SW CEU_ Adolescent substance use_ Trends, the Link to Insecure Attachment and Implications for Treatment-20241121_120355-Meeting Recording

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Disorders.
As well as a lot of comorbidities.
And that's been in different levels of care, everything from twice weekly talk therapy all the way up to inpatient and then different approaches as well.
Abstinence based approaches, which are fairly common in the field and then did harm reduction for a little while when I was out in San Francisco.
So I'll try to bring a flavor or some perspectives to all those different sort of situations where you have a kind of wide array of individuals that may come in contact. I know this is a hospital setting and so a lot of times people are in crisis and.
I think you have.
You have outpatient services.
I think Kendra told me as well anyway.
So today we're talking about adolescent substance use.
Where are the boy?
I sound really when I say it's where the kids at, what are they doing and then how does someone go from initiation?
Their you know, this doesn't happen anymore.
I'll get to this, but when I was younger, you would go to a friend's house.
Their parents would be gone and they'd go in a liquor cabinet.
Or someone would have some.
So how does someone go from initiation to disordered use and then even beyond that, how does someone go from a substance use disorder, which is a fairly low threshold to reach, you know?
Impacting elements of the life all the way to something more severe, like sort of what we might call addiction.

And is there a connection?
Then there's a lot of different lenses by which you can look at substance use disorders.
Is there a connection to attachment? Has been used increasingly in research last couple years to think about different diagnostic perspectives in the relationship between we can think of it in a continuum of secure versus insecure, which is pretty common in research to have that access.
What's the connection here with substance use disorders and then ultimately, even though my primary focus right now is on the research side of it, at heart I'm a clinician?
So what does this really mean for working with people?
So I guess to begin, you know, I always like to figure out the story like why?
Why even talk about this? You know, the first one is it? And I think Alexis kind of framed it a little bit.
You know, it's sort of something that's there for people kind of wondering what's happening. It's obviously important.
To educators, police to parents, politicians, different stakeholders in society have different levels of interest in this.
But even the teens themselves have a lot of interest in this type of thing.
Obviously it costs money, so they're, you know, a lot of times illegal activities.
So they worry about getting caught.
Or, you know, obviously we know with the risk of fentanyl in a lot of the drug supply, the concerns about whether or not someone could overdose and those things are communicated among.
But the other reason that youth have been at the spearhead of social change.
You know, particularly over the last 50-60 years and that it's certainly true for substance use disorders or substance use in particular.
And so when we look at the changes that have happened in the last six or seven decades, 11 has been a youth movement, particularly when we think about the 60s.
When we first had or maybe our most.
Kind of middle of the 20th century drug epidemic.
Up to what happened in the mid 90s, which was this kind of phenomenal burst in terms of substance, uses all sort of a youth movement. And then on the on the micro side, obviously if you're a parent, if you're even a teen, you know the question is you.
Know a certain percent of individuals that initiate use are going to end up with

disorders and then a certain number of those are going to not.
Naturally, remit these are going to persist with people.
They're going to cause all kinds of problems.
And beyond that, even just with the advancements in terms of how you can get substances and I mentioned fentanyl in the communities in the drug supply, really someone can expire or pass simply by having interest in trying drugs and have an Instagram account. So you know it's sort.
Different interests in here, though there are some really good indicators in terms of the overall.
Way in which teams are using which we'll talk about.
Let's take a look at the history here.
I think it helps put people in perspective a lot of times, especially for clinicians that are working with adolescents, and particularly those with comorbid substance use disorders or Co occurring disorders like times they're surprised at what I'm going to say in terms of where youth are at current.
Because there's a a view that this is a a, a really large social issue and it it continues to get worse.
And let's let's try to put it in perspective here. So in the 1960s is where we saw.
Really a, a a drug epidemic?
Obviously I'm 52 years old, so it's, you know, before my time, but.
The the visuals of it, you see individuals smoking cannabis or, you know, the LSD movement.
So there was just a real openness to it, a perceived lack of low risk, a lot of availability.
And then in the Seventies, 80s and 90s there were just sort of lot of different declines and rises.
LSD went down in the 80s. Cocaine.
Went up in the 70s and 90s and then I mentioned this before research I use.
There's two really large data sets when it comes to the epidemiological perspective on substance use.
One of them is Sam's annual.
Annual study. And then I use the monitoring the future.
It's based out of University of Michigan, but it's really large.
It's very good methodology, so I tend to.
To use that and the authors of it talk about the relapse phase in the mid 90s sort of

inexplicably, there was just this rapid rise in substance use across all substances with really without explanation. And then all kind of calmed down in 1997, again without expl.
So up to the pandemic up to the 2000s and into the 2000s, what we saw with team use was a rise.
And this is not going to be surprising. In prescription opioids, tranquilizers, sedatives. But everything else started to go into decline. When we look at things like cocaine or stimulants or LSD, even cannabis was going into Clin. And then the well, 2018, I guess, before the pand.
The.
I think you could probably call it the jewel effect, but.
Vaping became really popular with teams and so we saw nicotine in cannabis use to sort of spike it just sort of went up and we started to see this clinically at Newport really being problematic because the drool, a lot of the vapes, you know, they're really sleek and.
Small and they can stuff them in their pocket and they were going into the classrooms and you know the same thing.
They're smuggling them in into treatment.
And then the pandemic hit and everything went down.
Really, some of the lowest recorded use histories and a lot of the explanation was that kids were on lockdown and therefore didn't have access to it.
And I think that's only a partial explanation. Even before the pandemic, when I would walk around and talk to the teens, they were not going out on the weekends and substance use initiation is largely a social.
Event again.
I talked about, you know, go to parties.
You do different things.
The the fact is.
Don't do that anymore.
They're getting their driver's license.
Later, they're not dating as much.
They're not having sex.
I mean, again, on some measures you can say, oh, those are good things, but they're not hanging out with each other, which is a large way in which people communicate.
How do you substances where to get them?

