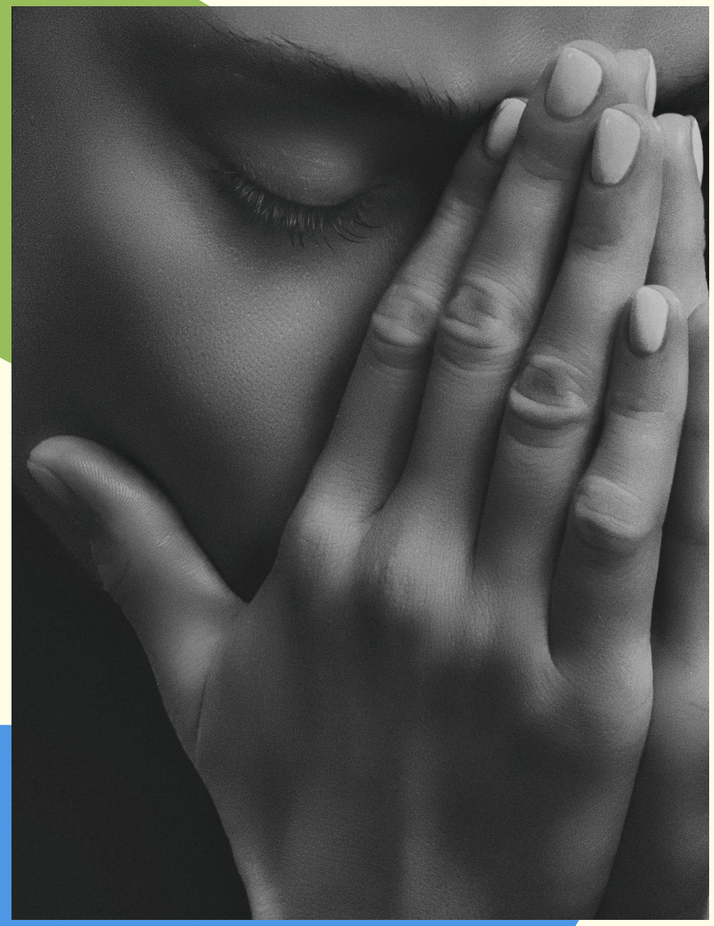
If it was a first attempt or if there was strong social support in place, I would refer them to traditional programs.

I was looking for only ONE kind of cat!

AIAT Overview

WHY does the ability to develop solid relationships in recovery matter?

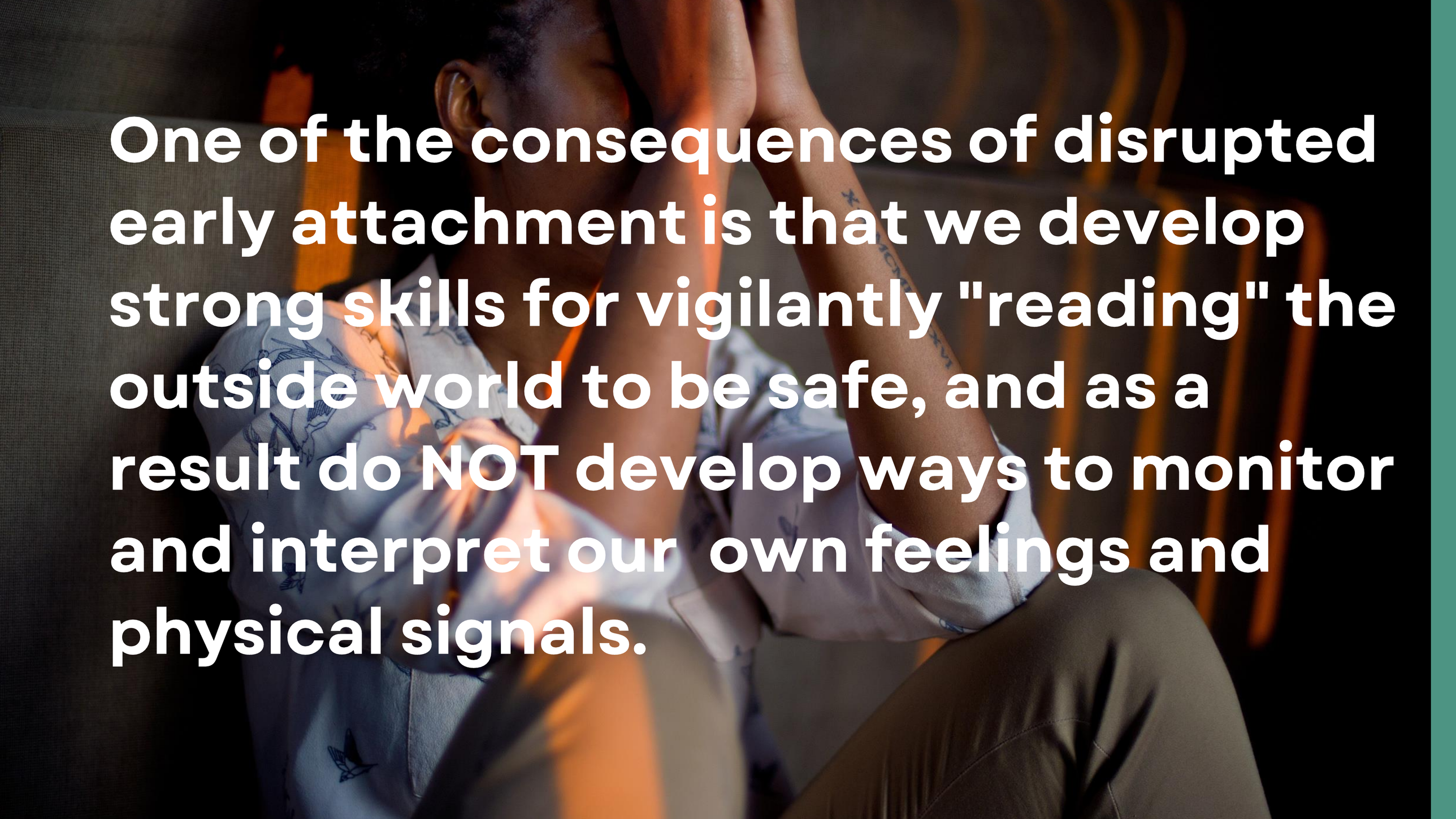
The Attachment Infused Addiction Treatment model, developed is based on a simple proposal: *individuals develop a secure attachment to substances to self-soothe in the absence of adults who cannot see and hear us accurately*.



While the use of substances is a reliable strategy that makes sense to the user, addiction hijacks the individual's ability to form effective self-regulation skills and utilize support to achieve long-term sobriety.

WHY does the ability to develop solid relationships in recovery matter?

When we look at the research about what helps people live satisying lives, especially people who have chosen to stop using substances, their ability to develop and keep a strong support system is key. **Said another way, people who cannot develop a few safe relationships tend to relapse.**



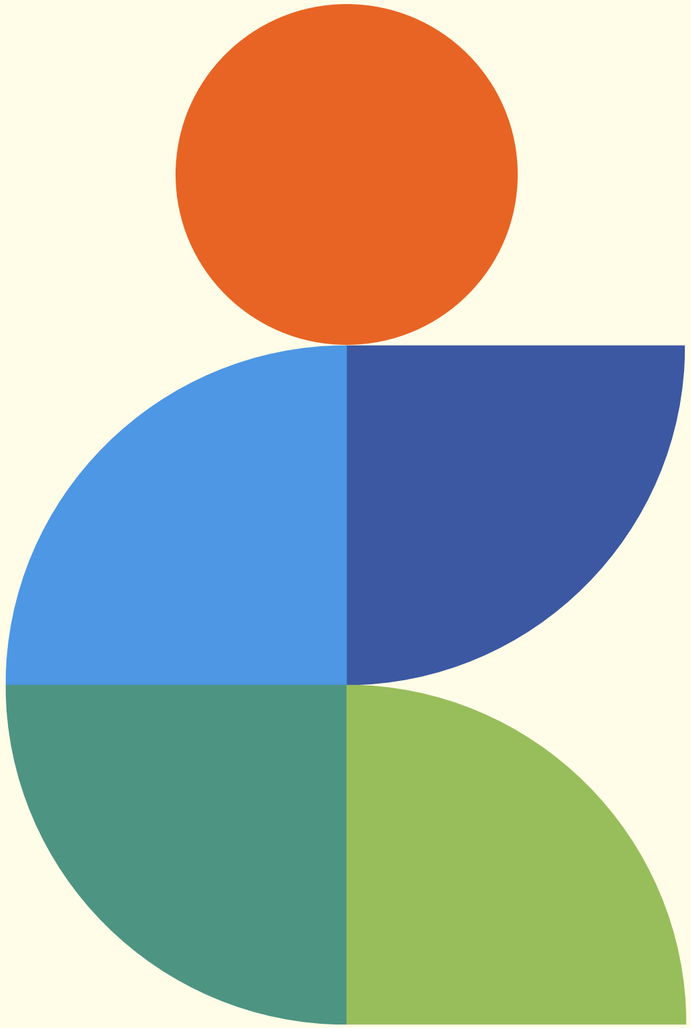
One of the consequences of disrupted early attachment is that we develop strong skills for vigilantly "reading" the outside world to be safe, and as a result do NOT develop ways to monitor and interpret our own feelings and physical signals.

We cannot accurately connect our physical sensations with our emotions, which leads to the use of "solutions" that don't match.

Like Vodka.

To try to create this connection AIAT has Integrated the OMD RPM Sticker - a small bio sticker on the person's chest that relays data to a small hub plugged into the wall at home.

Patients practice a quick daily check-in on an app, which includes reporting their readiness to change. The nurse or case manager monitoring their physical changes reaches out to the patient if they spot significant physical shifts, and helps the recovering person develop a stronger ability to read themselves in “real time.”



Physical Indicators Monitored Include. . .

Sleep

Respiration

Skin Temperature

Movemen

And t More

Heart Rate

Body Position

It has been interesting to look on the data dashboard and SEE internal changes corresponding to a relapse or anxiety in the same time frame the patient later addresses.

As a counselor, it has been helpful to review the client's data taken in "real time" over the last week, and notice discrepancies between their daily self report and the data reporting their sleep, heart rate, etc.

It shifts my dependence on self-report for data.

It is a clinical tool to provide more "real time" feedback, which I have incorporated into my clinical work with clients.

The real "meat" of the work is in the attachment based psychoed and focus in counseling.

Structure of the Program

Our intimate, 1-1 counseling, 90-day initial treatment structure includes:

Initial orientation to AIAT™ Model, and a Clinical ASAM Assessment to identify additional mental health concerns, orient to OMD RPM sticker, and/or Medically Assisted Detox. MD connection available as needed. Referral for MAT or psychiatry.

Daily app check in

Individual Psychoeducation session 1x a week

Individual Counseling session 1-2x a week

Attend one Support group of the client's choice 1x a week to track attachment style responses in "real time."

