ESSENTIAL THERAPY TRAINING

A Training Company for Therapists run by Therapists

# Working with adult clients with attachment trauma

18th Feb., 2021.

**Arun Mansukhani.**
PsyD.

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www.arunmansukhani.com/documentos

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## Contents of Workshop

- Trauma:
  - Historical volution and present concept. The posttraumatic response.
  - Traumatic events and psychopathology.
  - Types of trauma linked to Action Systems involved. Complex Trauma.
- Overview of Attachment Theory.
- How to work with patients that have childhood trauma and attachment issues underlying their present clinical problems.



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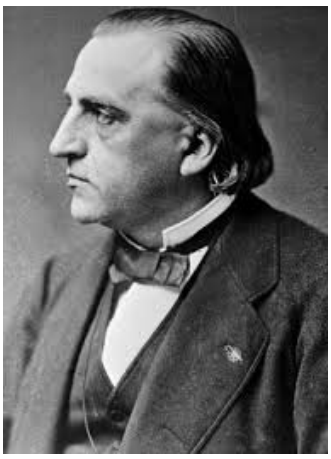
## Psychology and trauma



19th century: Hysteria. Charcot. Freud y Janet.

20th century in between wars. C. Myers

70s and 80s. The Vietnam War: PTSD.

End of 20th and beginning of 21st century:

1. Gender and intra-familiar violence.
2. Sexual aggressions and sexual abuse.
3. The distinction of different types of trauma and it's relation to psychopathology.



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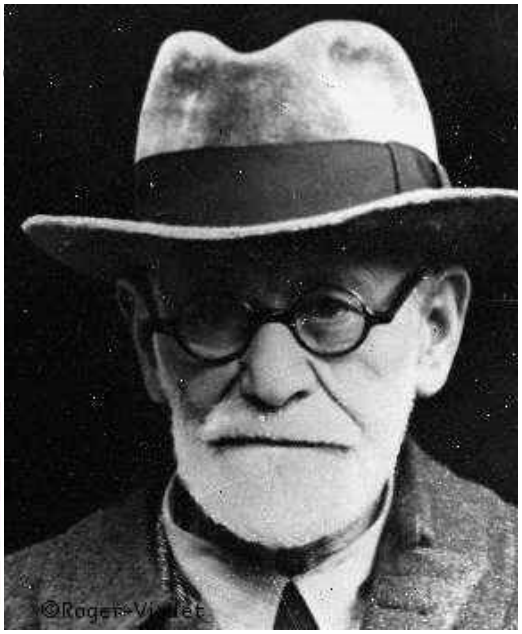
## Around 1880…

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## Around 1880…

- Mental illness (hysteria) was caused by psychological trauma (often sexual abuse).
- It caused an altered state of consciousness, which in turn caused most of the symptoms.

| JANET | FREUD Y BREUER |
|---|---|
| • Disociación.<br>• Psychological Analysis | • Double consciousness<br>• Psychoanalysis |

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"I propose the theory that behind each case of hysteria there are one or more episodes of premature sexual experiences, episodes that occurred in the earliest childhood, but that can be recovered by psychoanalysis despite the decades that have passed."

*Freud 1896: The Ethiology of Hysteria.*

"I was finally forced to admit that these seduction scenes had never happened, they were just fantasies that my patients invented."

*Freud. Letter to Fliess, 1897*



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"If there is the case of women who tell such an event in the history of their childhood, in which the father usually appears as the seducer, we cannot harbor **any doubt about the imaginary nature of this accusation** or the reason that led to it. [...] whether it actually occurred or if it is the result of fantasies [...] so far we have **not found any difference** as to the consequences [...] fantasies have a psychic reality and gradually we are understanding that in the world of neurosis it is the psychic reality that is determinant "

*Freud Introduction to psychoanalysis*

~~REAL EVENT~~ - FANTASY
~~TRAUMA~~ - FRUSTRATION
~~DISSOCIATION~~ - REPRESSION



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## CSA

**Developed countries:**

25% girls - 16% boys (1 d 4/1 d 6)

Only 1-2 out of 10 is reported.

**Developing countries (India):**

53.22% total. 52% 94 children. 47.06% girls.

21.90% sever forms of sexual abuse.

1973 Ann Burgess y Lynda Holstrom

Diana Rusell 1983: In-family abuse

Finkelhor 1990: 1st National Survey.

1994: First Spanish National Study.

Cabello (con Mansukhani y Gonz. De la Rosa) 1995. N=3000.

CDC 2005; 2008. N=17.000

Govt of India 2007 Study on Child abuse. N=15000.

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- 1890: William James describes mental pathology resting on trauma in Principles of Psychology.
- 1890 Alfred Binet develops the concept of trauma and dissociation in On Double Consciouness.
- 1893: Pierre Janet publishes Disociation, relating mental pathology to trauma.
- 1893: Freud and Breuer describe Double Conscience.
- 1896: Alfred Binet publishes describes the alters in Alterations of Personality.
- 1910-1970: practically no relevant work is published regarding dissociation and trauma (exceptions such as Mayers, etc).

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## Post war investigations

- 1910-1970: no work is published regarding dissociation, except:
- 1917: Rivers: Soldier's Declaration.
- 1915: Myers Shell Shock, The Lancet. Síntomas:
  - Tinitus, amnesia, headache, dizziness, tremor, and hypersensitivity to noise.
  - Neurasthenia: fatigue, anxiety, headache, neuralgia, depressed mood
  - Conversion disorder, mutism and fuge.
  - 1940: Describes Apparently Normal Part of the Personality / Emotional Part of the Personality
- II GM: Soldier fatigue.



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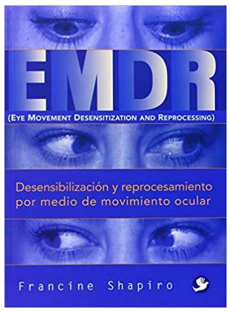
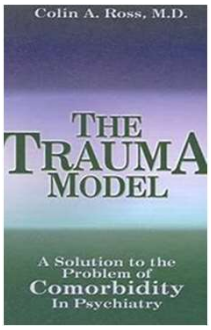
1983, National Vietnam Veterans Readjustment Study (NVVRS):

- 15% M and 9% W suffered PTSD.
- 30% M and 27% W would suffer at some point after Vietnam
- Reports of hippocampus atrophy (Sapolsky, 2017; pg78).

**PTSD**

Phobias
Depression
Dependence
BPD
Psychosis
Personality Disorders
Complex PTSD
…?!




**Findings suggest that early childhood adverse experiences could be related to 32% psychopathology in adults and up to 44% in children (Green et al, Archives of Psychiatry, 2010).**



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Child Abuse & Neglect

Slide courtesy of Dr. **Benedikt L Amann**
FIDMAG Germanes Hospitalàries Research Foundation
CIBERSAM

## Psychopathology in a large cohort of sexually abused children followed up to 43 years☆

Margaret C. Cutajar[a,*], Paul E. Mullen[a], James R.P. Ogloff[a], Stuart D. Thomas[a], David L. Wells[b], Josie Spataro[c]

Child Abuse Negl. 2010

**Table 1**
Comparison between the rates for various mental disorders in all the child sexual abuse and the control subjects.

| Diagnostic group | Controls ($n = 2677$) | | Cases ($n = 2688$) | | OR | 95% CI | $p$ |
|---|---|---|---|---|---|---|---|
| | $n$ | % | $n$ | % | | | |
| *Mental health contact* | 206 | 7.7 | 627 | 23.3 | 3.65 | 3.09–4.32 | <0.001 |
| *Axis I clinical disorders* | 187 | 7.0 | 495 | 18.4 | 3.01 | 2.52–3.59 | <0.001 |
| Psychotic disorders | 37 | 1.4 | 78 | 2.9 | 2.13 | 1.44–3.17 | <0.001 |
| Affective disorders | 86 | 3.2 | 173 | 6.4 | 2.07 | 1.59–2.70 | <0.001 |
| Organic disorders | 0 | 0.0 | 9 | 0.3 | – | – | – |
| Posttraumatic stress disorder | 20 | 0.7 | 108 | 4.0 | 5.56 | 3.44–8.99 | <0.001 |
| Other anxiety disorders | 60 | 2.2 | 155 | 5.8 | 2.67 | 1.97–3.61 | <0.001 |
| Eating disorders | 6 | 0.2 | 7 | 0.3 | 1.16 | 0.39–3.46 | 0.79 |
| Paedophilia | 0 | 0.0 | 3 | 0.1 | – | – | – |
| Known alcohol abuse | 13 | 0.5 | 75 | 2.8 | 5.88 | 3.26–10.63 | <0.001 |
| Known drug abuse | 20 | 0.7 | 115 | 4.3 | 5.94 | 3.68–9.58 | <0.001 |
| Other disorders | 17 | 0.6 | 60 | 2.2 | 3.57 | 2.08–6.14 | <0.001 |
| *Axis II personality disorders* | 18 | 0.7 | 96 | 3.6 | 5.47 | 3.30–9.08 | <0.001 |
| Non-cluster B PD | 7 | 0.3 | 31 | 1.2 | 4.45 | 1.96–10.13 | <0.001 |
| Cluster B PD | 12 | 0.4 | 65 | 2.4 | 5.51 | 2.97–10.22 | <0.001 |
| Borderline PD | 8 | 0.3 | 48 | 1.8 | 6.07 | 2.87–12.85 | <0.001 |
| Antisocial PD | 4 | 0.1 | 17 | 0.6 | 4.26 | 1.43–12.66 | 0.007[a] |
| *Non-psychiatric complaint* | 18 | 0.7 | 92 | 3.4 | 5.24 | 3.15–8.70 | <0.001 |

[a] Fisher's exact test.

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## Adverse Childhood Experience study

(Felliti and Anda, CDCP since 1995. +17000 subjects).

- Emotional abuse
- Physical abuse
- Sexual abuse
- Cohabitation with substance user
- Cohabitation with person with mental problems
- Witness parent treated violently (mother)
- Incarcerated household member
- Parental separation or divorce
- Emotional Neglect
- Physical Neglect.