Obviously there you know. Could what they're doing right now is they're on their phones on the weekends and then post pandemic. We were sort of monitoring and watching, seeing what would there be a rebound effect after the teens were.
Set free, so to speak, and it really hasn't been the case.
They've sort of remained at these.
The the pandemic levels the pre pandemic levels so it really in a lot of indicators.
Substance use is is trending down now.
The the unfortunate side of that is that once teams move out of the home or they go to college or, you know, obviously it could be both.
We're also seeing rapid rises in substitution young adults, so.
It's not all good. Even though the teens are using less once they get an opportunity to get outside of the home, they're kind of really going crazy a little bit.
Lots of parallels to just the overall youth mental health crisis, where you just see teams that don't have a lot of exposure, don't have a lot of opportunities for resilience.
You know you you go to a party in high school.
You you get overindulged, you make a fool of yourself.
You're really embarrassed.
You choose not to do that again.
And that they don't have those type of experiences. And so they go to college and then sort of go off the hook.
Then we take a look at this again.
Interestingly, some good indicators here.
The number of people that have never tried any substances has increased.
This is 2023, but increased significantly for 10th, 10th and 12th graders.
Again, any illicit substances near pandemic levels, marijuana dropped considerably, and we do think it's largely related to the fact that teens are not vaping as much.
That might, again, depending on the population that you work with team not to reflect you. What you're working with and what you're seeing and what you're hearing.
So I'm just talking about from a general.
Representative sort of sampling of the country that we're seeing, that vaping is going down and associated that cause teams are less likely to use cannabis as a leaf.
Cannabis, they're much more likely.
They're more likely to use it in a vaping device, and vaping is going down.

And then heroin, we're already starting to see.
At least a one year indicator of significant drops in deaths from opioid related deaths.
And heroin is the the teens are not using it.
They're not using narcotics.
It's really very low.
So, but it's not all good news.
There are some important changes.
There are a lot of new drugs on the market, like for example. Then when certainly when I was a teen, but even more recently, people that are millennials.
New and stronger drugs the advent of synthetic marijuana, K2 and spice.
Were the concentrates of cannabis the dabs, the wax crumble. All those things are relatively.
New and you take a look at something like Dad's, which her butane hash oil or cannabis concentrates. If if I would have, you know, like you said, fair enough to share it it, you know, back when I was in high school, the average cannabis was about four.
Percent THC. If you go into a state marketplace now and purchase leaf cannabis, it's about 20% THC. So about a 500% increase.
Typically from when I was a teen, but you can get concentrates that are 95%.
So really it it it really is difficult to kind of know what we're getting into and sort of in a large experiment. And then there's all sorts of other drugs that have emerged.
Kratom, which is an herbal extract that attaches to the opioid receptors. We saw a lot.
With Dexameth or Phen with Skiddling or robo tripping from core sedan and Robitussin overuse.
So there's and then you have different devices vaping.
In the hookahs those were hookahs, obviously been around for awhile but vaping is not and so that introduced a whole new generation of individuals in the substance use in particular because a lot of times they're odorless and very easy to use.
Again, what we were hearing from the teens was they would take these in filled with THC and they go into the restrooms, take a few hits of it, come back, go to the classroom.
Nobody smells anything you don't.
No other signs of and you can do GHB. You can do LSD.
Those, I think, ketamine.

There are other substances you can't put a note to cloud the filters like you can't put heroin into them, but I'm sure that there's some, you know, Silicon Valley people. Trying to address that right now and the new ways of obtaining back when.
The way I do sound like the you know, back in my day.
So typically if you wanted to purchase substances, you do it through a relationship. You you knew somebody and you met up with them or you went to a drug source location. Often inner cities and you purchase of the street. There was a way in which you had to go through these processes and that's not the case today.
You can purchase drugs through Instagram and Snapchat a lot of.
Not a lot, but teens are doing that.
But they also are using this end to end encryption devices like WhatsApp and Whisper, so you can't trace any of it.
And then there's darknet.
We don't see a lot of it.
We don't hear a lot of the teams talking about Darknet drug purchasing, but if you've ever seen it, you've ever seen it demoed or videos of it. It is super scary.
It looks exactly.
Not exactly.
It looks very close to Amazon.
So when you go on there, you put in fentanyl and it shows you different fentanyl options.
And then it just gets mailed to you through, you know, through the mail.
Really scary stuff again.
We didn't see a lot of it.
We're not really quite sure they knew about it.
Maybe they weren't telling us, but we didn't really see that a whole lot on.
We don't really see that a whole lot on our end.
So when it comes to factors in use, I mentioned that a lot of it has a lot of. It is initially socially based social determinants of health, which you know I have a whole another talk in terms of how NIH moved away from social determinants of health. Research and funding and really just focused on, quite honestly, quite honestly, just brain science.
It's really unfortunate because substance use and substance use disorders are very much socially part of the social contributions are very much.
There. So there's age effects.

So this is where you have changes in beliefs and perceptions and behaviours across multiple cohorts.
For example, an eighth grader has a less positive view and is less likely to use than a 10th grader.
1/10 grader has a less positive view of substances and is less likely to use in the 12th grader and then young adults are the most likely most positive view of substances.
And then there's period effects. These are changes that happen across all cohorts over a period of time.
So going back to, let's say the 60s, well, I guess.
You know, I mean, you could think of the 60s as a period effect, but I know it kind of stopped.
At a certain point where you didn't really see an adult, but you really saw a large portion of individuals have a very positive view of substances over a period of time, you know 1965 to 1975 or some period in there. And then there's Co.
Effects. These are where you have changes in attitudes and behaviors based upon.
The time when someone is born that follows through with them as the cohort ages.
Now you we could still use like hippie generation and their very positive view of cannabis and LSD.
You could, if you find people that are part of that generation, they probably still have a very positive view of both those drugs today and it really comes down to these three things, perceived risk, perceived availability and perceived acceptability. I can give an example of.
A.
You know the opioid epidemic, the most recent opioid epidemic, has often been attributed to an unscrupulous pharmaceutical company.
That targeted vulnerable populations, such as mining towns or inner city environments or or physicians that didn't know better.
That's part of the story, but there's a lot of different elements in there. When we take a look at when we take a look at the opioid epidemic, so perceived risk.
When it was in the form of a pharmaceutical or a pill.
The idea of it being risky was really reduced much different than having to stick a needle in your arm.
People were at that point the American Pain Society had advocated for pain to be the 5th vital sign.
And so physicians were asking people if they're in pain and then being told to