SAMPLE Psychoeducation Topics

Satir's Process of Change and Stages of Change

ACES, Neurology of Attachment, Psychological openness. Fight-Flight-Freeze system, Resilient Wobble

Social Network Mapping, Recovery Village and Relationship Rupture and Repair

Cognitive Empathy, RFQ Assessment, SAMHSA definition of Addiction, Tips to Inhabit Your Body

Attachment Style and Questionnaire (Anxious and Secure. Avoidant and Disorganized)

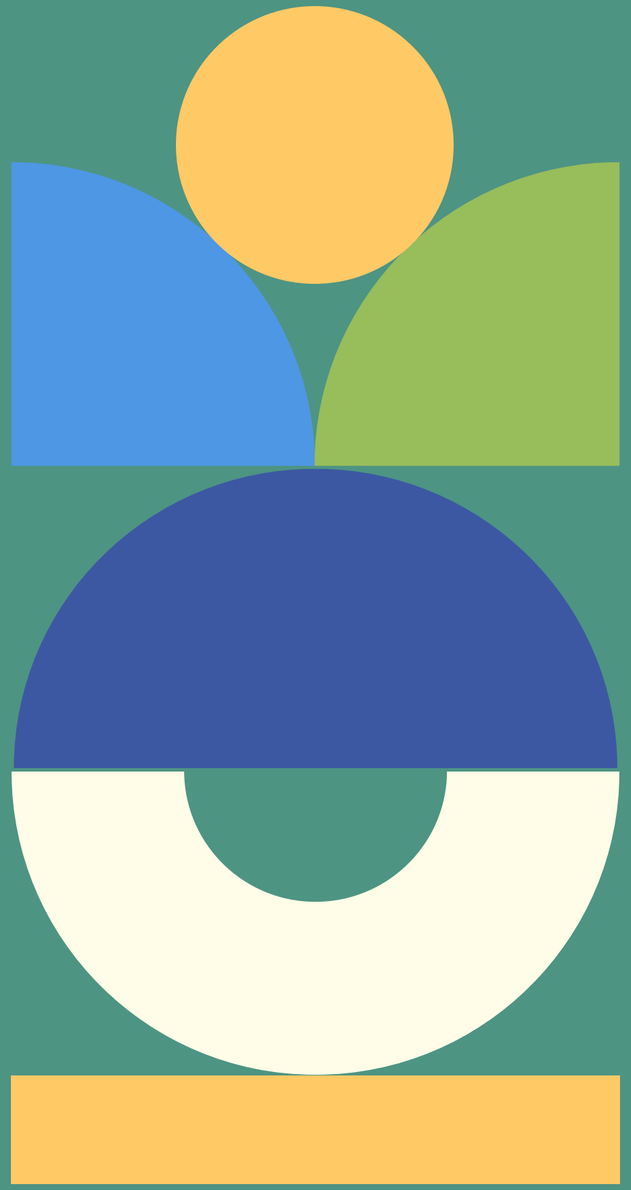
Early Attachment Disruption and Addiction impact on the Immune System

Relapse Plan for Relationship Triggers

Let's Dive Into Attachment Infused Addiction Treatment Theory

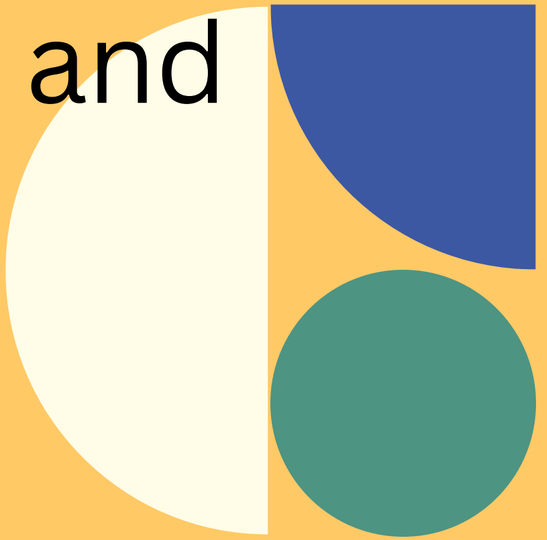
It has taken years to operationalize Attachment Theory as a practical intervention, especially with substance users.

I intially worked with Attachment Theory with Codependency, but over the years became more and more pulled toward people who had a multiple relapse history. As you might guess, they are often the same people!

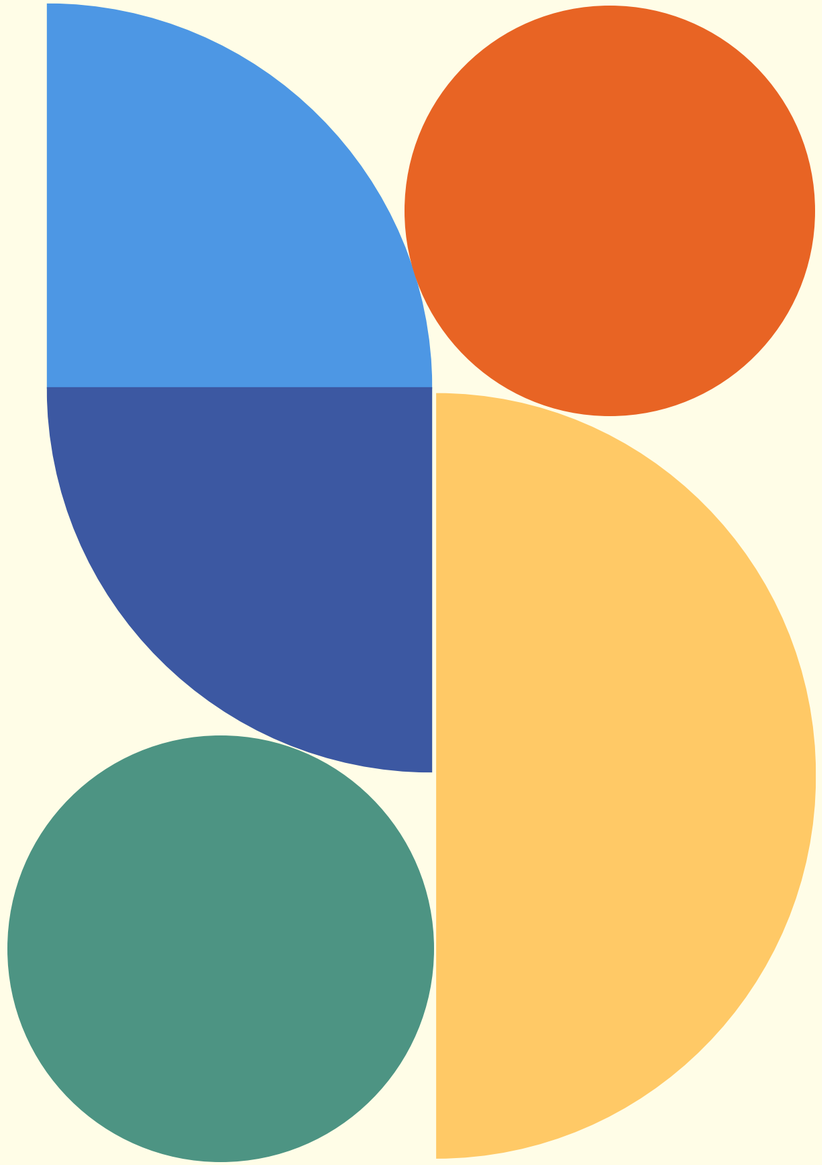


The Attachment Infused Addiction Treatment (AIAT) model operationalizes attachment theory in addiction treatment. Early attachment disruption with primary caregivers creates a lack of mirroring and emotional regulation development that leaves a deficit in a growing child’s ability to self-soothe.

It is the foundation of this model that individuals who have experienced substantial attachment disruption are unable to utilize the traditional structure of addiction treatment and Twelve Step culture.



This population, with their accompanying trauma, require an approach that directly addresses this attachment disruption within the addiction treatment structure and staff.



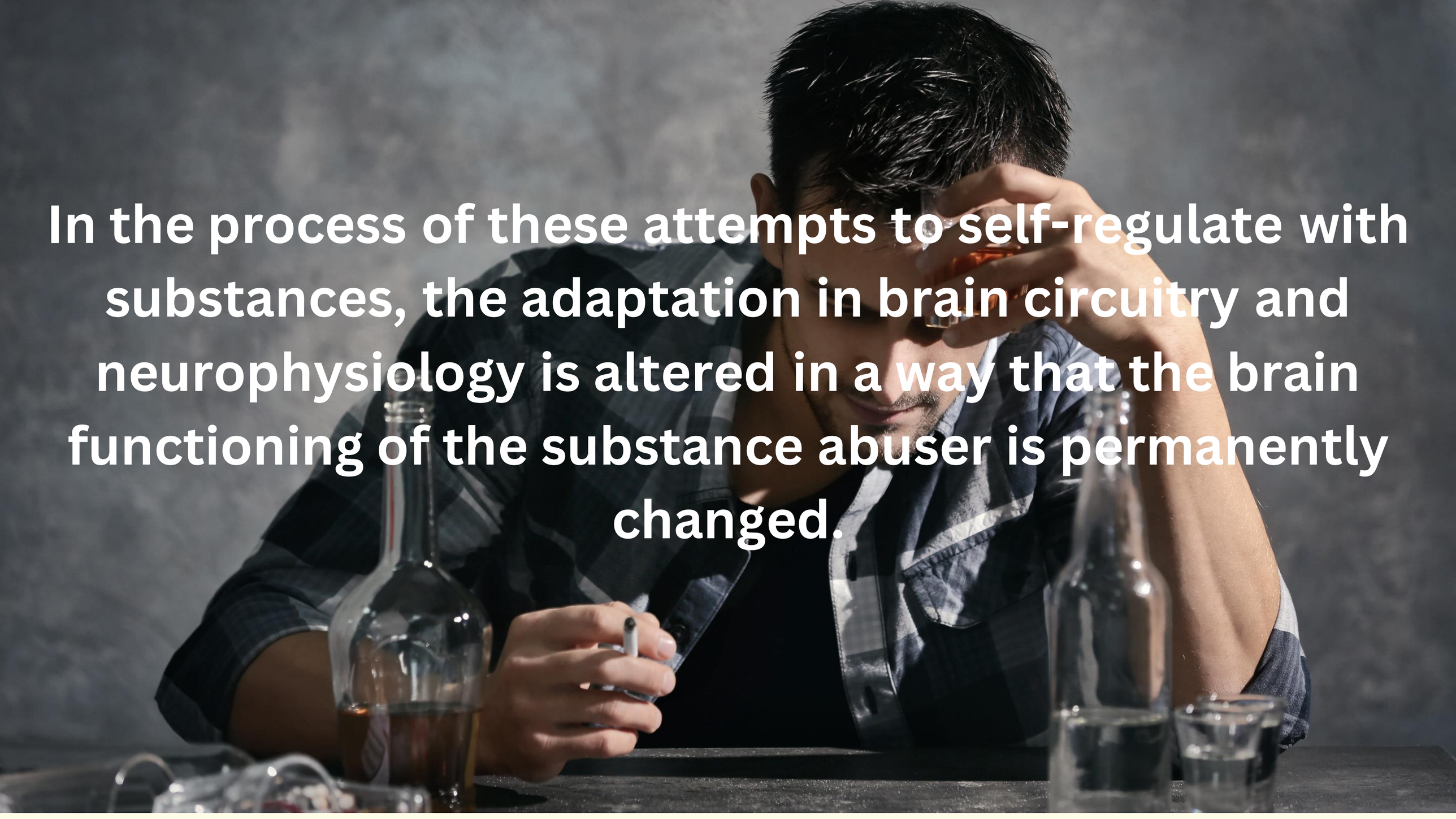
Recovering clients will need extensive assistance to gain self-regulation skills they can employ both individually and with others, and this includes strengthening their internal observer.