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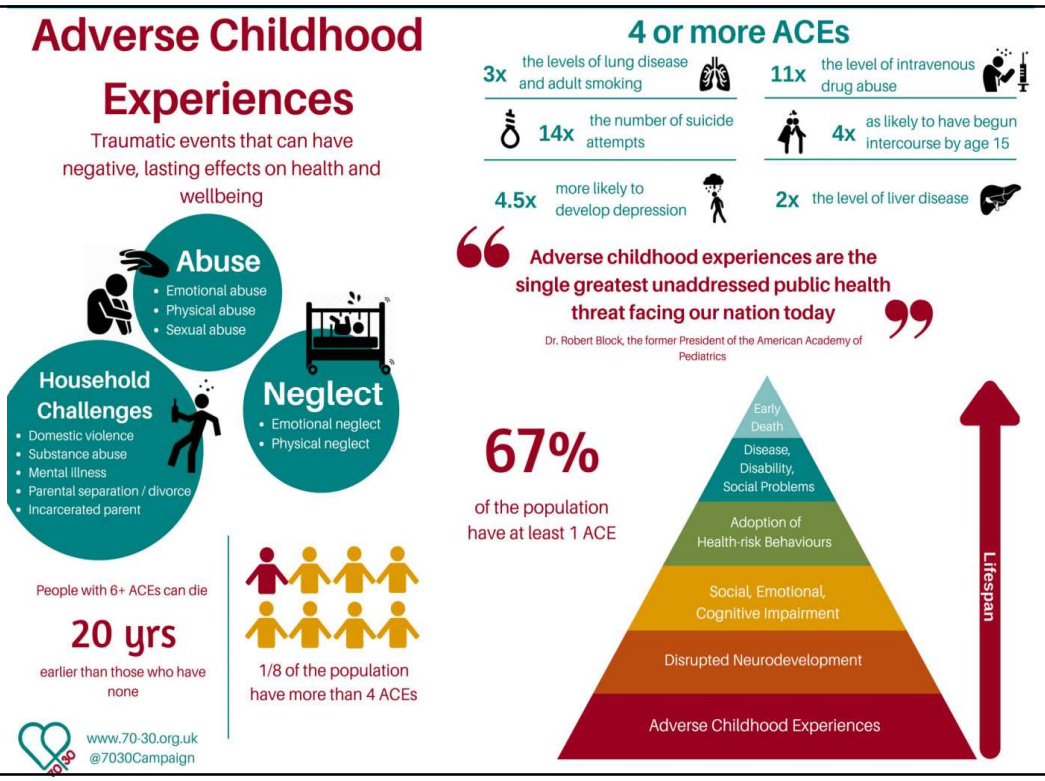


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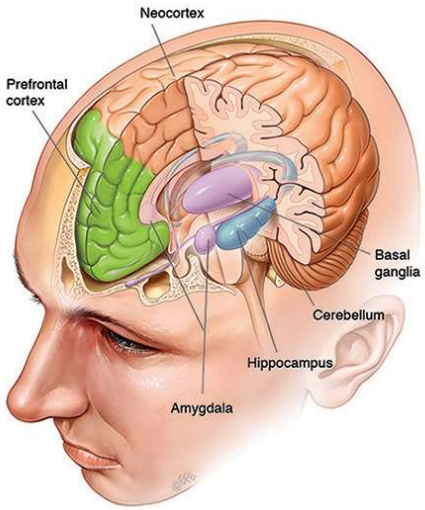
## ACE affects brain structures




- Corpus Calllosum reduced area (deficient hemispheric integration).
- Abnormal Amygdala size (depending on type/time of abuse)
- Decrease in the size of the Hippocampus.
- PFC: AC, of-vm PFC and dlPFC (reduction of myelin).

***Martin Teicher 2017***

↑*NE* *(Amsten et al 2015);* ↑ ↓ *Cortisol (R. Yehuda)*
↓*GABA (Anderson and Schmitz 2017)*

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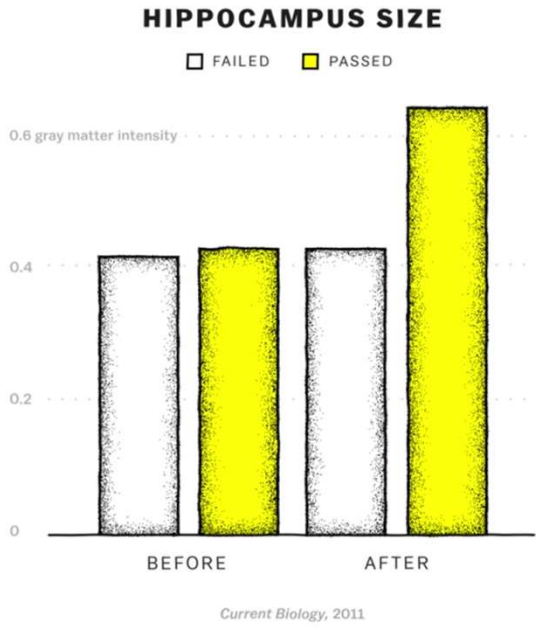


"Adult hippocampal neurogenesis is abundant in neurologically healthy subjects".

**Mª Llorens-Martín**

Centro de Biología Molecular Severo Ochoa

Moreno-Jiménez, E.P., Flor-García, M., Terreros-Roncal, J. *et al. Natural Medicine* **25,** 554–560 (2019).

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- Traumatic episodes are not processed and can't be integrated into narrative and biographic memory networks.

*(Van der Kolk 1995).*

- Dysfunctionally stored implicit memories (information) are the cause of a wide range of psychological symptoms and disorders.

*(Shapiro 2004,).*

- There is strong evidence that trauma is strongly related to mental health and health in general

*(Van der Kolk 1988, Herman et al 1989, Perry et al 1991, Holmes 1993 y 2001, Siegel 1999, Schore 2000, Centonze et al 2005, Kendler et al 2003, Ekman y Ametz 2006, Teicher et al 2006, Fellitie & Anda).*

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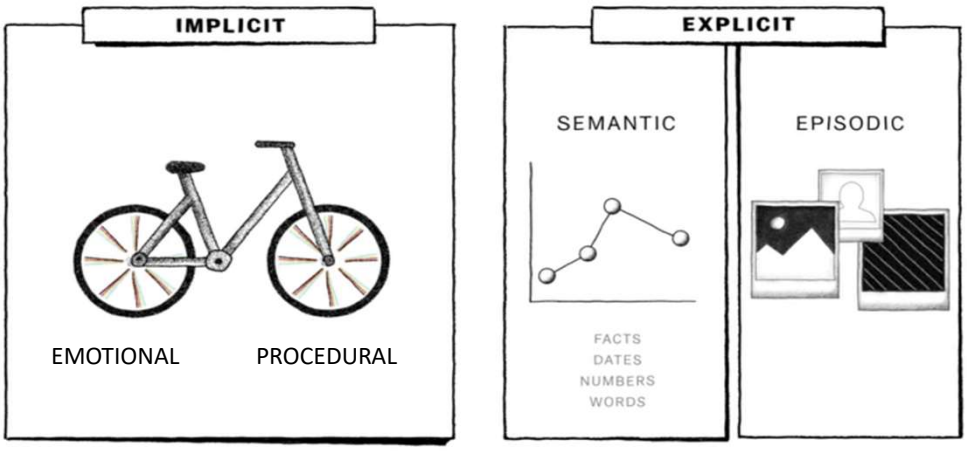
## Sensory Memory (raw) / STM / **LTM**

Deregulated / Regulated
Somatosensorial / Narrative
Unvoluntary / Voluntary
Timeless / Time

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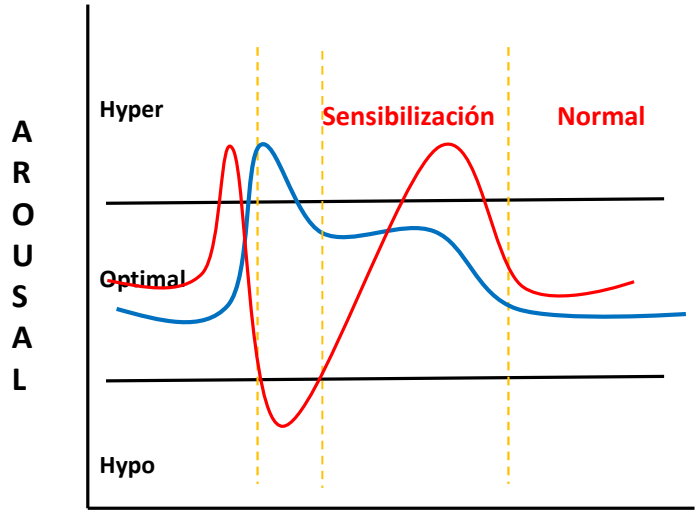