prescribe.
So they were very available at the time. And then if you know I'm I'm a I'm a doctor. But you know, a lot of people because I don't have an MD.
Don't believe you? Me as a you know it's different than a real doctor.
The one that wears the coat and they have a sort of secular.
Priest sort of space in society. You go see them when you're at your most vulnerable. Your body's often.
Many times it's, you know, compromised that might be mortality risks involved. And so you're just there and the person has this coat on, they have this, this prefix of doctor. You just kind of like, OK, whatever they tell me is probably a good thing. Whose lot of acceptability around it.
So this is how this is a large contribution. When we start to see movements and increases and declines in substance use.
So when does it become a problem?
Not surprisingly.
If someone initiates substance use as an adolescent, that's typically when we start to see it being a problem.
In early use increases the risk and I'm going to give some statistics here and then I'll I'll provide bit of a caveat to it. If you have a patient that starts using before the age of 14, they are at the highest risk about little more than one in.
Three lifetime risk for a substance use disorder.
And then each year between 14 and 21 that the the delayed a delay in initiation, the lifetime risk goes down about four or 5%.
And that sounds pretty clear.
And OK, if I just prevent my teen or the patients from starting use that a much less likely chance of becoming end up with substance use or I don't really know that that's the case. The authors of these studies sort of offer similar interpretation.
It may just be that individ.
Schedules that are vulnerable to substance use disorder tend to gravitate towards substances early, and they were just as likely to end up with a substance use disorder if it was delayed later.
We just don't know.
You really would have to do some experimental designs, which I don't think any IRB is going to going to approve in this day and age, but we do know that the more severe an adolescence, the more likely there are to extend into adulthood.

And not mature out now when I I mentioned some of my profession, my clinical history.
I worked a lot with people with very severe chronic, relapsing conditions.
And I knew about the maturing out natural remission literature, which said that a lot of people with substance use disorders get better without treatment or without involvement in 12 step programs.
And I I largely ignored it again.
It just wasn't speaking to the patient population that I was seeing. I since I've turned around back to it and have gone back to literature.
And do agree that there are a large number of individuals for whom this is true. If you went to, you know, if you think about your undergraduate experience, you probably met.
Or maybe it was yourself.
A lot of people that over consumed impacted your grades impacted your relationships and then you get out of college and you, you know, you become an adult or you know whatever you define as a term and you kind of change. And so that that's actually fairly common espe.
Because young adulthood is the most.
High, high risk when it comes to substance use.
But again, if it's more severe early on, the more likely this is a chronic condition.
Why though?
So going back to this social element, so even when opioids were perceived low risk, they were highly available.
And they were highly acceptable to use.
It still was only a minority of individuals that tried opioids that ended up with a disorder.
So what's the difference between them and somebody else?
That uses and doesn't have a problem with it so.
We're now going to start to narrow it down a little bit further. A lot of us, one of the common questions I get or assumptions I get when I've worked with families is around the genetic component.
What's the genetic load for substance use disorders? And it it actually is fairly substantial.
So that if you have a family member with a substance use disorder, you are, you know, interestingly up with this sort of.

In here, most genetic studies on substances source don't actually look at genes.
They look at twin adoption studies, but the math is good.
But it ends up being moderately to highly heritable. But like with other conditions like obesity or heart disease, there are definitely environmental factors that come into it.
And it has a lot to do with the degree of relationship.
So if it's your father or mother versus a cousin or grandparent, you're much more likely to.
Be to have vulnerability to compulsive use and disorder, and then we think about something like the field of epigenetics.
Epigenetics is the idea that evolutionarily we based upon experience or we or our genes get turned off or turned on during the course of life.
And it's a moderating effect for stressors for events.
It has evolutionary value.
It's good that this happens, but we also have pretty good understanding that there are.
Events that happen in particular early on, and I'll talk about early life stress in particular with the hypothalamic pituitary.
Adrenal access.
That confer vulnerability to compulsive substance use based upon the genes.
Some genes turn it on and some genes turn it off. Have been said that substance use disorder probably lies at hundreds of genetic Loki.
Each one contributes a minute amount.
We may be mapped a couple of handfuls of areas, so I really don't know.
That will, I guess, with AI and quantum computers.
There's hope that we'll ever figure out the brain, but generally speaking, it's probably pretty far off that we're ever able to fully map and understand from a genetic perspective.
This is again, not the soapbox here, but This is why I do think NIH, and I'm not the only one with this opinion, has been somewhat misguided in its almost.
Love affair with brain science?
It's, I think the general public has a much more confident view of what it tells us than it certainly does for me.
Early life stress may increase the risk of.
Pituitary hip pituitary adrenal axis.

It's like your internal thermostat that is another moderator of stressors.
It impacts things like immune system.
Metabolism.
Oh, don't dynamic nervous system responses to early life stress. Most of us are familiar with the Aces studies. The Phillips Aces studies, and it's the data's pretty hard to argue.
Aces has 10 questions. If you answer yes to six of them versus 0, you are 4600% more likely to stick a needle in your arm.
So again, we can see a clear association to early life stress.
That we do think impacts the HPA axis.
In a way that makes people just respond differently.
They don't moderate stress in the same way. They're the thermostats lower, so it kicks on quicker.
And then in more recent years, we've started to take a look.
An additional dimension of substance use disorders and it comes in the realm of attachment research, real quickly and obviously most people or everyone on this call is familiar with John Bolby and the work that he did.
But, and he wasn't the first one to say this, but he's the one that gets credited with this idea.
Really solidified it.
Made it part of our vernacular.
Where he was an ethologist and a evolutionary psychologist.
And basically what he said, with certain mammals and certain animals that are born too vulnerable and in order to survive, they have to connect to a caretaker. You know, I have a 10 and a four year old and even my 10 year old couldn't live on his own.
Very well, he would perish in a day or two, I think.
We're just not very.
We just mature very, very slowly and we have to stay connected to them.
If we do that, then we can have food, shelter and water and safety and all those things. And then you know after that then.
Mary Ainsworth came along with a strange situation study and saw that there were certain styles of attachment that tended to emerge in infants 9 to 18 month olds.
And they really were.
Responses to how do you handle negative experiences in close relationships?