They must develop the skills to accurately reflect on their own internal reality, and accurately reflect the reality of others (Reflexive Self-Functioning).

A large part of their treatment will include an intentional development of a social network as part of relapse prevention planning, with frequent reflection on their own attachment style and how their currently attachment strategies may or may not be effective with the others in the treatment milieu and external relationships

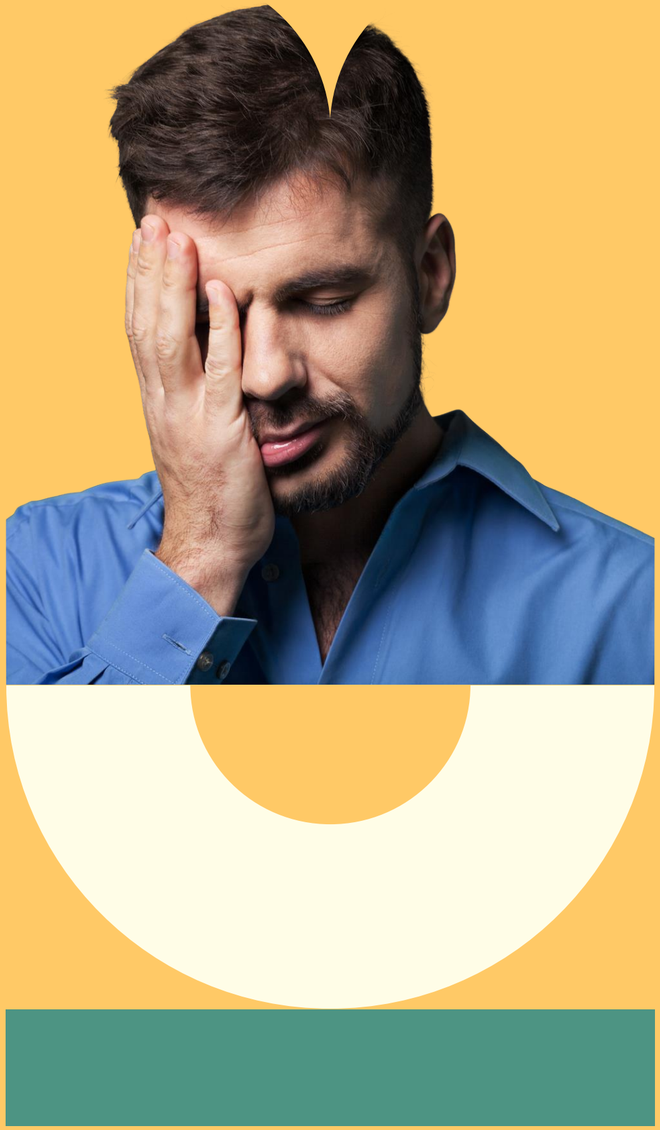
What links mental health and substance use cultures is early attachment theory and Edward Khantzian’s Self-Medication Hypothesis; his insight that addiction is pain relieving instead of pleasure seeking.

The psychological pain, and eventually physical pain, is temporarily suspended by substances which means that he sees addiction as a self-regulation disorder.


In the process of these attempts to self-regulate with substances, the adaptation in brain circuitry and neurophysiology is altered in a way that the brain functioning of the substance abuser is permanently changed.

In the process of attempting to manage attachment threats and mental health symptoms with substances, clients are neurologically hijacked and develop the disease of addiction.

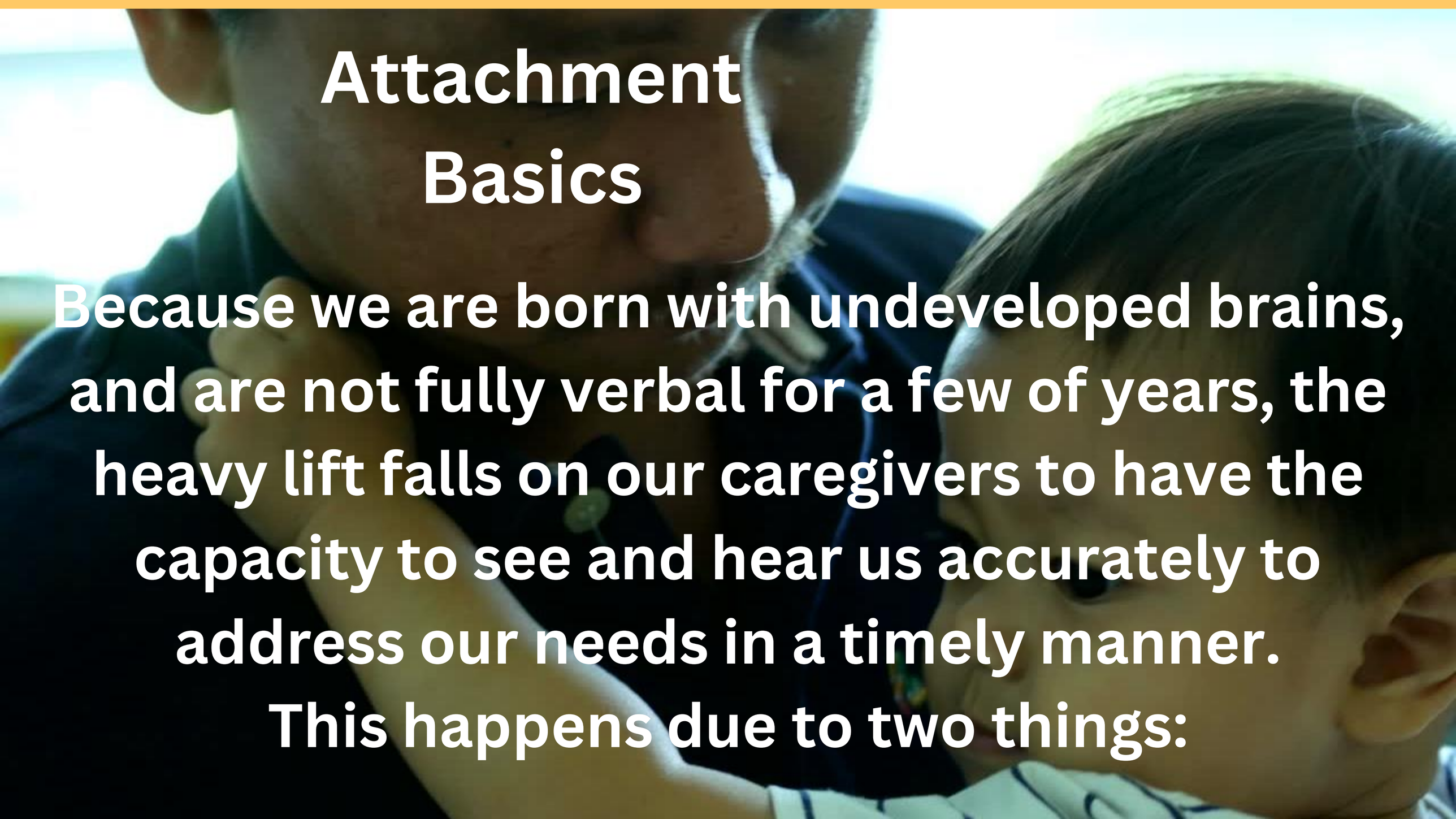
The Attachment Infused Addiction Treatment model situates the physical and psychological pain in un-remediated attachment interruption, which traps recovering clients in a hyperarousal or hypo arousal neurological response resulting in an inability to self-soothe or receive soothing from external resources.



Individuals who experience disorganized, avoidant, or anxious attachment in infancy develop difficulties in reflecting on their own thoughts and accurately reading the thoughts and intentions of others. This impaired ability prevents substance abusing clients from effectively identifying and interrupting their self-harming patterns.

Affective states cannot be completely regulated by individuals themselves as “we all are emotional regulators of each other.”

How is early attachment formed?