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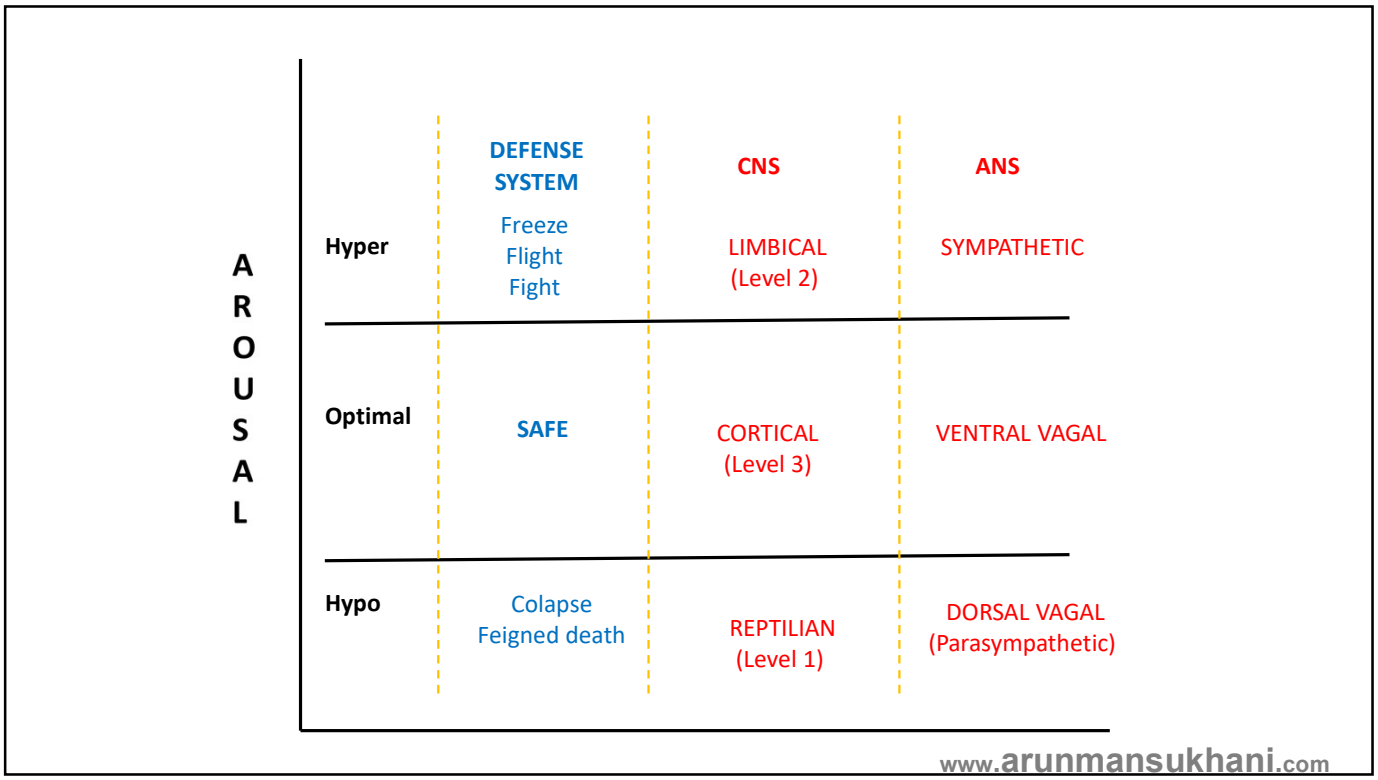
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DEFENSE SYSTEM
CNS
ANS
Hyper
Freeze
Flight
Fight
LIMBICAL
(Level 2)
SYMPATHETIC
Optimal
SAFE
CORTICAL
(Level 3)
VENTRAL VAGAL
Hypo
Colapse
Feigned death
REPTILIAN
(Level 1)
DORSAL VAGAL
(Parasympathetic)
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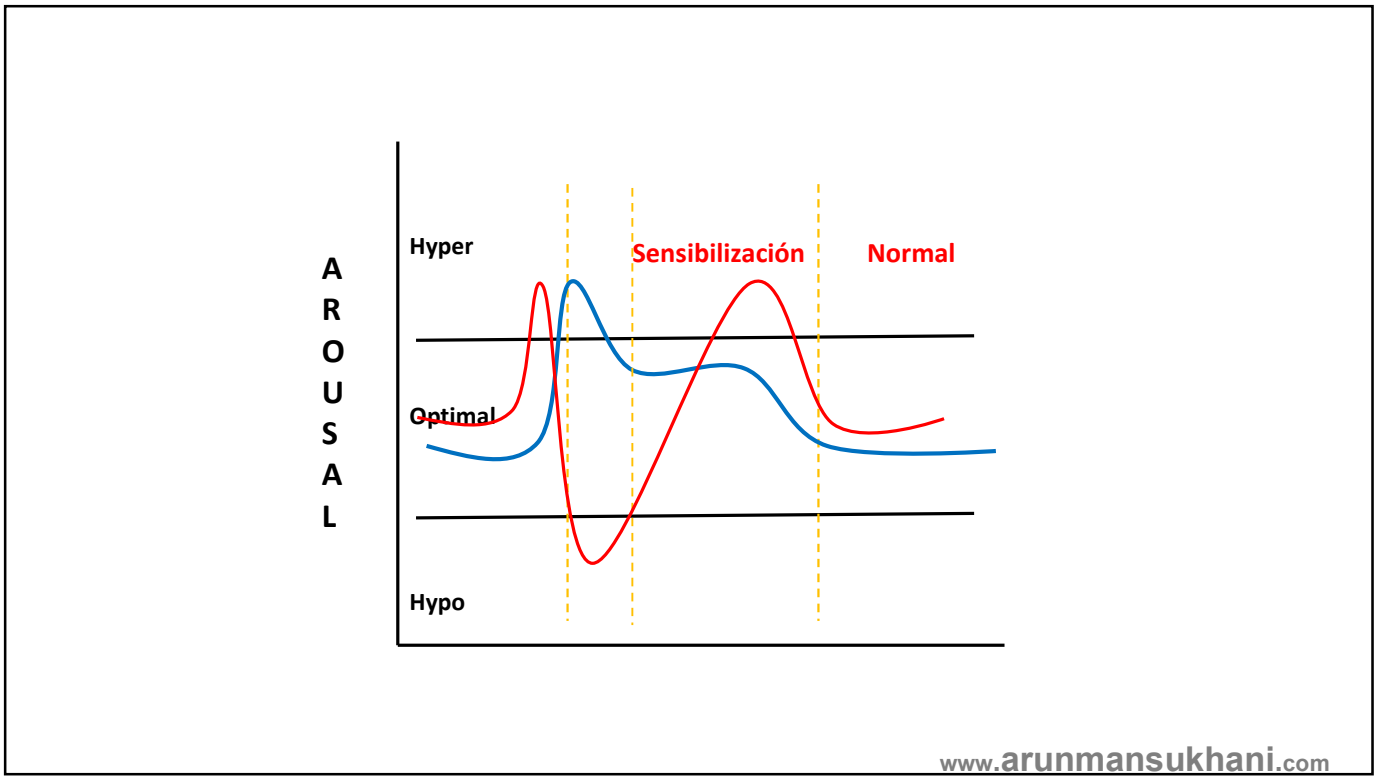
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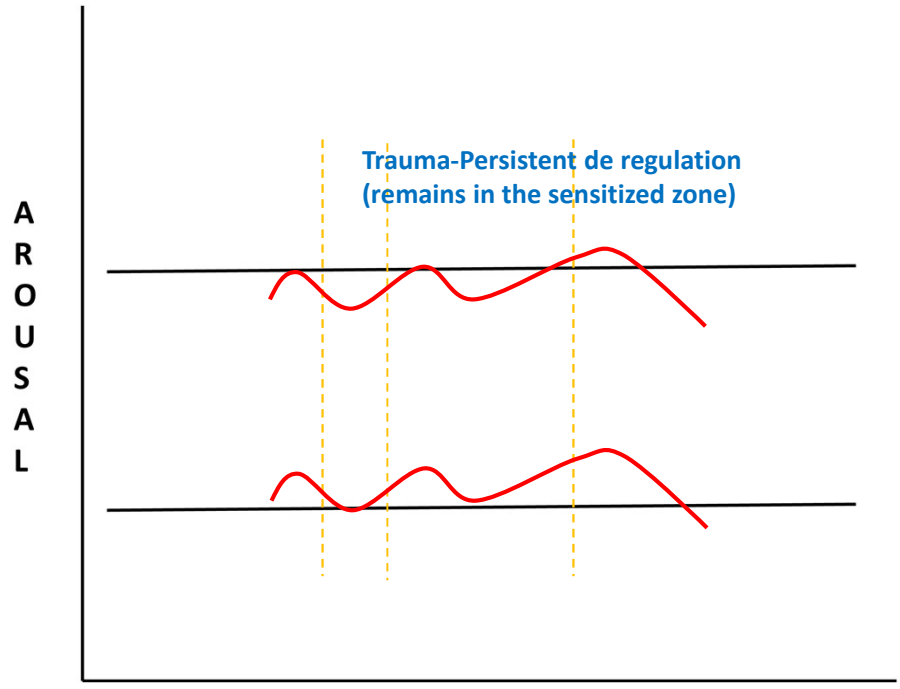


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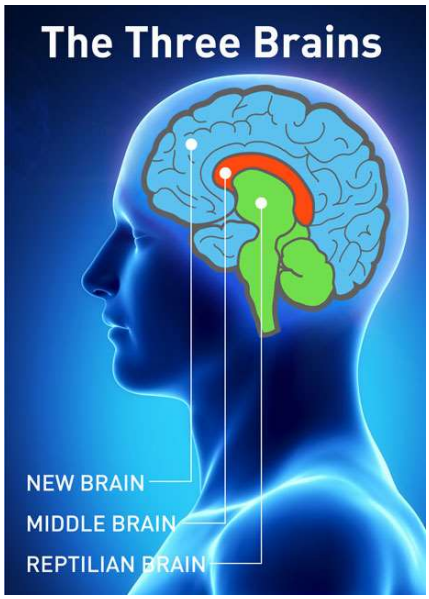


**A post traumatic response:**

Our nervous system fails to go back to optimal arousal levels (homeostasis) after hyper or hypo one of the action/emotion systems, remaining in a sensitized mode that results in frequent deregulation and, therefore, producing a stress response, not as a reaction to present threats, but to dysfunctionally stored "memories" and internal cues.