How do you regulate affect?
How do you express these attachment needs?
And she came up with the three secure, anxious, and avoidant.
And then later on Merrymane came along and said, hey, there seems to be this one that seems to be a combination of anxious and avoidant.
She called it disorganized.
So there's four that most people identify again from a research perspective, a lot of times it's just to secure insecure access. A lot of times, avoiding anxious is kind of combined and DISOR organizes not often included.
Something has to do with the measure issues.
One of the things that you know is important here and a question that's been raised ever since John Bolton presented this was OK.
How stable is that attachment security attachment style?
So that Mary Mayne at Mary Ainswor strange situation, infant, if they're identified as securely attached at one year, how likely are they to be securely attached at 20?
Or vice versa, if they're identified as insecure attache attached, and this is particularly well evident for adolescents because their.
Social environment is changing rapidly.
They have new friends there.
Maybe have mentors.
They're finding other adults to kinda look up to in a way that I wasn't available to them.
You know, if it's coaches or things like that available to them when younger and So what we do see is that parents are still important.
And and adolescents is generally a time of stability, so that most people, if they're whatever their attachment style is at 9 months to one year, maintain that style when they're 20.
But like for example this Jones and colleague study was a longitudinal study of adolescents who had had this strange situation.
Experiment done to them. As you know as infants. And we do see though that experience can change a person's attachment.
Security position or their attachment style and for them they saw that parental conflict was likely to take someone who was securely attached and move them over and to insecurely attached. And then with people when divorce happened that ended up in people with anxious attachment. So even though it.

Fairly stable.
It does.
It does.
It is impacted by experience.
That's really important when we get to the treatment perspective around all this, because if it's sort of set in stone, you know, like, OK, what do we do about that? But if there is the chance for new experiences to override that relational template, that's really important to know.
So.
Do find it useful to.
Spell this out a little bit by a little bit.
Context provide you know for the clinical side things so secure, enjoys relationships, positive view of self, OK alone anxious these are hyperactive strategies for closest and focus on their own distress and availability of others. You might see this clinically this is you know I worked I remember in.
Residential. These are the patients that you walked in Monday morning.
And they're already at your office door, and they need to talk to you.
They are hyper attuned to your mistakes to when you don't seem available or ready and interpret that in a live sort of.
It it came.
It's not as aggressive. It can be aggressive at times, but it just it's a real clear awareness about.
Your availability and sensitivity to their distress.
And then avoidant, you know, distancing strategies, you know, these are the these are the patient's.
Report things are fine.
They're they're not.
They they don't seem particularly motivated for closeness with the with the therapist or or or whatever.
I I do point out to supervisees and to you know, to to people that going back to this idea of how you communicate, attachment needs avoidant, even though it's John Wayne, I don't need anybody.
I can take care of myself.
That actually is attachment communication.
We are designed.

Evolutionarily, to connect to others, and when we deny that that is a way of responding.
You know, potentially to the fear of being hurt or the lack of trust that the person's going to reciprocate or be consistently available. And so as a defense to that they become avoidant in the world.
And then you have disorganized, which is kind of mixed features of both.
I hesitate to use this, but it helps.
It helps conceptually the most common diagnostic equivalent to this.
Obviously his borderline personality disorder, or the so-called you know, come here and, you know, come close or not that close.
That that, that is that that's the probably the closest diagnostic approximation to disorganized.
Tends to be the most severe psychopathology.
You know, really difficult to treat because you're sort of left flailing as a clinician, as a person trying to work with him.
You know 'cause it it you, you have a great session with him and then they skip the you know.
Then they don't come to the next one or they're angry at you the next one.
You're like I I don't know what happened.
I thought we were.
We're doing pretty good.
So how does this?
How does this happen?
How do we get secure attachment?
No, the theory is bulbi's theory.
Is as largely pushed through experience.
In in largely through this initial caretakers. Now when we get to risk factors, I want to be clear here.
That it's more complicated than just experience, and it's more complicated than just the caregivers.
The reason I want to provide that.
Larger perspective is because in the 50s I think it was the 50s, there was a term that went around called refrigerator moms.
And it was an explanation for the origins of severe autism and schizophrenia, and that the mother in those environments was like a refrigerator, was emotionally cold,

and that was the that was the a narrative that went around was very blaming.
Not very helpful.
And so I want to be really careful here that if.
A client, if a client of yours is insecurely attached, this is not meant to infer what their childhood experiences were like, and the parents were failures in that regard. You know, I like I mentioned, I have two kids.
I have.
You know, every day I feel like I'm, you know, I don't know what I'm doing as a parent and I'm trying to adjust. And I sometimes I feel great.
I know what I'm doing.
Other times I'm like, OK, like I already see him in therapy.
At 25, talking about his dad.
But.
General thinking is Child has an attachment need going with my like my son skin's his knee, he comes home, I put down my phone.
I check in with him.
I see it's not a big scratch, but he is bleeding.
I get a Band-Aid for him.
I check in with him how he's doing.
I clean it up.
He feels like he can come to me, he's protected, and then he's more likely to seek out support in the future and feel like this is a safe place.
Insecure attachment.
So I'll use that same example.
My son skins his knees.
I have some issues at work.
He comes home, comes in the house. I'm on my phone.
I'm not really paying attention to him, I tell him.
Hey, look, you know. Go, go wash it and put a Band-Aid on.
And what he really wanted from me is just confirmation, and it's not really bad. And he just wanted a little bit of support. And if I do that consistently enough, he's gonna feel like I'm just not responsive or misattoned to him.
He would feel unloved and unprotected.
You can have low expectations of others and for support and protection and struggle to explore and self soothe. And this is also part of the explanation as to why