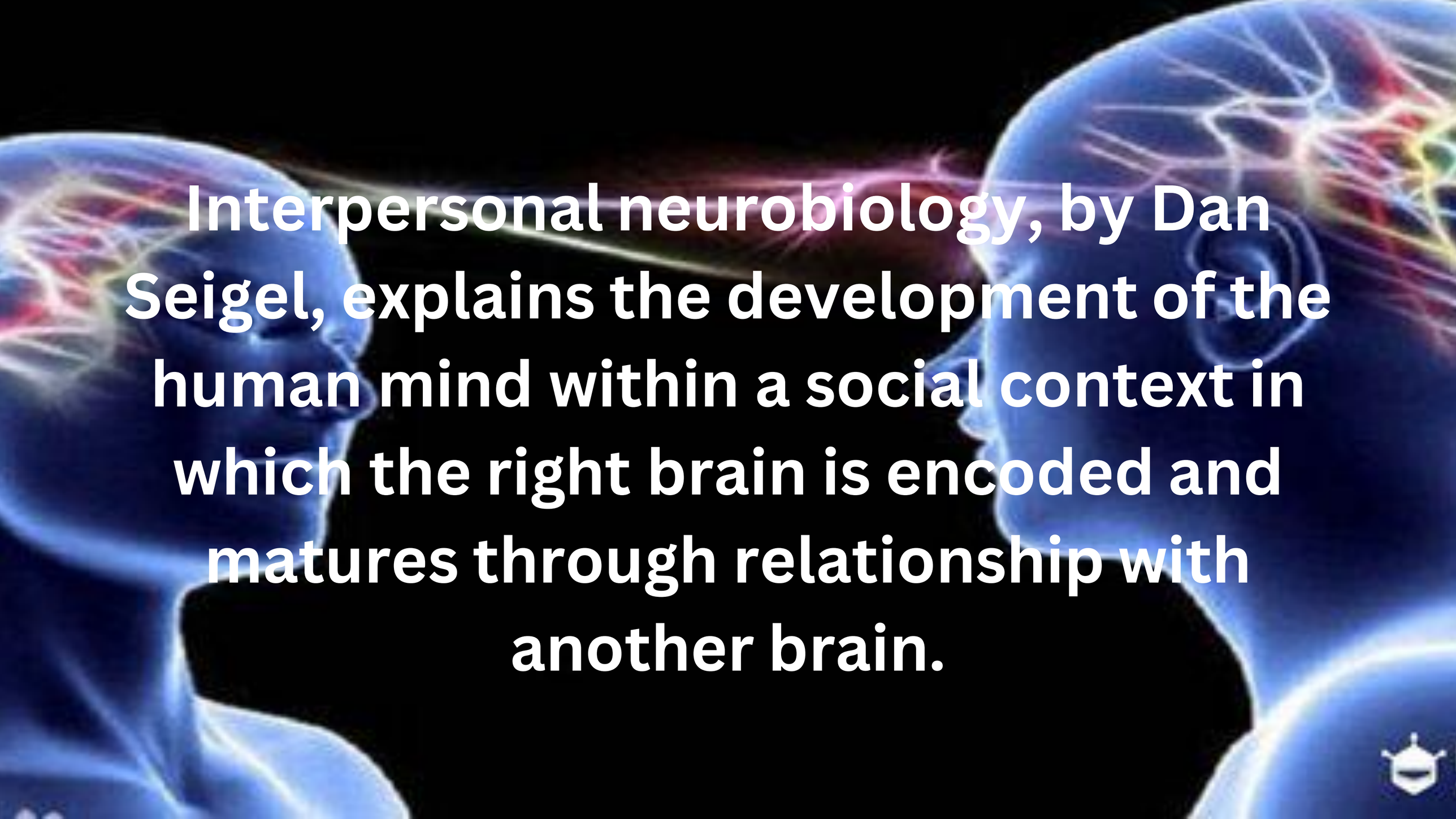
Attachment Basics

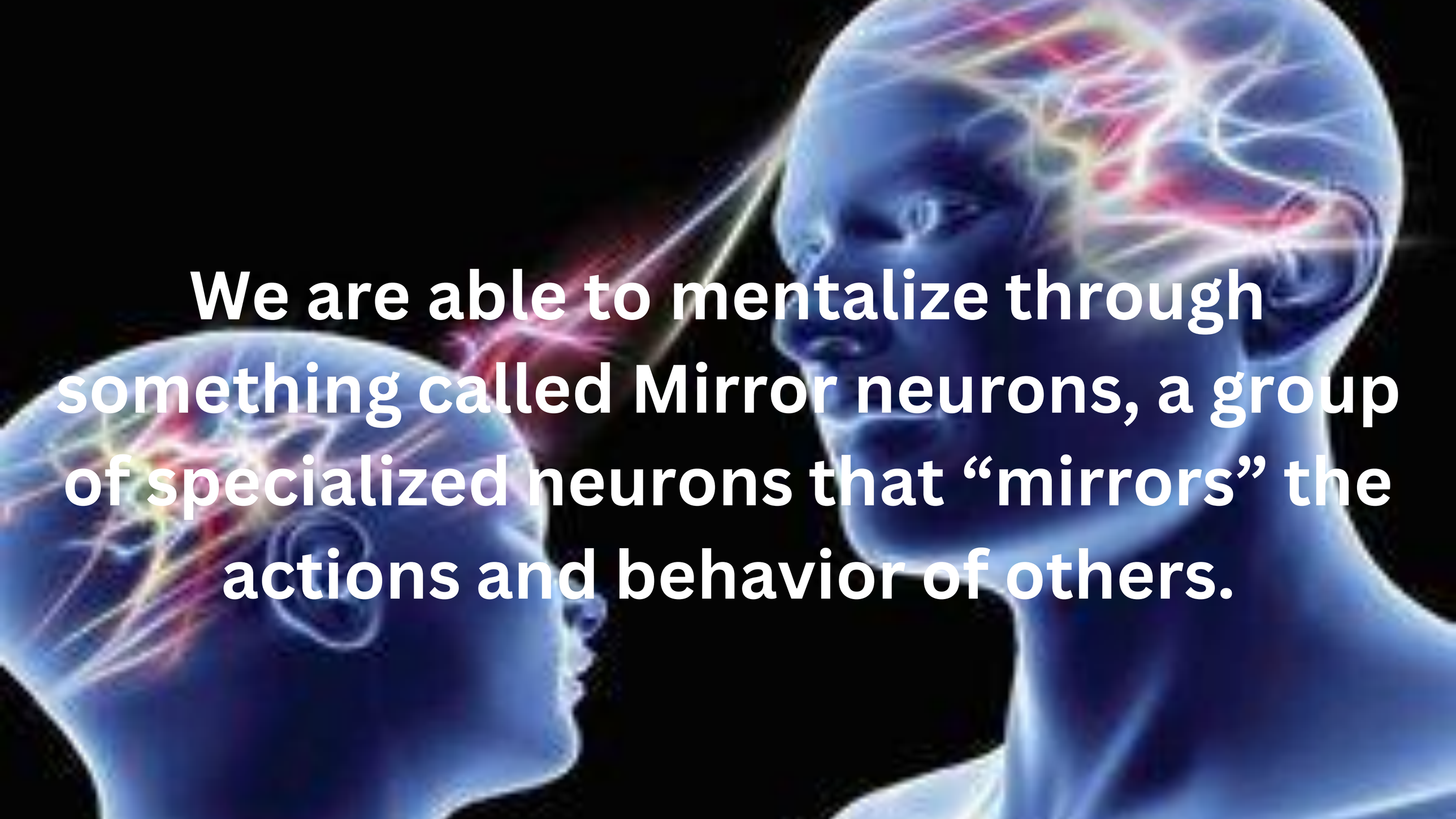
Because we are born with undeveloped brains, and are not fully verbal for a few of years, the heavy lift falls on our caregivers to have the capacity to see and hear us accurately to address our needs in a timely manner.

This happens due to two things:

The first part is mentalization, caretakers need to be able to mentalize, or hold a mental picture of us in their minds as separate from themselves so they can have empathy for us, and read our feelings and needs accurately. It involves the ability to infer someone else's mind by facial expression, tone of voice and non-verbal communication.

This means our caregivers think about us when they are away from us, have us in mind as they plan our care, and match our care to the needs and responses they are learning about us as WE are learning about us.

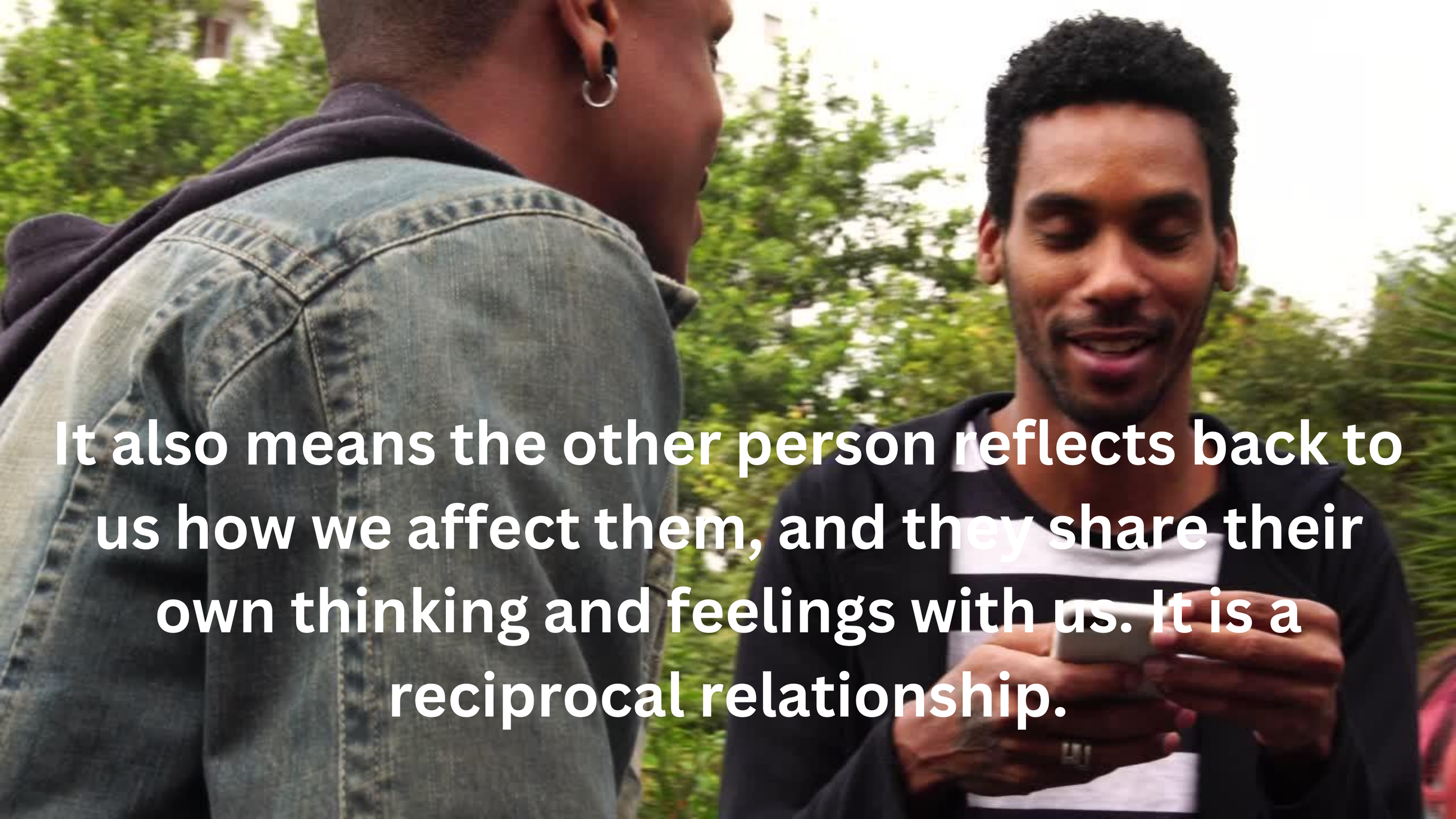

Interpersonal neurobiology, by Dan Seigel, explains the development of the human mind within a social context in which the right brain is encoded and matures through relationship with another brain.


We are able to mentalize through something called Mirror neurons, a group of specialized neurons that “mirrors” the actions and behavior of others.

The other important aspect to mentalizing and mirroring is that our caregivers serve as external emotional regulation for us because we are not capable of managing our own emotions when we’re so young.

So, we’re sponges for the emotional state of our caregivers.

(290) Dr. Dan Siegel - Explains Mirror Neurons in Depth - YouTube


It also means the other person reflects back to us how we affect them, and they share their own thinking and feelings with us. It is a reciprocal relationship.

Substance abuse has an effect on attachment, too.

The consequences of substance abuse are a host of well-known developmental risks and neurological impairments. From an attachment perspective, four mental processes might be directly affected by substance abuse.