**Internal World ≥ External world**
(Here and Now)

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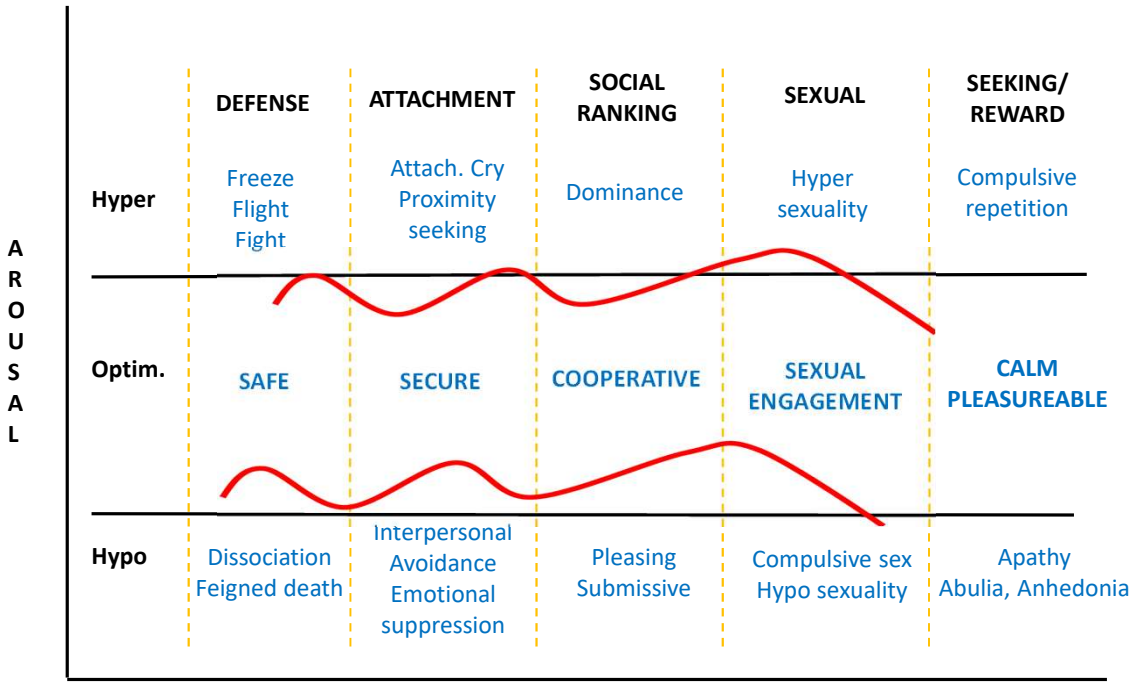


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## Systems: Control/Behavioral – Motivational – Action – Affective

- Biologically evolved neural programme, universal and that organizes some aspect of behaviour in a way that enhances survival or reproductive chances of an individual (*Mikulincer y Shaver 2016).*

- Implicit memory networks, they function as "automatic protocols" (*Bargh 2018)* that get activated and tend to homeostasis (*Sapolsky 2017*).
- Flexible goal-oriented responses (*Bowlby 1969)*.

- In childhood they function as on/off (binary) systems gradually developing in the adult as sophisticated, differentiated, integrated and under cortical control responses. Under stress, they go back to binary functioning.

- Attachment is the main system because it "has an organizing effect on the child" (West and Sheldon-Keller 1995), through regulation of the nervous system.



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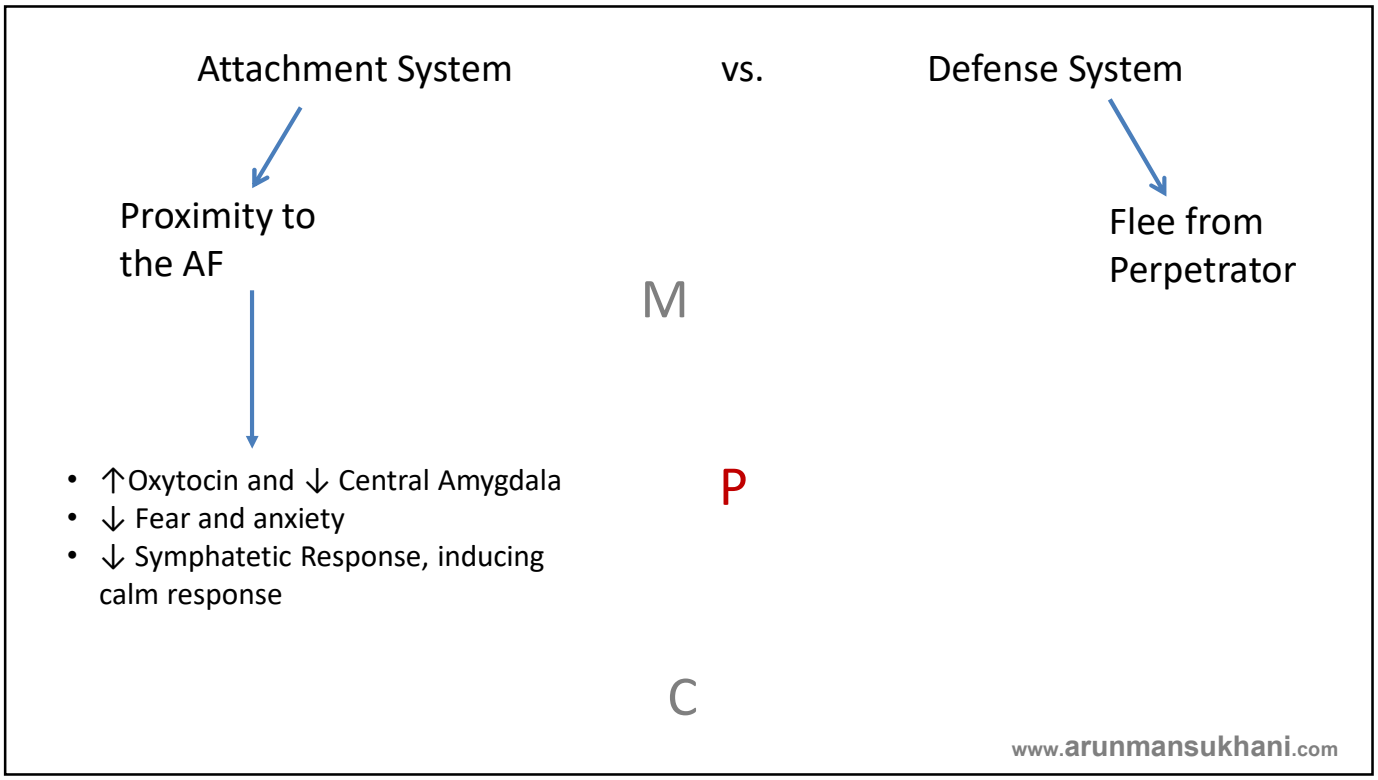


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**Why is ATTACHMENT So important ?**

It's "the organizing principle around which psychological development takes place". **Holmes 2001**. "It's the key system in the development […] and the complete expression of the rest of the systems". **West y Sheldon-Keller 1994**.

It's a protection factor for ACE, working both as prevention as well as repair. Most trauma is interpersonal.

Sets the implicit knowledge of:

- "How to do things with others". **Lyons-Ruth 1988**.
- Assumptions about the world (benevolence, meaning) and others.
- Self worth and self compassion.

Deeply influences self-regulation.

Related to health and mental health: insecure patterns are related to vulnerability factors for psychological problems (**Holmes 2001/2010**) and disorganized aspects to severe mental illness (**Liotti 2014**)



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## A few words about Social Ranking System

- Present in all social animals. Regulated by serotonin levels (Peterson 2018) and influences testorterone levels (Sapolsky 2017).
- Parent-offspring conflict theory: Children's demands vs parent's output (Trivers 1974). Parents are main Social Ranking agents.
- Attachment and SRS are partly opposite. When children perceive "weak" parents, they tend to go to dominant positions:
  - Higher anxiety levels, less self-regulation, more impulsive behaviors (Peterson 2018).
  - Anger at parents for lack of protection.
  - Higher Reactive and Displaced aggressive behavior to lower stress levels ("stress induced displacement aggression", Card & Dahl 2011).
  - Unstable self-esteem.



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## A few words about Social Ranking System (2)

Individuals that perceive themselves as higher SES are/have (Piff et al, 2012):

- More self-focused pattern of social cognition and behavior (Krauss, Piff & Keltner, 2011).
- Less cognizant of others (Krauss, Piff & Keltner, 2009).
- Worse at assessing others emotional states (Krauss, Coté & Keltner, 2010).
- More disengaged during social interaction (Krauss & Keltner, 2009).
- Less generous and altruistic behavior (Piff et all, 2010).



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- How to work with patients that have childhood trauma and attachment issues underlying their present clinical problems.



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## Attachment Theory

B
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## Attachment Theory



B
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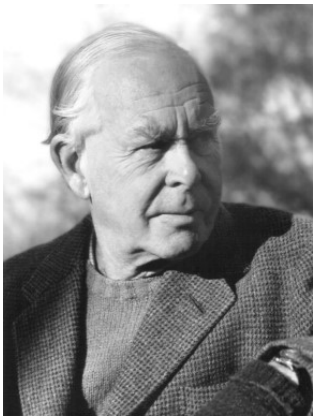
## THE NATURE OF THE CHILD'S TIE TO HIS MOTHER

*By*

JOHN BOWLBY,

LONDON

1. An abbreviated version of this paper was read before the British Psycho-Analytical Society on 19th June, 1957.
2. Although in this paper I shall usually refer to mothers and not mother-figures, it is to be understood that in every case I am concerned with the person who mothers the child and to whom it becomes attached rather than to the natural mother.



## The Nature of Love

**Harry F. Harlow** (1958)[1]

*University of Wisconsin*

First published in *American Psychologist*, *13*, 673-685

Address of the President at the sixty-sixth Annual Convention of the American Psychological Association, Washington, D. C., August 31, 1958. First published in *American Psychologist*, *13*, *573-685.*



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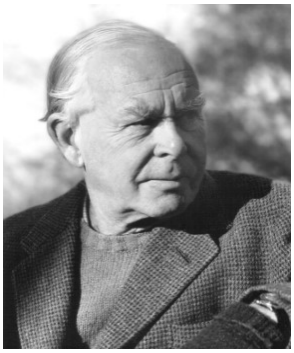
"The infant and young child should experience a warm, intimate and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment [… otherwise…] will result in sever anxiety conditions and psychopatic personality".