somebody would, even though they had bad experiences, would seek out relationship partners that do the same thing to them.
Because it there's a familiarity to it. You kind of know what to expect.
OK, this I'm going to or or.
Some people think it's also the idea of.
A repetition compulsion.
I'm going to fix this in this new time this.
This new partner will repair whatever happened before, so risk factors.
There's child determinants temperament, which is largely genetically driven, has a lot to do with it.
MY2 boys.
My youngest boy loves being outdoors.
I like hiking.
I like being outdoors.
I like getting dirty.
My older child is a house cat.
He would rather play video games and and read.
And never step out of the house if he didn't have to.
I have a much easier time connecting with my younger son.
I like to read and I like to stay inside too.
But as far as like the ability to connect, I don't play video games.
And I like to go outside. And so part of these are child determinants. You know how they're fit with people.
There's life events that again happen outside of the family. If there's neighbourhood stress, if there's financial stress.
The all sorts of things.
You know, it's obviously sexual abuse or physical abuse, caregiver stress.
It is very stressful to be alive today in general.
I know I remember like last month I got a flat tire and just how difficult it was to rearrange everything and to go get the tire fixed.
It's just something simple, much less if you have. If you have illness in the family, where there's mental health issues in the family or there's other siblings that are the children that are having issues, it is really run into or, you know, loss of job or obviously we.
Know from.

You know, the recent elections that a lot of people are are are reporting feeling.
Less optimistic about their financial viewers, you know, true or not, that's you know how people feel about it.
And then family interaction patterns, you know, kind of in there a lot of times low, low cohesion, low warmth is is typically attributed to insecure attachment.
So what's the connection here?
Well, let's go back to substance use.
We know that securely attached children.
Or less. They consume less substances.
As teenagers, and they're also not only just less substance use in general, but less heavy substance use.
I don't want to over interpret that as I mentioned previously, that does not. Is not a causality factor.
It could be that individuals that are insecurely attached already have a predisposition to a substance use disorder, and it was going to happen anyway.
But again, you can see some of the associations here.
But when we look at particularly.
Substance use disorders.
I don't know if you can see it, but you move this anyway.
I think it's fine.
The the the literature is pretty robust.
This Schindler article from 2018 is a great one around the link between substance use disorders and an insecure attachment.
Repeated repeated studies have shown that and it's even stronger for adolescents.
And we also know that there's evidence that substance use disorders themselves.
Impact attachment security.
Kinda makes sense.
The teen is maybe being dishonest. They're stealing.
There's they're doing different things.
So the parents become more scrutinizing or more laissez faire or whatever it is.
But it results in the negative impact of the relationship.
Look, this is where hopefully we can get into the meat of it.
So what does all this mean? So basic treatment considerations.
You know, one of the things that has always struck me and I it's always difficult to work with families around.

They it's particularly recently unless you know.
Five or ten years.
They any indication of substance use often creates a great deal of fear and anxiety.
And what I try to tell them is it it's it's normal, this is.
I'm not saying you don't pay attention to it, but risk taking, particularly in Eastern, I mean Western society is built upon risk taking.
We we encourage our teens to try different sports.
To try to, you know, they try different hairstyles.
They try different clothing, different friends.
They may try romantic partners for the first time.
This is largely supported by us.
We may not directly say, you know, go out, have sex or go out and, you know, use substances, but it's kind of an expectation, especially for, you know, Gen. X and older that you know where it was very common.
To parents to sort of turn an eye to some of these things. But the other piece here.
It's also biologically driven to take risks.
And I have the you can see a little figure down below there.
So there's different ways of considering brain development.
One is the the bottom up question. The subcortical on up and you can see there the red part is a curvilinear view.
Where there.
That's the.
The activity, the motivational stimuli, and the inflection point, largely between 13 and 17.
So 13 to 17 year olds, when they get presented with something that is around motivational stimuli, there is like you know, let's do it.
You know what you think about it versus do you see the linear, the line there that is frontal cortex?
That's the sort of top down perspective. That's a much more linear growth and development. This is why we say that.
People don't have full executive functioning until their mid 20s.
So again, biologically, we're just going to expect teens to be more risk taking, including with substance use.
And this ties into something called tempor this county, you may have may not have heard this before.

This is true for all adult for not just adolescents, but for all adults. Temporal discounting basically says neurologically.
When you try to project your future self, your brain basically views that future self as a stranger.
In in this case for the ERNS or Hirschfield and colleagues study, they were looking at whether or not people with people would save for the future.
So they would give them information about the importance of it, and then they'd follow up behaviouri. And did you make any changes to it?
And they would do functional MRI studies to see parts of the brain that are involved in executive functioning and planning and motivation and.
Again, you can see the the some of the.
Brain graphs down below and so essentially one I tried to tell parents one don't freak out if it's a single incident or you have some. You know, they're experimenting with things.
That in itself is not that bad.
The other piece is I tell people and this is for clinicians too.
Moralizing or telling people about future danger largely is not help now.
It doesn't mean that you don't say, hey, be careful. You know, you may have fentanyl. In that Xanax pill that you purchased that you thought you know, so they gives him a little bit of worry.
But from a neurological perspective, telling the team that if you continue to use at some point in the future, you may end up with real problems. It's equivalent to going up to a teen and saying, hey, you know, if you continue to smoke weed.
Some random kid in Texas that you've never met is not going to get into the college that you don't want to go to, or you want to go to. You know, they want to go to.
Is that what you want?
That's essentially what their brain is hearing on there. So it doesn't really help to do.
Feature casting, especially with adolescent their brain just isn't there again.
You might as well be talking about some random person in Brazil for how they're emotionally going to respond to that.
Abstinence is good.
I sound like.
A.
South Park. You know, Mr. Mackey, drugs are bad.
Abstinence is good.