From. Psychiatry, 15 October 2019 | https://doi.org/10.3389/fpsyt.2019.00727
Attachment and Substance Use Disorders—Theoretical Models, Empirical Evidence, and Implications for Treatment
by Andreas Schindler*
https://www.frontiersin.org/articles/10.3389/fpsyt.2019.00727/full

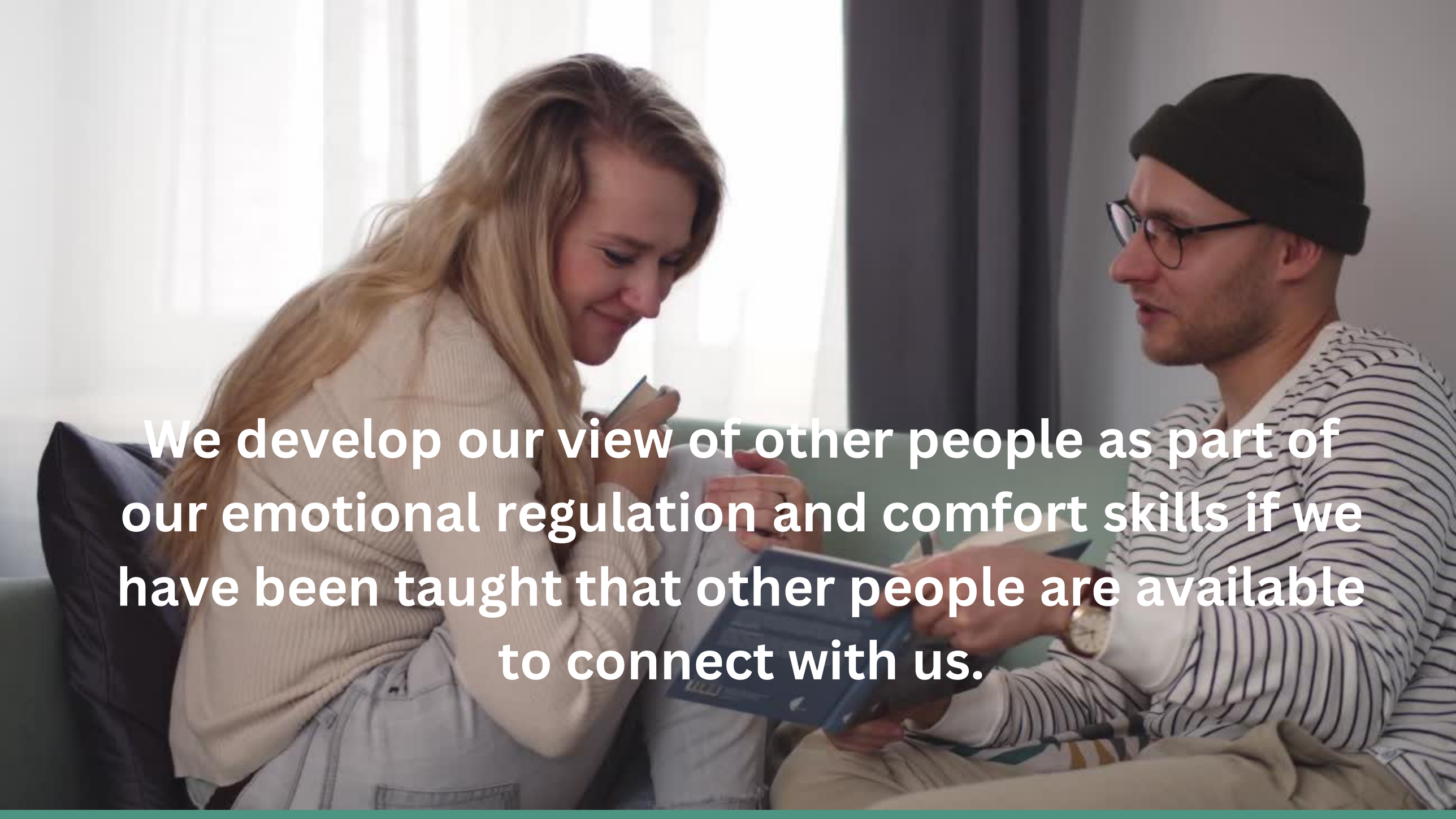
First, exploration of the environment is reduced or distorted, or risks are taken that would never have been taken in a state of sobriety.

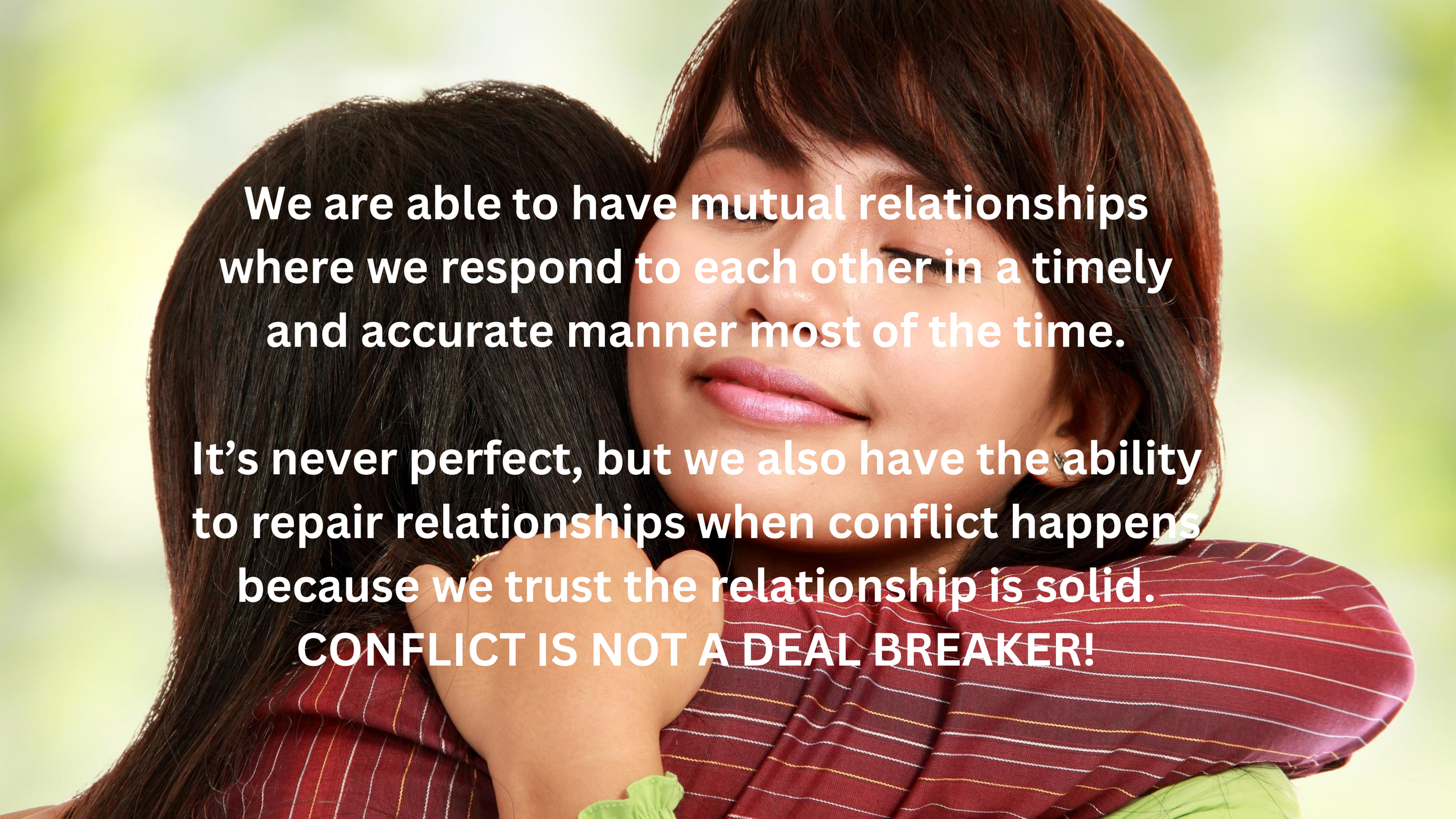
Second, mentalization, the exploration of the inner, mental world of oneself and others is reduced. This might even be a possible motivation for substance abuse: nonmentalization and nonperception of distress and painful memories.

Third, age-appropriate experiences in relationships often are inhibited or even prevented.

Fourth, affect regulation and reward might be replaced by substance abuse.

(305) How Childhood Trauma Leads to Addiction - Gabor Maté - YouTube (9:09)


We develop our view of other people as part of our emotional regulation and comfort skills if we have been taught that other people are available to connect with us.


We are able to have mutual relationships where we respond to each other in a timely and accurate manner most of the time.
It’s never perfect, but we also have the ability to repair relationships when conflict happens because we trust the relationship is solid.
CONFLICT IS NOT A DEAL BREAKER!

Reflexive Self Functioning (RSF)

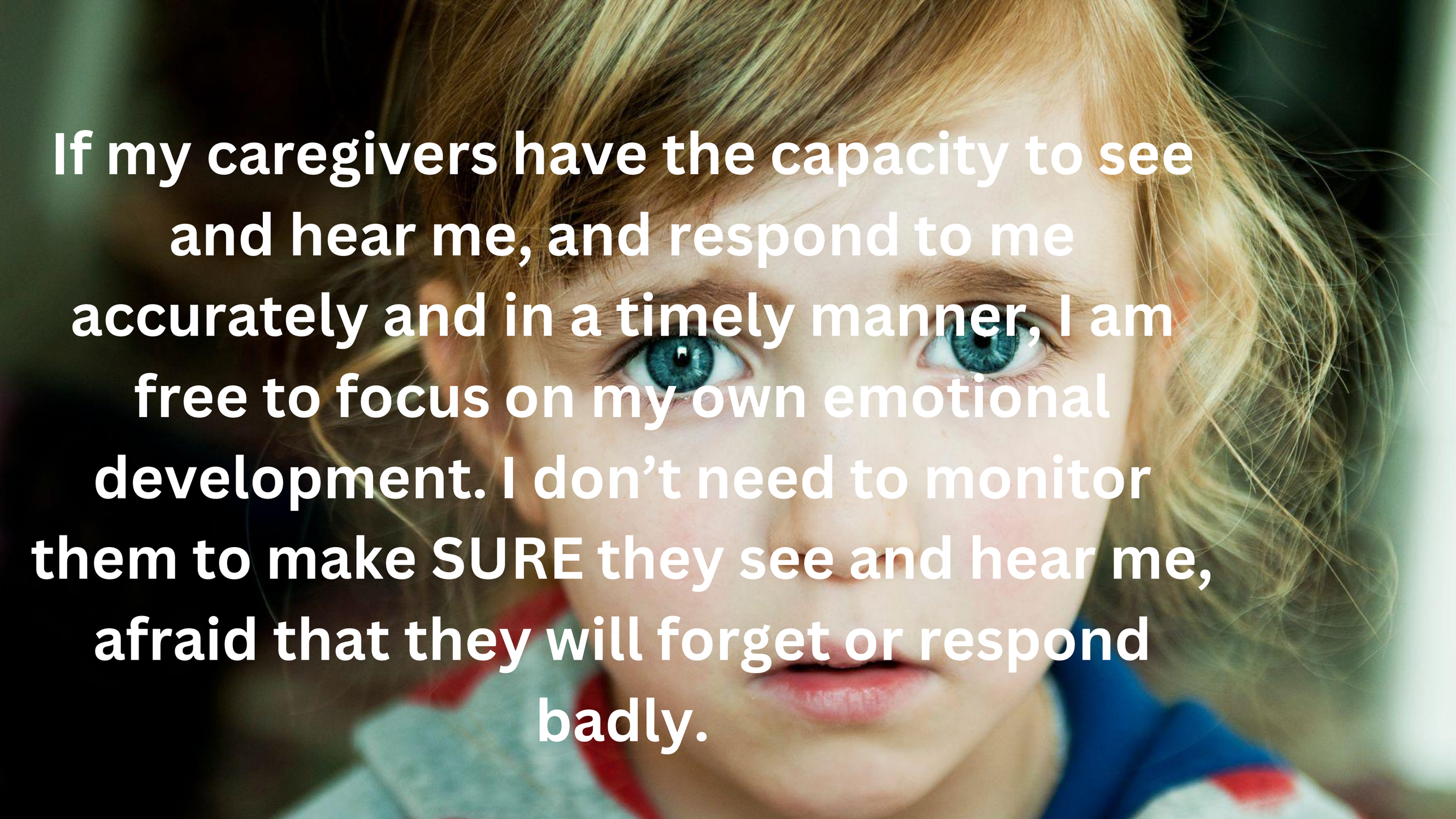
Highly self-reflective parents, Fonagy et al. maintains, are better able to see a situation from their infant's perspective, to empathize with their infant's emotions, and hence to respond to the infant's attachment signals with caring behavior that successfully meets the infant's needs for comforting.