**Bowlby 1951 Maternal care and mental health (WHO).**



"Attachment is the propensity of human beings to make strong affectional bonds to particular others".

**Bowlby 1977.**

Most primates differ from other animals (including most mammals) in that gaining proximity to a protective conspecific, as opposed to a place (e.g., a den or burrow) provides our primary solution to situations of fear.

**Bowlby, 1958, 1969/1982.**

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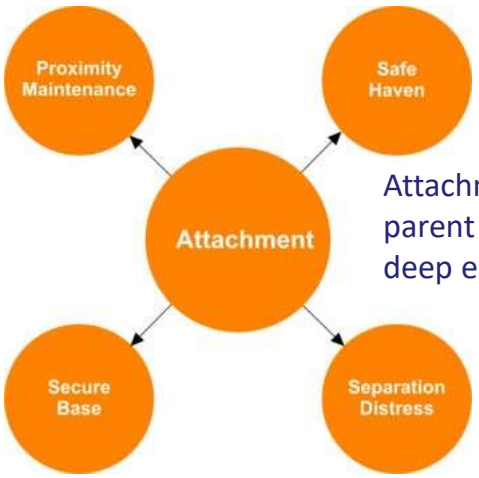
Strong affectional bond that develops over a series of repeated interactions between an infant and his/her caregiver




It's a primary bond: it doesn't form because of fulfilling any function ("cupboard theory") but rather, once the bond is formed it serves several functions (security, regulation, etc).

Attachment is a feeling state within both the infant and the parent (Condon, Corkindale, & Boyce, 2008), characterized as a deep emotional, psychological, and personal connection

It's activated with fear, pain, tiredness or inaccessibility or unresponsiveness of the attachment figure. (Bowlby 2005)

It's an innate behavioural system, that meets multiple functions (not only security, but also regulation, learning, etc) and is essential for survival (Bowlby 1999).

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## Mary Ainsworth

-Designs the SSP (observation). Starts investigation.
-Converts attachment into an interactive and dimensional variable. Identifies:
- •Secure attachment
- •Insecure attachment (divided into avoidant (A) and resistant-ambivalent (C)).

## Mary Main

-Identifies disorganized attachment (D).
-Designs AAI (narrative).
-Extends attachment to adults.



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## Strange Situation Procedure

1. Caretaker (CT) enters the room
2. CT interacts with the child.
3. Stranger (S) enters the room, interacts with CT, gradually interacts with the child. CT leaves the room.
4. S interacts with the child.
5. CT enters the room. S leaves.
6. CT leaves the room.
7. Repeat Phase 3.
8. Repeat pase 5 and end.

9 – 18 months

**Observe**:

- Exploration.
- Initiates contact w/ CT
- Calm and Regulation.
- Behavior with AF and with S.

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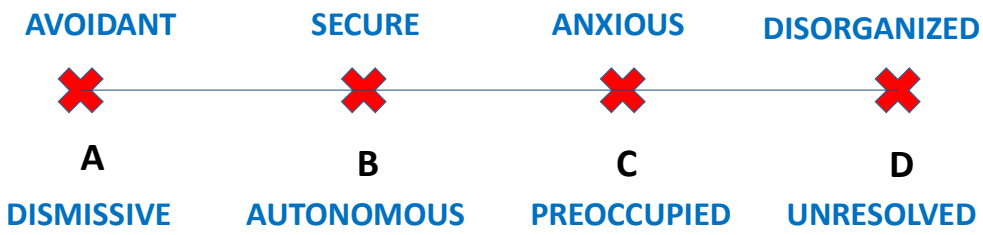
Attachment **Types**
(Ainsworth-Main classification, 1964, 1986)



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Attachment **Types**
(* *Ainsworth-Main classification*)

HYPOACTIVATION

HYPERACTIVATION

**AVOIDANT**

Efforts to reduce feelings. Equally regulated with or without the AF.

**SECURE**

Confident and regulated with the AF. Fast repair.

**ANXIOUS RESISTANT**

Anxious efforts to maintain their parents attention and responsiveness

**DISORGANIZED**

Disorganized and contradictory behaviour. Unclear objective. Collapse.



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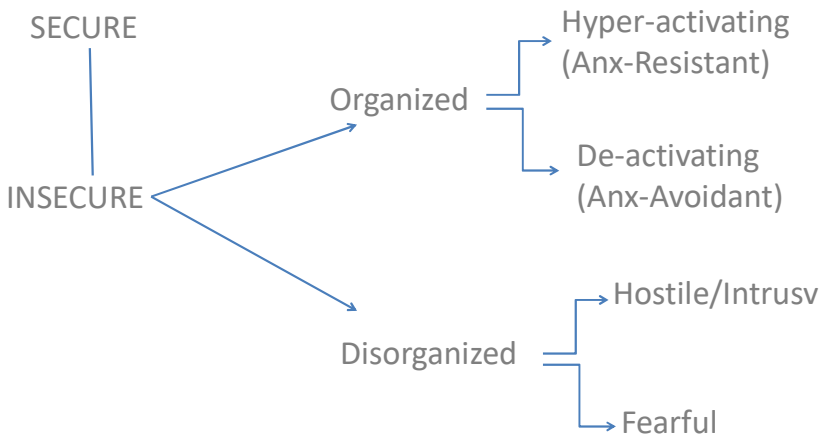
## **Attachment** Types




**Holmes, 2012*
**Mikulincer and Shaver 2008*
**Lyons-Ruth and Jacobwitz, 2008*

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Attachment types are universal (Hazan & Shaver 1994) and present a high reliability and validity (West & Sheldon-Keller, 1994)

**Distribution in general population.**

- Type A* → 21%
- Type B → 65%
- Type C* → 14%

Van IJzendoorn, M.H., & Kroonenberg, P.M. (1988). Cross-cultural patterns of attachment: A meta-analysis of the strange-situation" *Child Development* 59, 147-156. N=2000

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From 1990 D category is introduced.

## Distribution in general population.

- Type A* → 23%
- Type B → 55%
- Type C* → 8%
- Type D → 14%



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## CT features/abilities that correlate with secure attachment

1. **PHYSICAL AVAILABILITY:** Proximity, accessibility, reliability (consistency and predictability). (Bowlby) **EMOTIONAL AVAILABILITY (ATTUNEMENT):** Sensitivity to child's needs. Responsiveness. Cooperative (Ainsworth, 1989). Capable of reflective functioning (Bowlby) mentalizing ability (Fonagy and Steele) or Mindsight (Siegel)
2. **POSITIVE AFFECT**: Engagement, positive affect, play, non-responsive warmth. Mutual gratification.
3. **REGULATION**: Regulate and able to regulate. Help in assimilating negative experiences. (Stiles et al. 1990) and setting limits (negative affect tolerance).

→ **The Child receives what needed behaving as a child.**



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## **CT features/abilities** that correlate with **anxious attachment**

1. **PHYSICAL AVAILABILITY:** Too much or too little, inconsistent accessibility and low reliability **EMOTIONAL AVAILABILITY (ATTUNEMENT):** Too sensitive or erratic sensitivity. Erratic responsiveness, non reliable.. Interference (Ainsworth, 1989). More moved by their own than child's needs.
2. **POSITIVE AFFECT**: Difficult for them. Frequently anxious or hyper activated (anger, frustration, etc). Also tired and hypo activated.
3. **REGULATION**: Frequently hyper, not good at regulating, assimilating negative experiences. (Stiles et al. 1990), repairing (Tronick) and setting limits (negative affect tolerance).

→ **The Child has to optimize attachment with the caregiver with his behaviour (demands, anger, take care of…).**



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## **CT features/abilities** that correlate **with avoidant attachment**

1. **PHYSICAL AVAILABILITY:** Excessive (invasive) or defective proximity. Consistent. **EMOTIONAL AVAILABILITY (ATTUNEMENT):** Low.
2. **POSITIVE AFFECT**: Difficult for them. Frequently tired or frustrated.
3. **REGULATION**: Frequently hypo, not good at regulating, assimilating negative experiences. (Stiles et al. 1990), repairing (Tronick). Child has to learn how to self-regulate through emotional suppression.

→ **The Child has to optimize attachment with the caregiver through avoidant behaviour: maintain proximity with someone who doesn't tolerate it very well.**



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## **CT features/abilities** that correlate with **disorganized attachment**

- "Fright without solution"-"Approach-flight paradox" (Hess y Main 1992 / 2006):
  - Afraid or fearful (Hess y Main 2006). Hostility or helplessness.
  - Unresolved trauma. Absent. Dissociated (Hess y Main 2006).
  - Neglect. Mental illness.
- Simultaneous activation of attachment system and other systems. Paradoxical bind: the more stress, the more the attachment.
- Child will try to optimize attachment with behaviours belonging to other systems.



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Attachment System vs. Defense System

Proximity to the AF

- ↑Oxytocin and ↓ Central Amygdala
- ↓ Fear and anxiety
- ↓ Symphatetic Response, inducing calm response

Flee from Perpetrator

M

P

C



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| Caregivers Parenting Styles | Children attachment Types |
|---|---|
| Responsive, sensitive, attuned, positive affect… | Secure |
| Inconsistent, insecure… Avoidant (tired caretakers) | Insecure but organized ambivalent |
| Cold, dismissive, critical, Too invasive | Insecure but organized avoidant |
| Frightening or afraid. Absent or confusing. Dissociation. Sever pathology | Disorganized |

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## Multiple attachment

Schaffer and Emerson, Glasgow Study, 1965:

- 7 m: 29% attached to 2 persons.
- 10 m: 60% more than one attachment figure.
- 18 m: 87% more than one AF y 30% 4-5 AF.

Ainsworth et al, 1978:

From 30 months onwards, the primary attachment figure type will have more influence then other figures (Ainsworth et al. 1978)

Main y Weston 1981:

After 24 months, the attachment type exhibited by the child will star stabilizing as an internal model of attachment is created.