Most treatment programs are abstinence based.
A lot of times you run into issues, especially with referral options too.
It's another reason why there's typically.
An absence.
Focus. It helps in a lot of ways.
You know you a lot of times, there's comorbid conditions.
I cannot properly diagnose if I don't remove one of the variables and you can't just remove depression.
So the easiest thing to do is control for the substances.
So you remove the substances a month later. The depression still exists, OK?
We have a separate depression condition versus you get abstinence and the depression goes away and you're like, OK.
I kind of see the relationship there.
But it's also a potential complication.
One primarily, especially if they've had early life stress, if this it is a coping skill.
We've taken it away from them and.
If they're not buying into treatment, if they're not buying into other things, they can actually get worse.
So it is a potential complication around it, just something to kind of monitor with people and I know harm reduction with adolescent seems to me when I first heard about it, it seemed kind of like what are you talking about?
But there is advocacy for harm, you know, for adults, it seems a little bit clearer for me.
I've worked in that environment.
Adolescents like I don't let you know. I wouldn't ask my.
Son, before he's 18, you know whether or not he should eat vegetables or do his homework.
You know you don't.
There's a lot of things in life.
You know that we sort of take away the decision piece from adolescence because we don't expect him to make good choices. And so the idea of, like, hey, you know, let's make sure that you don't reuse needles for 16 year old. Seems really kind of alien to me.
Seems.
But there is advocacy for it, and a lot of it has to do with the idea that it doesn't

match the positive views that adolescent have towards substances.
So what would you rather have?
Would you rather have somebody that's talking honestly about what they're doing or do you want someone to hide or to terminate treatment? And you know, I talked to somebody that's a big luminary in harm reduction. He actually advocates for harm reduction, like in residential programs and, you know.
It's just beyond me.
How that would conceptually work like?
You know, you let some patients have access to substances and I don't know it it, but again, going back to my early bias against natural remission and remittance for substances were I want to remain open minded to it.
I want to really sort of hear what individuals saying and I want to be open to the data.
The more specific considerations here you know we talked about.
You know, getting family history.
Is there early life stress in their abuse or neglect?
Obviously important.
How severe the substances all those are high risk factors in terms of how to be concerned. Again, if a parent comes to me and says, hey, I'm in recovery from a substance I was drinking when my kid up to the point I was my kid was five years.
Old a lot of yelling in the home.
And they're currently drinking daily. Like, that's really, really concerning.
I have much more.
Certainty about where that's going.
The other element here that I often ask any individual with a substance use or ask about their subjective experience of using and what I mean by that.
Like, what's it like?
Why do you like doing it?
Like what's?
What is it about it and the reason I do that and I refer here this is Bill Wilson's quote, Bill Wilson, a Co founder of a A whose parents abandoned him.
When you're a child.
And who started drinking alcohol as a young adult?
And his quote is low. The miracle, the strange barrier that exists in between me and all men and women seem to instantly go down. I thought that I belonged where I

was belonged to light. I belong to the universe. I was part of. Things at last owe the. Magic of those first three or four drinks. And so when I think about an abstinence approach with someone like Bill Wilson, it's almost, you know, cruel.
See, I'm going to take away that thing.
That was so impactful to you without offering something, so I do try to get this objective experience. OK, what is it about it?
You know, what do you like about it?
I think it's really important, even with that, I still caution families that I still have prognostic insecure insecurity.
Probably true to that too.
But uncertainty, you still quite don't know when your adolescence again, all those other risk factors in place.
Usually have pretty good confidence.
Hey, this is going down the wrong bad path here.
The other piece here, most sites do not do assessment for attachment security I do.
Recommended Schindler recommends it.
It's fairly simple.
Go into an easy measure, with the caveat that a lot of you are already doing this.
You're just not calling an attachment security. If a client is distancing themselves, they're not showing for appointments.
They're telling you everything's fine, even though you know it's not.
There's no kind of relational issues.
Right. You already know that there's an avoiding component there.
You're just not calling it that, but in case you are interested, the ecrrs is online.
It's public domain.
It's based off the 36 item ECR and it measures anxious and avoidant attachment dimensions.
It's reliable and valid. It can be reused as a repeated measure.
That's what we do.
We we do it.
At intake Day 21 and every two weeks after and you can kind of.
See and you can do it for different people.
You can do for the therapist. You can do for parents, for friends.
Romantic partners.
One of the downsides of the Ecrs there's no clinical cut offs, so it's not like there's a

number lower means more secure. Higher means more, more insecure.
So it's not like the like the phq 9 or the GAD 7 where it's like mild, moderate, severe depression or anxiety.
You don't have that, so it's a little bit more difficult.
You typically wanna do if you have a repeated measure. You wanna see it going down.
And obviously if you have a patient that's insecurely attached, right, that gets part of what the that's part of the definition of insecure attachment is they have a difficult time connecting to others, particularly authority figures.
So what I talking about? A population where it's hard to connect with.
Already mentioned kind of some of these examples, so you have you know those those three different ones.
The role of the therapist.
So sometimes then the point is well, I have this disorganized attached patient.
You know, they're not gonna be able to connect with me anyway.
Well, I do caution people that when we do take a look at like, for example, this Baldwin and colleague study that even when we pull out.
Relational challenges, in other words.
That's an explanation.
Well, it's easier to connect with people that are securely attached.
Well, that's certainly true. They're more.
They're more ready to be trusting and engaging in like a therapy process.
But the fact is therapy's contributions are still more important than patient, regardless of the attachment history.
That's something important to keep in mind.
Some of you are probably, you know, depending our teen whisperers, whatever your environment, you're just really good at connecting with them. They feel safe with you.
Or you may find that you're not that person.
You just stumble.
You don't feel particularly fluid when you talk to them, and that's just kind of true.
So just kind of know about yourself, your ability to kind of connect, you do play a very important role in count transference can be really useful.
I won't get into the concordant complimentary types.
Cache transference obviously, is a psychoanalytic term that is sort of diffused into all