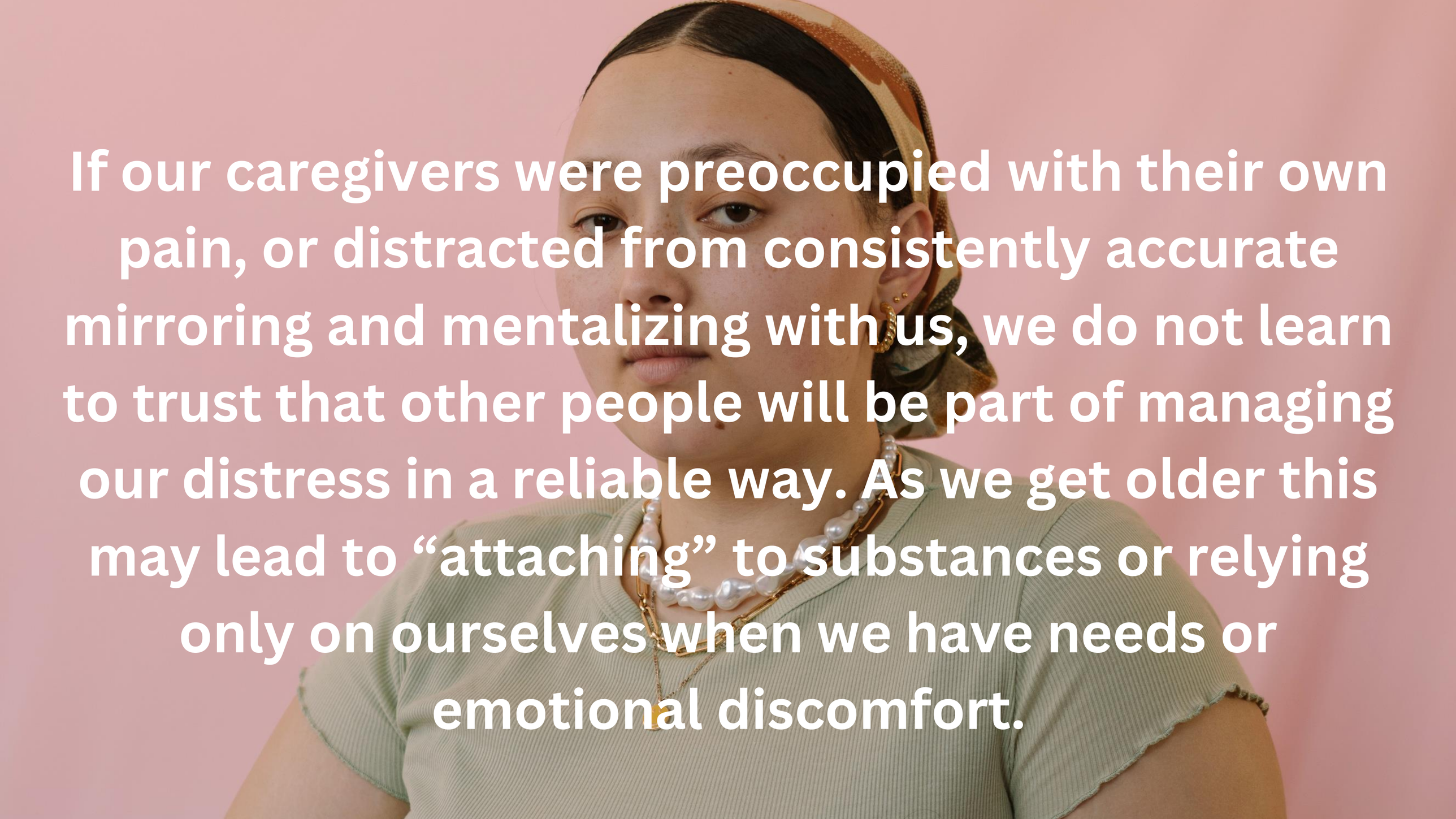
Evidence suggests that the capacity for what Fonagy calls Reflexive Self Functioning (RSF), the capacity for mentalizing, can develop only in a secure attachment relationship where the child does not have to be preoccupied with the availability or well-being of the mother.

SUDS and RSF

Substance abuse and intoxication weakens RSF, both in relation to understanding oneself, and in relation to give attention to the mental states of others.

On the other hand, weakened or impaired “baseline RSF” may contribute to frustration and high emotional arousal, which in turn is often resolved by using substances. The latter implies that substance abuse also can be viewed as a clinical expression for weakened RSF and accompanying problems with affect regulation.


If my caregivers have the capacity to see and hear me, and respond to me accurately and in a timely manner, I am free to focus on my own emotional development. I don’t need to monitor them to make SURE they see and hear me, afraid that they will forget or respond badly.


If our caregivers were preoccupied with their own pain, or distracted from consistently accurate mirroring and mentalizing with us, we do not learn to trust that other people will be part of managing our distress in a reliable way. As we get older this may lead to “attaching” to substances or relying only on ourselves when we have needs or emotional discomfort.

Our roadmap of relationship (Internal Working Model) reflects the way our caregivers demonstrated:

- awareness of our signals
- the ability to interpret their meanings
- and responding in a timely manner

Attachment Strategies

Our relational Internal Model stays with the child throughout the child's life, and is totally changeable. The model changes when the experience changes, thus the word "working."

Our internal models come with strategies for forming future attachments with other people, conceptualized on a continuum as styles of protected and defensive behaviors based on our fear of rejection or abandonment, or a perceived attempt to humiliate us.

When caretakers are unavailable, children may develop a defensive strategy of dismissing or excluding certain emotions and experiences and primarily trust their thinking to “read” a relational situation. They avoid attachment.

Shutting down our attempts to connect, or downregulating, inhibits seeking support and creates a focus on self-reliance. We may cling to “things” and “ideas” because we find people too threatening. Why do you think I have so many letters after my name, lol!

Alternatively, when caregivers are unpredictable, children may use coercive or clinging strategies and primarily trust emotion to “read” a relational situation. They anxiously attach.

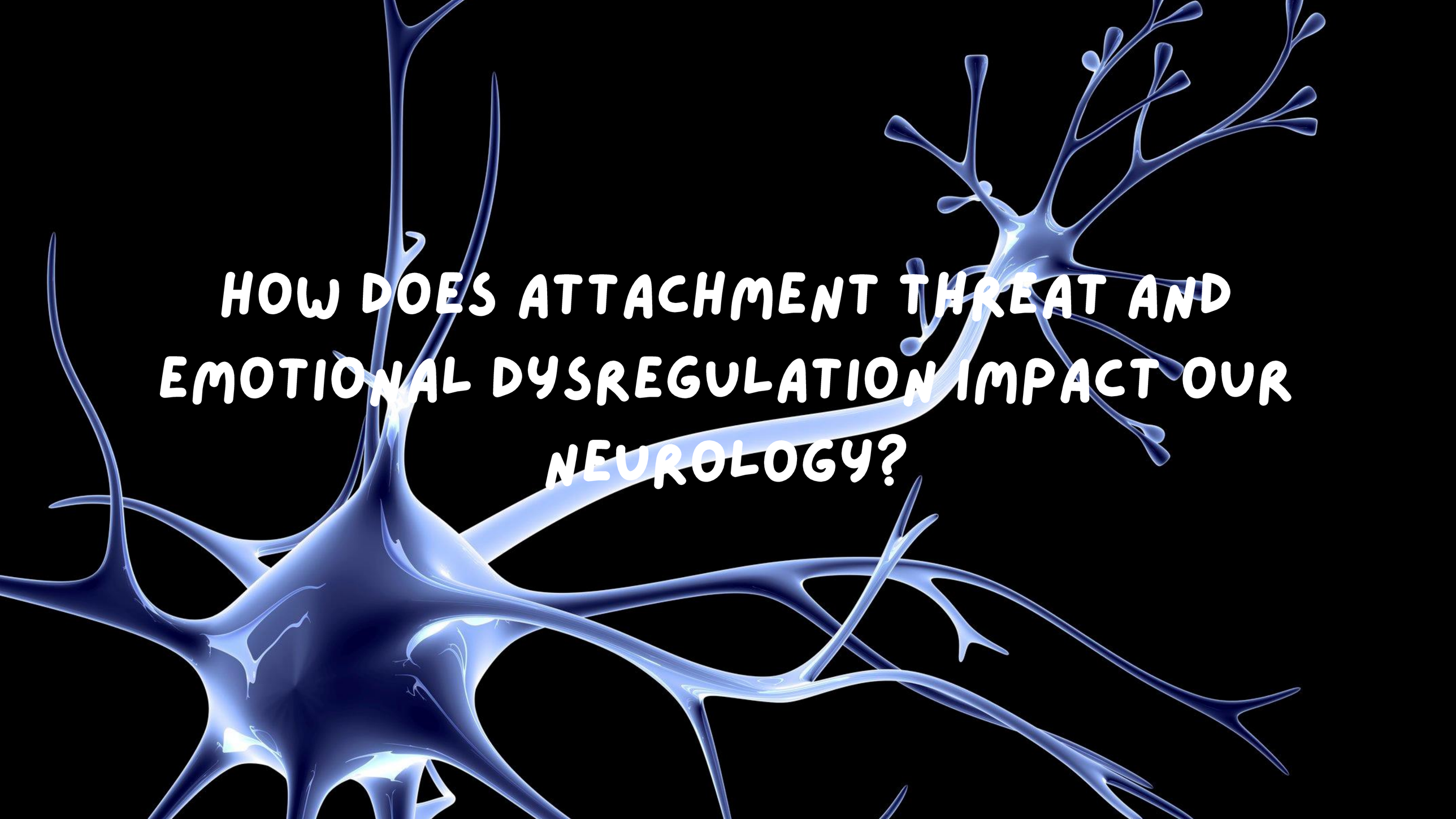
When caregivers are scary and volatile, children may freeze or leave their bodies, called dissociating, in order to feel safe. Relational situations feel inherently unsafe. They have disorganized attachment.