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## Attachment throughout life span

- 0-6 m: Primary or dual attachment.
- 6-9 m onwards: Secondary figures: grand parents, uncles, teachers, pets…
- 2-3 y onwards: growing independence
- Teenage: peer groups and first romantic relationships.
- Adulthood:
  - Reciprocal attachment with friends, couples, etc.
  - Attachment with children.
  - Change of relationship with parents.



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## Attachment throughout life span

- ***Holmes 2001:***
  - *Intergenerational continuity parents AAI – children SSP: 75%.*
- ***Waters et al 2000; Hamilton 2000:***
  - *Concordance at 20 between SSP y AAI: 72%*
  - ***Weinfiel et al 2000**: Traumatic experiences are responsible of the most part of disruptions in continuity between child and adult patterns*
- ***Jeff Simpson y colb. (Minessota Longitudinal Study, since 1975),** secure children in SSP:*
  - At 6 higher social competence (rated by teachers).
  - AT 16 higher levels of intimacy and closer relations with significant others.
  - 20s Higher level of positive experiences in intimate relations; higher conflict resolution capacity.
  - greater sense of self-agency, better emotional regulation, higher self-esteem



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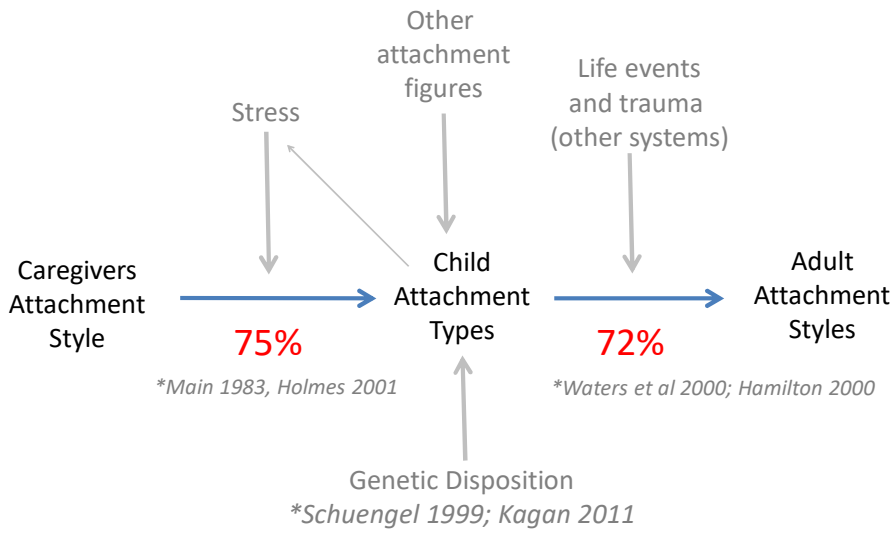


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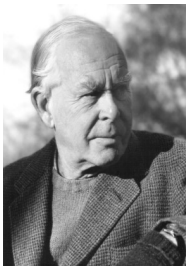

"Attachment theory […] propensity to make **intimate emotional bonds** to particular individuals as a **basic component of human nature**, already present in germinal form in the neonate and **continuing through adult life** into old age […] It performs a natural healthy function, even in adult life".

**Bowlby 1988/1992.**

"In adulthood the **attachment system** operates coordinated together with the **mating (sex) system** and the **care-giving system** to accomplish the set goal of the pair bonding system ".

**Ainsworth 1985/1999.**

*Hazan y Shaver 1986, Sue Johnson 2016, Mikulincer y Shaver 2016, Fisher 2016*

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## Adult attachment

- It's an implicit memory system (Amini et al 1996).
- It will activate under stress, loss, loneliness, intimacy, fear, etc.
- They can be an overall style, although "adult patients with insecure attachments present a combination of avoidant and resistant features" (Holmes, 2009).
- Will show different styles horizontally, vertically, with different children....
- In Insecure Patterns, the AS activates more frequently and in a more dual manner. "In insecure attachment, the individual's relational strategies are dominated by set, clearly repetitive patterns of attachment" (West y Sheldon-Keller 1994).
- Disorganized attachment is not a 4th category and occurs due to enmeshment of attachment and other systems.



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| Avoidant features<br>Hypo activation of AS<br>(up-down regulation) | Resistant features<br>Hyper activation of AS<br>(down-up regulation) |
|---|---|
| Auto-regulation: intimacy avoidance<br>Emotional independence | Co-regulation: solitude avoidance<br>Emotional dependence |
| ↓ Emotional empathy<br>↑ Need of setting limits | ↑ Emotional empathy<br>Difficulties setting and accepting limits |
| Window of control. Stability: emotions and sensation suppression | Narrow Window of Tolerance.<br>Frequent deregulation |
| Internal resources | External resources |

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## Otras medidas de evaluación en apego infantil

**CONTROLADAS:**

- SA extendida a 2- 4 ½: elicitar estrés con separaciones prolongadas, cambios de género, etc
- 6 a: Prueba de Main y Cassidy: 1 hora de separación.
- MIM (Marschak – Yale).

**ENTREVISTA:**

CAI (Target et al 2003): 7-11.

AICA (adolescentes).

**OBSERVACIÓN**

- 1-5 a. Q-Set (Waters y Deane 1985): 100 ítems

**REPRESENTACIÓN:**

- Métodos con muñecos: MSSB (3-8), SSAP (4-8) y MCAST (4-8)
- Completar historias: ASCT (3-9) – Bretherton
- Viñetas: SAT (versión para 11-17 y 4-7)

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## Adult Attachment - Assessment

- AAI (Main y Godwyn 1993).
- AAI – Reflective Function (Fonagy y Target 1997).
- AAP (George y West 2001):
  www.attachmentprojective.com
- ECR Scale (Brennan, Clark y Shaver 1998):
  www.psyweb2.ucdavis.edu/labs/Shaver
- RSQ (Bartholomew y Horowitz 1991)
  www.sfu.ca/psyc/faculty/bartholomew/research/index.htm

  * Risky Situation (Paquette y Dumont, 2013)

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## Autonomous adult attachment narrative

- Consistent narrative, the person explains, goes into details. Realistic, not polarized or idealistic. Makes sense.
- Wide range of internal work models (IWM). Flexible.
- Differentiates healthy relationships. Values positive interactions.
- Cooperative and able to protect himself.
- Has an intuitive understanding of attachment and considers attachment bonds very important.
- Is regulated (neither excessively excited nor excessively distanced) and with appropriate emotions according to the narrative (within the window of tolerance).

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## Narrative of preoccupied adult attachment (ambivalent)

- Defines childhood as good. Gives many details but contradictory or erroneous. Hard to follow.
- Goes from exaggerating to minimizing the importance of attachment.
- Can express different emotions towards the same person.
- Hyperactivation patterns, poor self regulation. High emotional expressiveness. Frequently shows dependency patterns.
- Difficulties in self-regulation and especially co-regulation.
- Unsecure. Low self-esteem
- Frequently disturbed when talking about childhood, showing anxiety, worry - anger, anger, guilt. A lot of emotion and little containment.

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## Narrative of avoidant adult attachment

- Defines childhood as "good", "without problems" or "normal". Does not give many details. Few memories. Little flexible narrative.
- Minimizes the importance of attachment relationships and the importance of childhood.
- Does not perceive other adults as regulators or comforters.
- Strategies to avoid privacy. Self-dependent, counter-dependent.
- Sometimes, good capacity for social analysis.
- Self-regulatory deficit that leads to restricted emotional capacity. A lot of cognitive analysis.
- Distanced from emotions while narrating childhood events. Disdain or attitude "deep down you can not trust anyone." A lot of contention, little emotion.
- Avoidance patterns, control, hypoactivation and self-soothing.



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## Disorganized adult attachment narrative

- Very few memories. Disorganized and incoherent narrative. Frequent fabulation. Very difficult to follow.
- Has no sense of security.
- Sudden emotional changes or dissociated behavior.
- Impulsive. Changing and contradictory behaviors.
- Difficulties with self-regulation.
- Impulsive. Bizarre behaviors: fearful or fearsome.

- Can be very much under control until the attachment system is activated, becoming confusing and disorganized at that time (Liotti 2011) and expressing a lot of emotion.

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## Contents of Workshop

- Trauma:
  - Historical volution and present concept. The posttraumatic response.
  - Traumatic events and psychopathology.
  - Types of trauma linked to Action Systems involved. Complex Trauma.
- Overview of Attachment Theory.
- How to work with patients that have childhood trauma and attachment issues underlying their present clinical problems.



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## Patients with attachment issues

- Don't understand why we have to work on the past instead of current issues.
- History taking is deregulating and evocative (Steele 2016).
- No explicit memories (Amini et al. 1996). Attachment blind (Siegel 2012).
- Frequently destabilized when activate their AS (hyper and get locked out, hypo and get shut down) and/or
- Fear of de-stabilizing (window of control)
- Problems with recall and connection: dissociative features, semantic (resistant) vs. episodic (avoidant) memory problems, BASK dissociation (Braun 1988), Suppression…

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## Phased intervention

- Phase 0: Reception: build safe therapeutic relationship.
- Phase 1: Stabilization, Safety and understanding.
- Phase 2: Working with the inner world.
- Phase 3: Help process past memories.

**Think about them more as processes happening during therapy.*

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## Phase 0- Therapeutic relationship

"Therapy is an in-vitro experiment in intimacy"
(Holmes 2010).

### Clients

Activate their (damaged) attachment system:

- Low self regulation and/or extreme control.
- Difficult at an interpersonal level. Positive and negative transference. Frequent enactments (Schore, 2015).

### Therapists

Activate his/her own attachment (damaged?) system. Frequently anxious-resistant, care-giving. (Diamond et al 2003; Barr, 2006). This will happen especially during enactments.