of psychotherapy.
Most most of us use to some degree, but.
Transference helps us also diagnostically and with respect to like insecure attachment. If you start to have thoughts around patients, you know whether or not they don't want them to come or you don't like patients where you have strong feelings around them. That also helps with the sort of.
Diagnostic for insecure attachment.
So common therapeutic options.
Cognitive behavioral therapy is very common.
Motivational enhancement therapy.
You know, that's probably the preferred.
Method in large part because it's intuitive.
It's easy to train toward.
It's designed to amplify ambivalence.
The the caveat that I'm using the word caveat the piece to keep in mind with M ET is there has to be the ambivalence. If you have a patient, that is I.
I don't really care.
I'm going to continue to smoke and I'm going to continue to drink.
You know, nothing's really gonna help. Including MVT. 'cause. You have to have something to leverage against. There has to be some awareness of, OK.
I don't. You know, I I wanna continue to use, but I also don't like the fact that I'm in arguments with my family or or I'm, you know, whatever it is you have to have something kind of in there. Then you have to have more traditional recovery. Coun.
And then peer group counselling peer support is a growing.
You may have it there.
A growing sort of movement there.
Good growing body of literature in terms of efficacy, certainly when we think of like 12 step, that's sort of the the the philosophical foundation of it that you have just individuals with severe substance use disorders helping each other and really highly effective.
When we switch to psychopharmacology, there's not a lot when it comes to treatment for adolescence, buprenorphine or suboxone, which is buprenorphine, and naloxone for opiate use disorders.
For 18 year old, I think 18 can't remember if they've moved that. Then I think maybe 16.

And then you have bupropion or Wellbutrin for.
Nicotine.
Disorders. That's 18 and older, but really there's not a lot of formal psychopharmacology or pharmacology for.
For adolescent substance use and when it comes to attachment models with respect to substance use disorders, we're really in the initial stages of integration.
So even though we see the strong connection between substance use disorders and attachment insecurity, and we know that experiences can impact attachment.
Security.
The number of models that are available or is kind of limited to early phases.
We're gonna talk about attachment based family therapy in a minute here. But family therapy, which I can argue is an equivalent to an attachment based family therapy at heart family therapy, is essentially that it's a way to reduce conflict, increase cohesion, increase empathy and warmth and.
Look, this actually is more effective.
Ones that I talked about.
It's highly effective.
It's many decades of research to support that.
So I'm not suggesting that intervening with families and getting them into family therapy is going to resolve adolescent substances disorder.
That's overstating the case. What I can say when we look at the different options in here, the one thing I emphasize more than anything is family involvement.
That is going to be more effective than anything else.
And you know, again we we focus on that as a clinical model.
We're heavily family therapy based. It sort of our clinical model wraps around our attachment based family therapy not just for substance use disorders, but particularly for internalizing, you know, internalizing sores, depression and anxiety. But we also use it for other specialty components, eating disorders.
OCD.
We use it as a compliment like ERP.
OCD.
And real quick PSA on here, you know talking about the importance of the therapy relationship and family therapy. I put this in here.
I'm a big common factors person.
Common factors versus empirically supported treatment is sort of the the binary by

which people think about treatment effectiveness, you know well it it's act or it's DBT or it's ERP.
And then the common factors.
Is like patient characteristics or empathy.
You know the treatment alliance and so wampled has this really wonderful graph of meta analysis that took a look at treatment effect sizes. Again, you can see that when it comes to change in impact on treatment, it really comes down to the common factors. There are people that.
Are critical of bump holds analysis.
I think it holds up well, but I just kind of put that in there.
The most important thing is connecting with the teens.
You know, getting them in family therapy.
So unfortunately, family therapy is low priority from NIH in terms of research funding.
Insurance companies we use mostly commercial insurance.
They don't, really.
It's not really like a big focus for them, even though the data is strong and there are a few attachment models.
Mentalization based family therapy and then attachment based family therapy, which is what we used kind of disclosure conflict of interest.
I do work with Guy Diamond's is one of the Co model developers, he.
Helped implement it at Newport.
I also work with him as on research projects, just to be kind of fully transparent on there.
But the idea with Abst is it's five tasks and the first one is the relational reframe.
And it really is taking the problem that brought them into treatment and moving the family as you know, moving the patient as the problem and the family solution.
When I I when I was on site, I met with every family that admitted and they would come in hot.
Hey, my center child just tried to commit suicide there being discharged from inpatient hospital, you know?
We don't want them trying to commit suicide again or their grades have just fallen off, or sneaking out of the house.
They're punching holes in the wall. We got to get their grades up. We got to get them, not sneak out of the house and lie to us and punch a hole in the wall. And it's

really hard to be like, OK.
That is all important and we'll get there.
But what we need to do is focus from them to understanding the relationship with you, because they're going to move back in with you.
And the question that sort of is inherent in there is when the child is sad or afraid, why don't they go to the caregiver for support?
And that's what we want.
We want, not necessarily, that your the child goes to them for every injury at that point in your skin, knee or fear, you know, or broken relationship, but that there's a sense of warmth and cohesion as well as accountability in the home.
So give a quick explanation as to how this works.
For there's a video I sometimes have embedded, but didn't do it this time, so I'm gonna read through this.
Hopefully I can see it because I.
Need to move this.
Well, we'll figure out.
Try to figure it out.
So this is a real quick case study.
There's a video that sometimes goes with this and I just didn't embed it, so the therapist says I'm so glad to have you all together this week.
Explain to all of you today that we will focus on Evan sharing with you.
Dad was getting his way from coming to help and support him and struggling.
Dad, your job is to be curious, to try to understand your son's experience.
Mom and Dad struggles.
You can help him like we discussed.
Evan, your job is to be honest and share your dad.
We've talked about with that said heaven. Please turn your your dad and tell him what has gotten a wave relationship. OK, well, I guess, dad, I've never felt good enough for you.
I donof like I can do anything right in your eyes.
But I think it's a bit of an exaggeration.
Evan, what about your part in all this?
I mean, you're supposed to be.
I'm supposed to be OK with you using drugs therapist. Kevin, I know this is hard to hear.