Both fight and flight circuits are simultaneously activated which is a biological paradox. It is experienced as fear without a solution, leading to dissociation for survival.

We are trapped in fear without solution.

We are neurologically feeling flooded the more hypervigilant we are for possible threats to the self cause by our inability to connect to our attachment figure.

In all cases, we do NOT trust our relationships to continue or meet our needs consistently.


HOW DOES ATTACHMENT THREAT AND EMOTIONAL DYSREGULATION IMPACT OUR NEUROLOGY?

Brains scans show that people who lack emotional awareness because we have shut down have lost interconnected neurocircuitry in critical areas. The more emotionally unaware we are, the less activation we show in an area of the brain known as the “insula,” a region involved in introceptive awareness – how aware we are of our bodily cues that tune us into what’s happening to us at the moment.

The neurological actions of chronic stress can also worsen our emotional processing, recognition, and regulation deficits. This can appear as a severe form of dysfunction in emotional awareness, social attachment, and interpersonal relating.

In all of these strategies our thinking and emotions are no longer aligned which interferes with our ability to accurately “read” the internal reality of ourselves and others.

See why vodka and gambling begins to make sense?

Theorist Philip Flores believes that addicts, even before their addiction kicks in, struggle with knowing how to form emotional bonds to connect to other people. This makes sense now, right?

In general when attachment security in our early lives is disrupted or inhibited, the activation of other important behavioral systems (e.g., exploration, caregiving, sociability) is also impaired. Fortunately, as we heal our capacity for attachment, we increase our ability to tolerate the anxiety that comes with exploration, caregiving, and sociability. We might even start looking forward to them!


Brain Integration, developed by being mirrored accurately, is the basis of secure attachment.

Name K.L.
Age: 40
Ethnicity and Gender: White, cis, male
Marital Status: Never married, Living with girlfriend of 2 years with her 2 children 3, and 9
Employment Status: Employed as Service Technician. Work has been consistent over the years. Strong work ethic when not using.
Referral Source: Girlfriend
Level of Service Client Entered Treatment: AIAT Outpatient

Treatment History:

Most recent Salvation Army 9/21 with 5 relapse episodes since.
Multiple residential, IOP, and RCP treatment episodes since 18 years old.
ALWAYS COMPLETES.

Has attended 12 Step groups, successfully at times, over the years.
Longest period of sobriety was 2 years in southern CA, when he had an N.A. men's group, worked with supportive co-workers who were sober, and was involved in a church. "They didn't know I was an addict, so didn't treat me like one." Relapsed when girlfriend abruptly left with her children (who he had been raising) and he was alone. Went to jail, then Salvation Army.
Denies "cravings" as he understands it.

Criminal Justice:

Recent Probation completion 3/22
County jail 17 times, Prison 5 times. Wide range of charges from fraud, grand theft, gun possession, drug-related charges. . . CRIME IS Co-Occurring Addiction with Meth.
STATES “I do well under probation and parole. I think the structure is good for me.” Does not commit crime when sober. When sober, volunteers with homeless.
Note: Eagle Scout when in High School.

Psychiatric History:

No prior psychiatric evaluation or treatment. Pt describes self as “high strung” and that he never stops thinking. There is suicide and bi-polar disorder in his family history. Prison Psych suggested he had depression but NO treatment offered.

Reports suicidal at 13 years old. Dad walked in to garage while he was trying to hang himself, and dad said, “So, have you gotten that out of your system?” and never mentioned it again. No further suicidal attempts.

Relationship history

Has been with under-functioning women with children then takes responsibility for providing for them. Adult children from previous relationships still call him “Dad.” Went to jail 3 times to prove he loved his ex. Current children are close to their bio-father who sees them on the weekend only. Bio-dad does not provide, so Pt is primary support for the household though girlfriend does work from home as a recruiter.

Family History:

ACES: 2

Parents alive and still involved in client care. Has one older and one younger sister who resents him as the “problem” child in family. Describes stay-at-home mom as harsh, cold, frequently told him he was going to “be like your grandfather” who had sexually and physically assaulted her. Used silent treatment as punishment. Dad, an engineer,is 1st generation Norwegian, and managed the household through anger outbursts. “Wait until your dad gets home.” Has mellowed with age, and pt feels connected to Dad. Parents solution to manage pt was to move to a ranch and have him work hard with the animals and property to keep him too busy to “get into trouble.” Over-control/Under-control family dynamics.

Withdraws from family when he is using heavily.

Note: History of being sexually harassed by older women at work since 19 years old. Once sexually assaulted when passed out by male roommate. Current sexually unwanted attention from female office manager. Girlfriend observes his poor boundaries with women on the phone, though he does not act on it. He attributes this to wanted to be needed and accepted.

Health & Nutrition:

Girlfriend works from home and prepares home cooked meals, including making his lunches for the day. No fast food. Drinks juices and milk, 2 sodas at work. Only medical issue is current shoulder pain for last five weeks. Will connect with primary MD, but some confusion over insurance. MediCal in Fresno – never transferred to current county. Might have Kaiser through work. Priority will be to manage this.

DSMV Diagnoses

Substance use Disorder:

Methamphetamine

R/O BiPolarII

Stated or Identified Motivation for Treatment (What is the most important thing the clients wants you to help them with?)

He is seeking treatment because current partner and boys are upset when he disappears. Usually, 1-2 months at a time when using. Has been relapsing since discharging probation in March. Last use meth use was last month, though drinks 1 beer 4x a week and cannabis nightly to sleep.

I. Current Placement Dimension Rating (See Dimensions below 1 - 6)
Stage of Change: PreC, Cont, Prep, Action

Dim 1	Action	(1)	Withdrawal consists of sleeping and irritability
Dim 2	Action	(1)	Needs a primary MD, MAT/Psych evaluation recommended
Dim 3	Prep	(2)	Craving may be expressed as anxiety; reports self as “high strung”
Dim 4	Cont	(3)	Is ambivalent about full abstinence.
Dim 5	Prep	(5)	Has multiple treatment episodes, and unable to stop relapse cycle at this time.
Dim 6	Action	(3)	Home and work is stable, though relationship is unstable due to anxious attachment coping skills and current substance use. Additional: Girlfriend is drinking heavily – states it is in response to his disappearing – and is unwilling to address this as it is not illegal.

ASAM 3:

Problem: Ongoing sense that he is “hijacked” by stress and cannot manage his impulse to use.

Goal: Pt will recognize desire to return to use triggers and relapse sequence to better interrupt cycle when it occurs.

Action:

• Referral to MD for craving and anxiety management to support emotional regulation and impulse and R/O BiPolarII

• Wear RPMbiosticker with daily log to develop greater awareness of physical cues preceding a return to use.

• Attend weekly Mindfulness/Nutrition support group to better manage emotional reactivity

ASAM 4:

Problem: Continues to fantasize that “functional meth use” might be possible for him, and that he can find a strategy to use without consequences.

Goal: Pt will identify the advantages and disadvantages of his relapsing pattern and its impact on his stated life and family goals.

Action:

• Explore past and current impact of substance use as the relapse patterns continue, including remaining connected to treatment team via text and sessions during relapses to clarify impact of substance use on his life in “real time.”

• Complete OMD Readiness to Change scale daily

• Develop willingness to utilize care coordinator and counselor support and interrupt a return to use as he moves toward abstinence from methamphetamine.

ASAM 5:

Problem: Pt continues to experience frequent return to use despite having tools to abstain.

Goal: Pt will employ harm reduction strategies as he decreases his methamphetamine use moving towards abstinence.

Action:

• Complete Change Plan Worksheet

•Identify relapse sequence and preceding triggers as return to use happens to clarify holes in prevention plan

• Identify alternative distraction strategies to support alternatives to using

• Develop willingness to utilize care coordinator and counselor support and interrupt a return to use as he moves toward abstinence from meth.

ASAM 6:

Problem: Pt demonstrates disruptive emotional escalation behaviors such a commanding, yelling, using drugs and disappearing to demand attention when perceiving his girlfriend or mother as emotionally unavailable, which alienates opportunity for support and leads to isolation.

Goal: Identify reactive anxious attachment strategies used when he perceives the other person has become emotionally unavailable and decrease escalation behaviors.

Action:

- Pt will complete his daily OMD log daily to track feelings of anxiety and desire to escalate, and work with his counselor to identify perceived behaviors in others that are triggering i.e. Girlfriend drinking
- Complete ACES, Attachment Inventory, AIAT RFQ, Resilience inventory, Social Networking Map
- When triggered, utilize Emotional IQ skills, cognitive reflective and emotional and empathy skills, and resilience strategies for more effective relationship connection to support ongoing recovery.

Contacted Erika, RPMsticker nurse monitor,
“*Thank you for checking up on me because at times I feel I don't deserve to have people who care about me but the fact that you're checking up on me now shows that I do matter and that this does matter, so thank you.*"”

Then goes dark for 5 days: Not responding to Erika or I
When he does: *I'm high and haven't been home. At work right now and hella busy. But yes for the most part I'm ok'.* My message: *'Hi K. . I hope you will still come tomorrow. Remember the goal is to get stable ASAP. Thinking about you.'*
K replied. “I’ll be there”

He said it was the first time he had ever talked about using WHILE using, and laughingly suggested that we were “fucking up his high.”
This relapse/get sober repeat cycle is harder than just staying in my addiction.

Pt presents as tearful, anxious that people around him can see he is impaired. Storing drugs at work.
States, “*You are the only reason I haven’t fallen further into my disease. You and Erika always seem to message me when I need it – non-judgmental.*”

Note: realizes his cannot be a functional addict – “losing my best friend” or PRIMARY ATTACHMENT

. “*You remind me of how a mom can be without the craziness*”. His mom: “You have to help yourself: You got yourself here.”
States that Erika and I pull him out of his self-pity.

Counselor discussed referral to local preventive care doctor, to addressed need to craving medication and support for his anxiety. It will be an out-of-pocket expense for the evaluation but we cannot delay further. Working to not be hijacked by thoughts and emotions. Agreed to make an appointment

"I shut off my conscience then you and Erika show up and act like my conscience. I can ignore my family because they are just trying to control my using. WE are conscience because we aren't biased – no personal gain for us."
"*Relapse planning makes sense now. I didn't try it when I was younger. Too much effort. I didn't know I would still be here 20 years later with bigger responsibilities and bigger problems."*

Always thought stress triggers his using. Now sees he was NOT stressed, but he was coming out of his skin, restless -CRAVINGS. Wanted to believe he was stronger than his biology – "*but I have been lying to myself abut that. I call it stress. If I have cravings its means I am not unique – I am an addict just like everyone else"*

Sees how his cognitive rigidity can cause conflict with kids.
Recognized urge to use over the weekend and was able to detail it. SEQUENCED

Been utilizing transition skills with boys and it is working. Looked at his “mansplaining” to his girlfriend and looking at the purpose of communication. Holds girlfriend verbally a hostage to make his point.