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## Phase 0- The therapist in the therapeutic relationship

- Be sure that the past that is being re-created is not his own but the patient's:
  - Have worked on his/her attachment history. (**Earned Secure Attachment**, Mayn & Goldwyn, 1984; Hess 2008).
  - Ba a **Safe Base** for the patient (Johnson 2016).
  - A interactive co-regulator: capacity of being in **relational mindfulness**.
- Has to enter (and therefore validate) the clients's worldview before challenging it. This implies understanding (the function) and respecting bonding patterns and "parts".
- Understand the importance of enactments and handle them. Frequently, they are the begining of therapeutic change and the first chance the patient has of experimenting a healthy relationship.

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## Enactments

- Therapeutic relationship may be the first healthy relationship that a patient has had. But therapists are not perfect, and make mistakes.
- Sometimes can be very subtle (i.e., pleasing patients).
- Enacments are situations where the patient's (and/or the theapist's) wound has been accidentally touched:
  - Therapists behaves as someone from patient's past.
  - Client behaves as someone from the therapist's past.
- This activates the pain and the defense mechanisms.
- They are ruptures in the therapeutic relation and an excellent chance for repair.
- Reacting authentically, with a "non-defensive recognition" leads to a corrective experience

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## Working with enactments

- Realize that an enactment is happening.  Be able of staying in co-regulation.
- Speak carefully but openly:
  - Explore what just happened, the system, including the therapist.
  - Express the therapists feelings.
  - Very important not to react as someone from the patient's past (or the therapist's).
  - Watch what is happening to the client: help them express their negative feelings; help them talk about the "soft" feelings beneath the "hard" ones.
  - Non-defensive recognition. How can we solve this? / what can we learn from this?
  - Try and  connect with past situations/people where the person felt the same.
- Don't question the therapeutic bond.

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## Phase 1: Stability, Security and Understanding

- The most relevant phase, present throughout therapy, with 4 main objectives:
  - **Stability**: Emotional regulation. Capacity of self-soothing.
  - Relational **Security**. Start feeling safe enough to explore insecurity (Holmes 2010) ).
  - **Understanding**: Help mentalize (understanding and integration of life history) (Use BS).
  - Capacity to talk about disturbing situations while staying in **dual focus** or a **mindful state**, with the therapist's help.

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## Phase 1- Working towards safety, stability and understanding

- Perceive overwhelming / avoidance pattern and where the patient's difficulties lie.
- Check for resources (during session) and self-soothing. Help the patient perceive them and voluntarily start regulating them.
- See the main attachment style. Interaction with therapist. Detect other Behavioral action systems at play.
    - Resistant: help with regulation.
    - Avoidant: help with connection (with themselves).
- Address the patient's fears towards therapy. Don't be invasive.
- Keep an eye on NC and PC. References to the past. Out of place words.
- Realize the rhythm the patient requires, to be exposed to manageable bits of disturbance. Widen the WoT.

Regulation = Safety = Attachment

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## Phase 1 - Specific techniques (couple)

The objectives: improve co-regulation and safety.

- Restore safety and auto and co-regulation: Tolerance window.
- Techniques to promote co-regulation in sessions.
- Improve Communication and interaction patterns.
- Positive and negative affect tolerance.
- Conflict Reduction Relapse prescription.
- Work in limits
- Conflict analysis: conflict as a window to another type of relationship.
- Work with specific problems: sexual (sex as re-traumatization).

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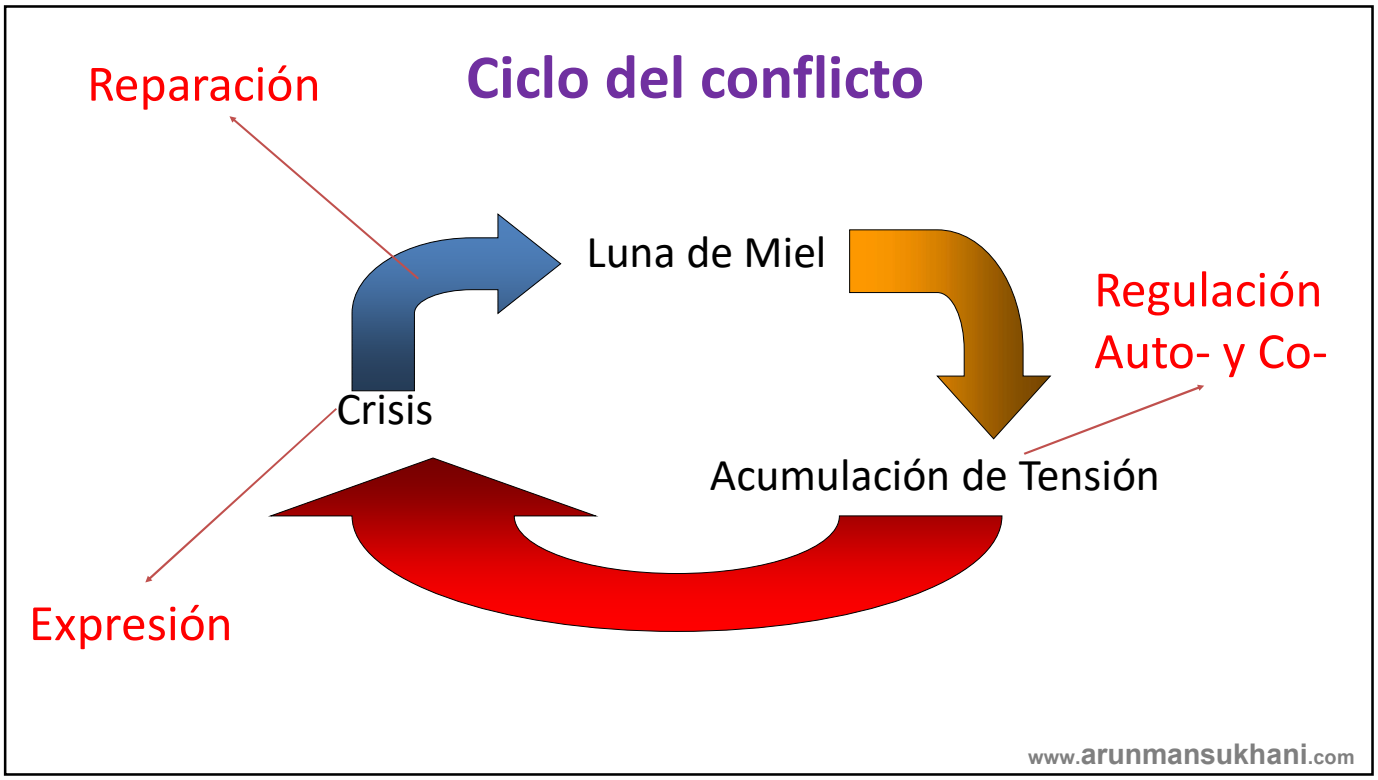


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## Phase 1 - Specific techniques (individual)

The objectives will be: emotional regulation, energy regulation, creation of **healthy internal adult** and improve internal dynamics (self-compassion):

- Creation of routines and structures. Work with regulation of energy levels. Homeostasic. Addictions.
- Beginning of pleasant activities: hedonic, eudaimonic and met objectives
- Assertiveness, work with limits (own / others).
- Detect and avoid non secure places / people.

- Self-knowledge. Self Acceptance. Self-compassion. Build a secure base within the self.
- Work with the inner adult. Work with the inner child.
- Differentiation of emotional parts
- Future templates.

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## Phase 1-2: Inner adult

Help create/get in touch with the **Healthy inner adult:**

- Calm, self regulated, able to co-regulate, in contact with his needs (self-care) and empathic (caring for others).
- Not counter-phobic, tired, angry, hurt,…
- Capable of autonomy and intimacy.
- Compassive. Self-reinforcing and capable of reinforcing others.
- Resources (not defenses).
- Capable of putting limits on himself and others.

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## Phase 1-3: Positive affect tolerance

- It's important to start working with positive affect tolerance, before going to negative affect tolerance.
- Sometimes it can be very evocative because it was not previously received, being seen, feeling of not deserving, impostor syndrome.
- It may connect with fear of being hurt (or ridiculed) because of past experiences.
- Mistrust



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## Phase 2: Work with Defenses

Awareness

Apreciate function / praise

Stay with it

Connect with the cost

Process double defense / wound

Work as part

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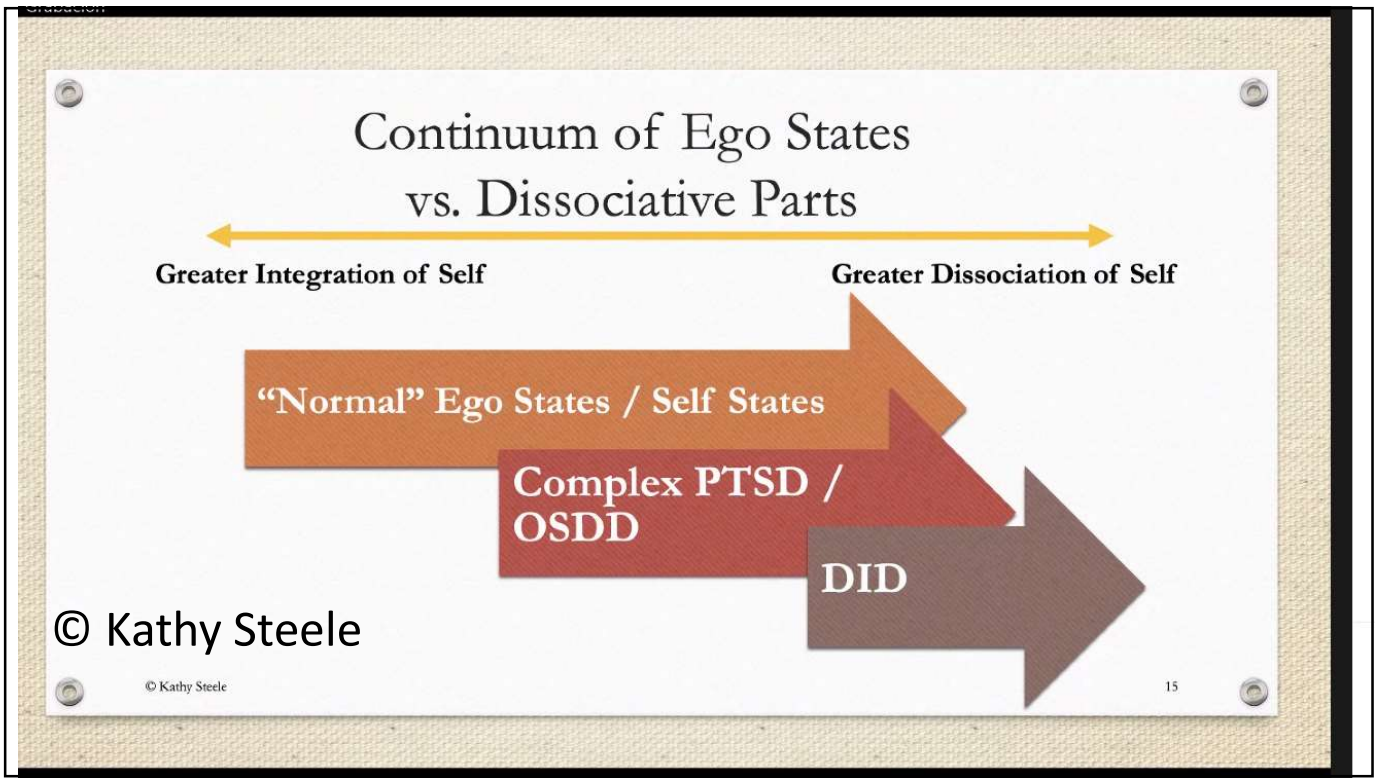