You know, concern.
You are about evidence.
Drug use, I promise, we're going to get into that.
But before we can do that, we need to address issues in your relationship.
Talking about drug use requires trust.
We need to build it here, OK?
Kevin, can you find out from Evan? What has happened has made him feel as though he can't do anything right in your eyes. Perhaps it all perhaps went all sorted adolescent. He used to make comments.
All the time about my school and I know what upset you and that's why I stopped doing it. But trying to motivate you.
Hold on, Kevin. You just said something really important.
You said you know how upset you made him.
You and I talked about how you felt like you couldn't measure up to your own dad.
You know how he's feeling.
So we'll often do intergenerational parenting.
We'll talk about how they were raised as a way to build empathy, to elicit parental empathy.
And father. Yeah, you're right.
Therapist. Nicole, can you help Kevin here, mother?
I'm OK, Kevin.
Can you find out what is like for your for Evan, when you comment on his struggles at school?
What was it like for you when you would make comments?
It would make me feel like a failure. I started thinking I was dumb.
I also felt like you didn't me.
And then father?
How did you feel back then?
It made me feel worthless.
And Father says, I know what that's like and it sounds simple, but it really is these powerful moments where the parent is able to put themselves back into their shoes of what it's like to be a teen. And the team gets a sense that the parent is act.
Making a bid for connecting with them.
And look, it's not gonna fix everything.
And it has to endure and be practiced outside of treatment. But in our experience,

and again the data supports this with respect to family therapy.
This is the best way to intervene, particularly if you have high risk factors or things are going on.
So in conclusion.
This is often benign.
You know, I try to tell families not to worry about it so much. Not to be over reactive.
And generally speaking, it's in decline.
There's many.
There's far fewer people, teens using substances, but it's also changing. I mentioned there's fentanyl and the drug supply, they're getting it through Instagram and Snapchat.
There's, you know, cannabis concentrates that you know, there's associations to psychotic disorders.
Then we also know that there's a link to insecure attachment with these things.
And so we really wanna focus on assessment the therapeutic alliance. And if you can really work with the families, depending on your environment, you may not have that much time.
It may not be reasonable, and obviously there are many different environments where the feeling is not available or they have their own pathology, or there's a there's a.
Less than amicable divorce.
And so you create all sorts of challenges. In order to do this.
But again.
There's no other way to sort of frame it other than if we're able to intervene upon this, this is going to be the best possible route.
So I'm gonna pause there, see what questions we have thoughts around it.

KE **Kendra Eierman** 1:05:12
No questions and the chat related to the presentation.

 **Weston, Casey, D** 1:05:23
I have a question.
When when you speak about family therapy being effective for that adolescent, would it also for, would it also be effective for an adult who's going through this? Would it be similar or would it be different?

Michael Roeske 1:05:40
Adults are gonna be the same, you know, it's a.
It's a little bit different in terms of how it's handled obviously, but yes, the family therapy is is vitally important for adults as it is for adolescents.


Spain, Carey, A 1:06:07
Are you aware of any school based curriculums for drug prevention?

Michael Roeske 1:06:17
I.
I I you know I'm not.
You know, I I know some of the literature on the dare efforts that actually indicate it increased substance use, but I don't know in terms of more modern approaches.
What's there? I, you know, I went through the idea of temporal discounting generally speaking.
Teens are not terribly motivated by the the possibility of some future calamity.
So they're they're just not.
And so it's kind of, you know, how do you best do that as a question on my best at?
So I I try not to be.
I tried to provide educational components but not to be too heavy on it.

Kendra Eierman 1:07:22
A question in the chat box from Emily.
How many sessions of family therapy, on average, seems effective when focusing on this attachment based model?

Michael Roeske 1:07:35
That's a great question.
Abft was set up.
It was designed for outpatient 16 to 20 sessions. Obviously, if you're in a residential or even a shorter length of stay like a inpatient where you have very little time to connect, I can say that our average length of stay is about 50 days.
And we do weekly and then biweekly during task 3 psychotherapy, so it can be a short, it can be 7 to 10 sessions.

And we just got published on a paper that looked at abft in residential and its impact on attachment security and depression symptoms. And it, you know, it's statistically significant results.
So it's a little as seven to 10 sessions.
Well, if there's nothing else you guys can get 18 minutes back in your life.
It's always a nice thing.

AM **Andrews, Alexis, M** 1:08:56
Thank you so much, Doctor Ruski, for doing this presentation for us, and if there's any other additional questions that come in, I can send them.
Kendra your way, if that's OK.

MR **Michael Roeske** 1:09:10
Absolutely, yeah.

AM **Andrews, Alexis, M** 1:09:10
OK. Perfect. But again, thank you guys so much for your time and for the presentation. And I think you're doing another presentation for us later.
In the New Year, I think if I'm not mistaken.

KE **Kendra Eierman** 1:09:24
It's actually a that's doctor Loftus, but.

AM **Andrews, Alexis, M** 1:09:27
A different doctor, OK.

MR **Michael Roeske** 1:09:29
Oh, Merl is good.

KE **Kendra Eierman** 1:09:29
Doctor Russell.

MR **Michael Roeske** 1:09:30
I like her. Yeah.

Andrews, Alexis, M 1:09:31

Yes, OK.

Well, thank you again for giving us your time and putting this presentation together and giving us your expertise.

And I said, I really appreciate that.

But again, if there's any additional questions from anyone else, just go ahead and let us know and I will get those sent over to you guys.

OK.

Michael Roeske 1:09:53

Great. Thank you everybody. Thank you.

Andrews, Alexis, M 1:09:53

Thank you.

Spain, Carey, A 1:09:54

Thanks.

Fivecoat, Jewel, LMSW 1:09:58

Thank you.

Andrews, Alexis, M stopped transcription