Struggling with feeling flat, hard to manage the lack of drama. Scheming and plotting creates the dopamine high! States Erika and I are the rail that keeps him on track.

Will zoom with MD tomorrow for final appt and get medication prescription.
Is increasingly noticing that when confronted by the strong emotions in himself or others, he down-regulates with drugs.

Started medication on Tuesday: Clonidine to sleep and Gabapentin during the day.
States he has been lying abouthis clean time, “chipping”– afraid his sobriety reflects on Erika and I and we would feel badly.

Counselor expressed concern about this and client states, “*Don’t want to change it (Erika and I) because you guys are keeping me accountable. You screwed up my high with guilt!* ****First time he has practiced honesty with everyone without repercussions.

Still struggles with a desire to be a maintenance user and get away with it. High from the sneaking – less than crime but less risky.

Afraid that recovery will not give him the option to disappear, and offers the possibility of failure. However, loves to disappear when hiking, camping. . .sees this is possible.

On medication starting to catch himself getting “worked up” on phone with girlfriend – talks self off the cliff telling self “*Not really that big a deal*”

States he appreciates the structure the RPM sticker offers to the IOP. “*I wish I had learned about these attachment skills when I had kids before*” Erika and I are in some ways antidotes to this critical voice because we stay connected without judgement.

Week 7 BIG DEAL – Called to AVOID using

FROM ERIKA NOTES: K.L. texted me and Mary early this morning at 7:11am PST to say *'I'm tired and wanna get high right now.'* I responded to this by saying 'Are you going to work today? Hang in there and make it to work first. Then let's set another goal after that. You're likely tired from the weekend, and that was the fun part that you can remember and work through being tired. Do you want to talk to Mary about your feelings too?'

He told her he was at work already and that he texted Mary as well.

He said he was using his support network and talked with his coworker as well. I told him this was good, that we are all here for him, and that I am proud of him for reaching out. I also told him to feel free to check in more today if he finds that helpful. He said he would. That last message was at 7:38am PST.

At 11:37am PST I messaged him to ask how he was doing and he responded that he was doing ok and that now that he was busy working he was doing well. He stated *'I'm glad I told you and Mary.'* I told him I was glad too and then told him to make it through work and then he can go home and get some rest. He then told me more about the weekend.

Something “clicked” this weekend and he asked his girlfriend to break his meth pipe that he had hidden in the closet.
On meds is feeling more in control of his reactivity.

Noticed he was being an “asshole” the day before and he was able to shift gears.
Girlfriend is noticing strong changes in client demeanor, More playful, more balanced.

Connecting the vulnerability of the kids in his home and his own vulnerability and how his innocence was distorted by people pleasing . Recognizes that he doesn’t want that for these boys, and he can’t just walk away – he matters to them.

Offered that he has more awareness of stressors and reactions when wearing bio sticker.
Noticing even when he is not wearing it because it has become a habit to pay attention to his physical reactions.

Actually danced at home when cleaning which stunned him. “*The meds are actually helping!*”
Still seeing rigidity in his thinking – wanted to point out how his boss was wrong today, but was able to pass it up. Noticing he is not lying sober.
Still triggered to remember using. He is using cognitive strategy, “*I don’t need YOUR(meth) help getting through this. I can do this without you*."

Erika called him noting shifts in his body temperature and heartrate. His baseline is beginning to develop since he has stopped using. Is going to meet with kid’s bio-dad today to ask about moving in January, so is anxious.
Notices that adversity is like growth mindset and it resilience building.

Took 2-3 hits of meth last night when moving incarcerated friend's car, and found a pipe. Threw it away. Sequenced:

Will keep close watch over him this weekend, as will Erika. He realizes this is the first time he has ever been able to see exactly how a relapse happens instead of "it just happens."

RFQ Hypermentalizing – Don't consider other's perspective

Bridging through relating, "*This whole thing AIAT is about connecting!*" Tying working on his hypermentalizing with management style.

Tearful – "*It's scary to leave it behind. Every time I doubt myself or feel betrayed by someone I care about I numb it with meth.*" (primary attachment,) recognizes he cannot use "recreationally."

Reviewed treatment plan again for progress he has made with recognizing his triggers, identifying his patterns and ways to interrupt them, and positive use of his support system – he is touched that It seemed so specific. Pt notes that in treatment he usually identified core issues but this is the first time he feels he is actually working on them -like shifting patterns with the kids.

He Recognizes Boundaries are too fluid – cannot see what is NOT his responsibility.
Tries to communicate wants and needs through grumpiness.
Notices his stress when the kids say “I love you” feeling the responsibility that comes with it.

Triggered to use – recognizing that feelings of betrayal from coworkers and girlfriend's emotional absence creates so much anxiety for him he thinks of using. States, "*It's easier for me to be angry. I hate admitting I'm* "*needy.*" Not needy, but values connection and it is a priority to him.

Met with couple, and addressed Pt's anxiety in response to disconnect when she drinks, which looks like nitpicking and criticism because he is not being honest about his inability to connect with her because he doesn't want to look "needy." She acknowledges that she is anxious he will leave again, and begins to look for signs and winds up drinking to manage her anxiety. Created an anxiety management plan with her with includes women's AA meetings/Al-Anon and individual counseling referral.

KL not used meth since last week, using vm videogames and girlfriend for support. Glfd has been drunk once, and pt was able to not use and call a friend to talk to. Developed Relapse Prevention Plan with a focus on attachment management. He feels he is running TO something and not AWAY from something, which is a new feeling for him. Smoking more cigarettes

Pt’s plan include “establishing healthy relationships in So Cal so I can’t bullshit.” Reconnect with church support, NA support, and Salvation Army.
Primary trigger is DISCONNECTION from grlfd and parents
Will continue monitoring by OMD nurse through move with daily check-ins
Will meet weekly with counselor on zoom
Stay on Clonidine and Gabapentin through transition to So Cal.

Text from K to Erika, OMD nurse: *Feeling like using. I've told [Gfd] and after I finish this I'm going to text Mary. Today was a lot trying to pack toys and clean out some of the toys. Had boys helping which wasn't much help, actually the opposite. Just didn't wanna just toss stuff that may be important to boys and have them think I didn't care. But fuck that was hella stress full. [Gfd] went to visit a friend and I started thinking I could get high. I ran some errands and ended up calling and telling [Gfd]. I'm ok and she's coming home soon. A little frustrated with myself right now but I also know this is to be expected. I don't wanna lose this momentum I have going. Greatful for this outlet to vent. Happy holidays*

3.

Step One: What Is My Attachment Style?

The first step toward applying attachment theory to *your* life is to get to know yourself and those around you from an attachment perspective. In the next chapter, we'll walk you through the process of determining your partner or prospective partner's attachment style based on various clues. But let's begin by assessing the person you know best—yourself.

WHICH ATTACHMENT STYLE AM I?

Following is a questionnaire designed to measure your attachment style—the way you relate to others in the context of intimate relationships. This questionnaire is based on the Experience in Close Relationship (ECR) questionnaire. The ECR was first published in 1998 by Kelly Brennan, Catherine Clark, and Phillip Shaver, the same Shaver who published the original "love quiz" with Cindy Hazan. The ECR allowed for specific short questions that targeted particular aspects of adult attachment based on two main categories: anxiety in the relationship and avoidance. Later, Chris Fraley from the University of Illinois, together with Niels Waller and Kelly Brennan, revised the questionnaire to create the

ECR-R. We present a modified version that we think works best in everyday life.

Attachment styles are stable but plastic. Knowing your specific attachment profile will help you understand yourself better and guide you in your interactions with others. Ideally this will result in more happiness in your relationships. (For a fully validated adult attachment questionnaire, you can log on to Dr. Chris Fraley's website at: http://www.web-research-design.net/cgi-bin/crq/crq.pl.)

Check the small box next to each statement that is TRUE for you. (If the answer is untrue, *don't* mark the item at all.)

	TRUE		
	A	B	C
I often worry that my partner will stop loving me.	☐		
I find it easy to be affectionate with my partner.		☐	
I fear that once someone gets to know the real me, s/he won't like who I am.	☐		
I find that I bounce back quickly after a breakup. It's weird how I can just put someone out of my mind.			☐
When I'm not involved in a relationship, I feel somewhat anxious and incomplete.	☐		
I find it difficult to emotionally support my partner when s/he is feeling down.			☐

RESILIENCE ASSESSMENT

Responses to Stressful Experiences Scale

The following statements describe how some individuals may think, feel, or act during and after the most stressful events in life. Please indicate how well each of these statements describes you during and after life's most stressful events.

4	3	2	1	0
Exactly Like Me				Not at All Like Me

During and after life's most stressful events, I tend to …

1. …take action to fix things.
2. …not give up trying to solve problems I think I can solve.
3. …find a way to do what's necessary to carry on.
4. …pray or meditate.
5. …face my fears.
6. …find opportunity for growth.
7. …calm and comfort myself.
8. …try to "recharge" myself before I have to face the next challenge.
9. …see it as a challenge that will make me better.
10. …look at the problem in a number of ways.
11. …look for creative solutions to the problem.
12. …put things in perspective and realize I will have times of joy and times of sadness.
13. …be good at determining which situations *are* changeable and which *are not*.
14. …find meaning from the experience.
15. …find strength in the meaning, purpose, or mission of my life.
16. …know I will bounce back.
17. …expect that I can handle it.
18. …learn important and useful life lessons.
19. …understand that bad things can happen to anyone, not just me.
20. …lean on my faith in God or a higher power.
21. …draw upon lessons learned from failures and past mistakes.
22. …practice ways to handle it better next time.

Scoring and Algorithm

Note: For each assessment, there is a scoring algorithm leading to one of three acuity ranges: Low, Moderate, or High The items are scored 0-4 as described below.

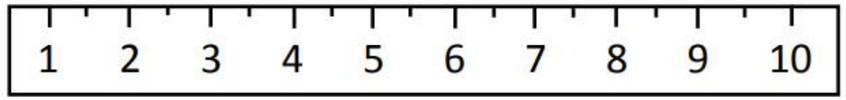
Total score is sum of all 22 items, possible range 0 – 88.

Algorithm

Total = 71 – 88	High Resilience
Total = 50 – 70	Moderate Resilience
Total = 0 – 49	Low Resilience

Substance Use Motivation Ruler

Are you motivated to end your substance use? Rank your motivation on the ruler from 1 to 10. A "1" means that you have absolutely no motivation to end your use. A "10" means that you are completely ready to be sober, and have no doubt about the decision.



Why is your motivation where it is? Why not lower? Even if you marked only a "2" or a "3," there must be a reason you didn't write "1". List some of your motivators.

1 _____

2 _____

3 _____

4 _____

5 _____