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## Phase 2 – Parts according to function

**Daily functioning parts** (cortical). ANP, "manager parts".

**Emotional parts** (subcorticales):

- Defensive parts: controlling, avoidant, adictive, dependent, pleasing…
- Disorganized parts: Son defensivas pero con rasgos muy destructivos.
- Hurt parts. "Basic Fault" (Balint 1979).
- "Exiled parts", parts that are stuck in trauma.

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## Phase 2 – Working with the internal world

- Static phase: Describe, analyze, name... Increase awarenes.
- Increase tolerance, and capacity of the adult to manage.
- Dynamic phase: interaction between parts: drawings, dynamics, meeting places, etc.
- Work with:
  - Co-consciousness. Prioritize adult parts.
  - Present orientation.
  - Understanding and empathy. Confidence. Phobia reduction.
  - Integrative capacity.

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## Phase 3 – Process memories

- MF based therapies.

- ACT – EMOTIONAL REGULATION
  - S. C. Hayes (2004) - Gross y Thompson (2007), Barlow (2004).
- **EMDR**
  - F. Shapiro (2001).
- FOCUSSING
  - E. T. Gendling (2001).
- SOMATIC EXPERIENCING
  - P. Levine (1997).
- SENSORIOMOTOR PSYCHOTHERAPY
  - P. Ogden y K. Minton (2000).

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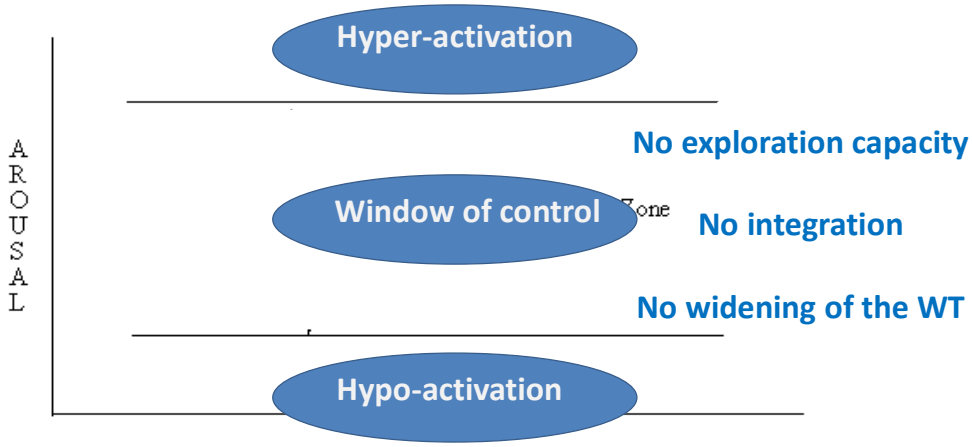
## Phase 3 – Process memories

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## What stops/hinders processing?: Loss of DF.

- **Leaving the WoT (loosing DF)**:
  - Hyper-activate and get locked out.
  - Hypo-activate and shut down.
- **Fear of leaving the WoT**. Fear of unmanageable feelings or other mental content . Activate Avoidance Defense Mechanisms:
  - Conscious Suppression. Avoiding, redirecting attention.
  - Denial, idealization.
  - Unconscious suppression (Window of control).
  - Partial Dissociation: BASK model (Brown 1988).
  - Defenses: Introjection, Identification
- **Structural Dissociation** (defense and/or failure of integration).



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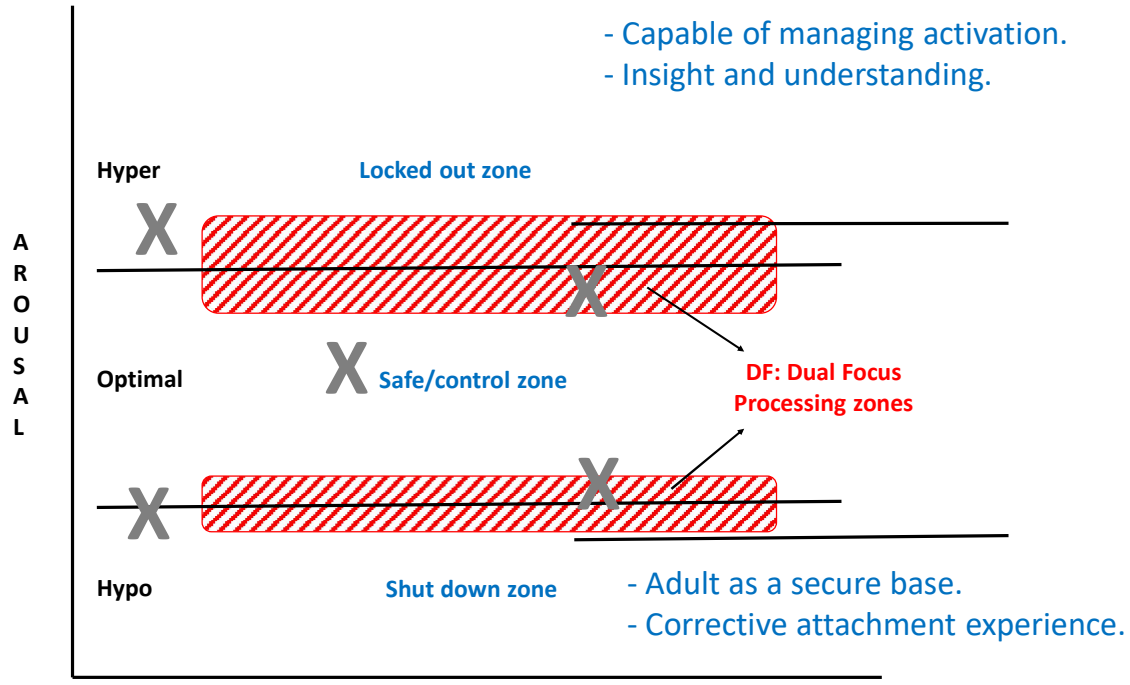


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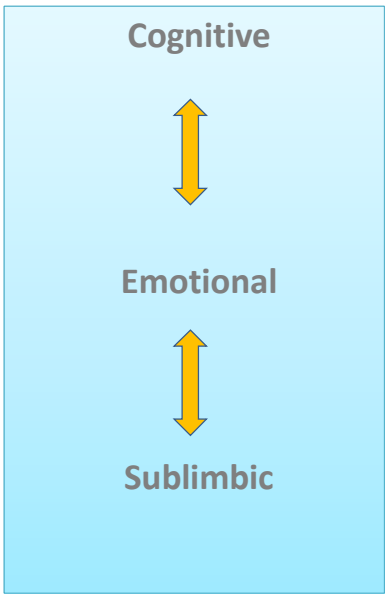
## Partial processing




- The meaning of the self
- De-sensitize situations, images change

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## Phase 3 – Emotions

- Basic emotions (wound):
  - T: panic, disgust, helplessness, …
  - AT: anxiety, sadness, loneliness, …
- Defensive emotions: anger, guilt, shame + counter-shame (hate and aggressiveness)
- Also child part emotions vs the adult emotions. Process both.
  - Emotion of the adult when sees the child: What do you feel now when you see that child? (If very intense negative emotions work with parts
  - If defense process as defense.
  - How is / was the child? How do you feel about that?
  - Can you feel (adult) what the child feels?
  - Joint processing (lap or through the eyes)

* If Inner Child spontaneously appears, it is a self resource, reprocessing is not over.

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# Phase 3 – Sensations

- Can be overwhelming at times and may require DF at initial stages to calm them. They may also block the processing and have to be separated at times from emotion and cognition to allow processing (DF very useful for this).
- Can also be absent or felt only in the head. In these cases (except when its a headache) it's very useful to ask:
  - "You feel this in the head and were else?" or "when you feel this in your head, what do you notice is happening in your body?"
  - "As you think about this, ¿what's happening (or changes) in your body?"

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## Phase 3:

Use **present interpersonal conflicting situations**:

1. Daily life, couple, work, etc. and connect with the past.
2. Problems with children:
   1. Reinforce them as parents for their sensitivity and concern
   2. Ask for the feelings while the child misbehaves. Start with the Main AF.
   3. Sugest to work on their emotions to help the child.
   4. Take about feeling and expectations: brings up the idealization (the defense against the attachment wound).
   5. Work either with the wound or the defense. Or use SP with a present difficulty and take it to positive end (opens up the attachment system).
   6. Make them understand that you can't fight the past and the present at the same time

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# Thank u!

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