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Attachment: The Antidote to Trauma

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Attachment:
The Antidote to Trauma

Joshua Straub, Ph.D.

Objectives

- Demonstrate the importance of the therapeutic relationship in helping traumatized clients, particularly those diagnosed with PTSD, overcome trauma-related symptoms
- Demonstrate how strategies such as meditation, mindfulness, and mentalizing are utilized in helping clients integrate traumatic experiences with their emotions and beliefs
- Develop an effective strategy for helping trauma victims gain attachment security and therefore engage in healthy relationships with their family and with God

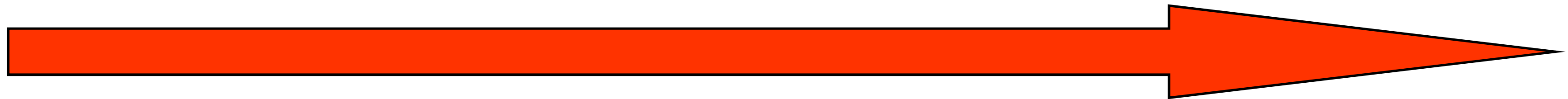
A range of disciplines

- Neurobiology
- Developmental psychology
- Traumatology
- Systems theory

Factors to Trauma

- Identified risk factors of early adverse life experiences
- Peritraumatic dysregulation (hyperarousal and dissociation)
- Posttraumatic social support difficulties

The Johns Hopkins'
RESISTANCE, RESILIENCE, RECOVERY
An outcome-driven continuum of care



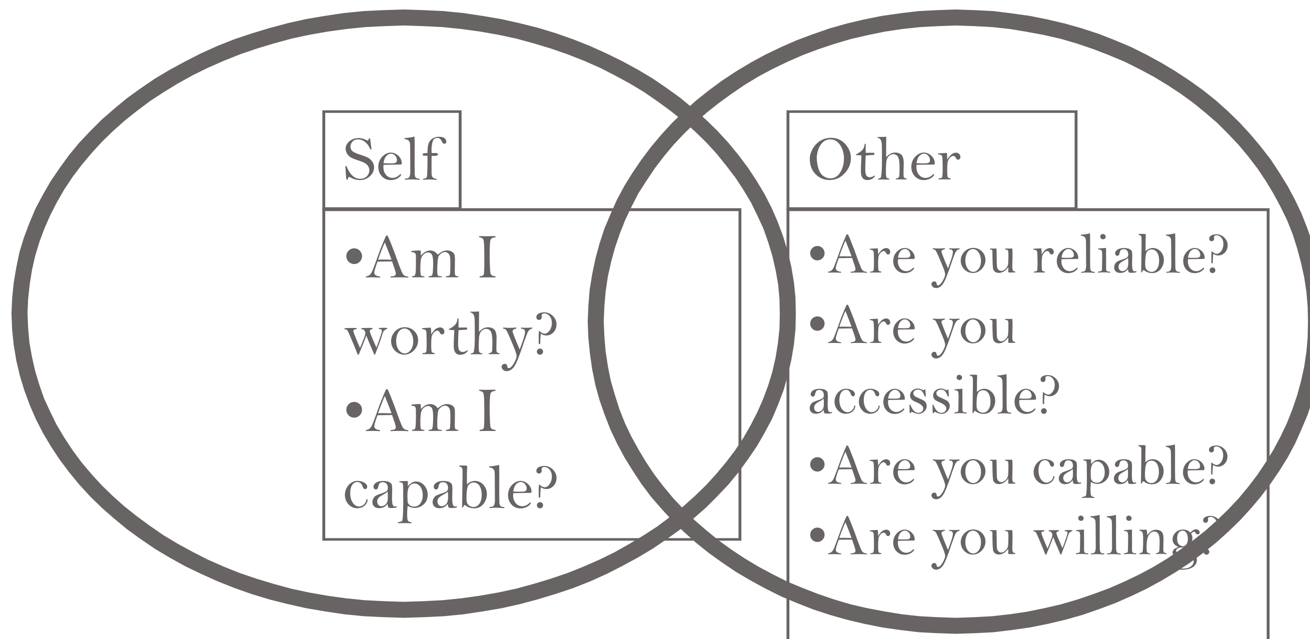
Create Resistance	Enhance Resiliency	Speed Recovery
Assessment	Assessment	Assessment
Intervention	Intervention	Intervention
Evaluation	Evaluation	Evaluation

[Kaminsky, et al, (2005) RESISTANCE, RESILIENCE, RECOVERY. In Everly & Parker, Mental Health Aspects of Disaster: Public Health Preparedness and Response. Balto: Johns Hopkins Center for Public Health Preparedness.

Attachment Theory

- How relationships shape our brains ability to regulate emotion and learn to participate in close, intimate relationships
- Emotion regulation is the ability to tolerate and manage strong negative emotions and to experience the wide range of positive emotions as well
- Key question: "Is this world I'm living in a safe or dangerous place?
- Forms basis for what Bowlby described as Internal Working Model

Core “Relationship” Beliefs



Internal Working Models

- Self – Am I worthy of love?
- Other – Are others reliable? Trustworthy?

- A set of conscious and unconscious rules that organize attachment experiences and act as filters through which an individual interprets relational experiences (Main et al., 1985)

- Self – Anxiety
- Others – Avoidance

(Bartholomew & Horowitz, 1991)

Attachment versus Close Relationships

- Secure Base – Exploration
- Separation → Proximity Seeking
- Safe Haven
- Loss → Grief

Measuring Attachment Beliefs

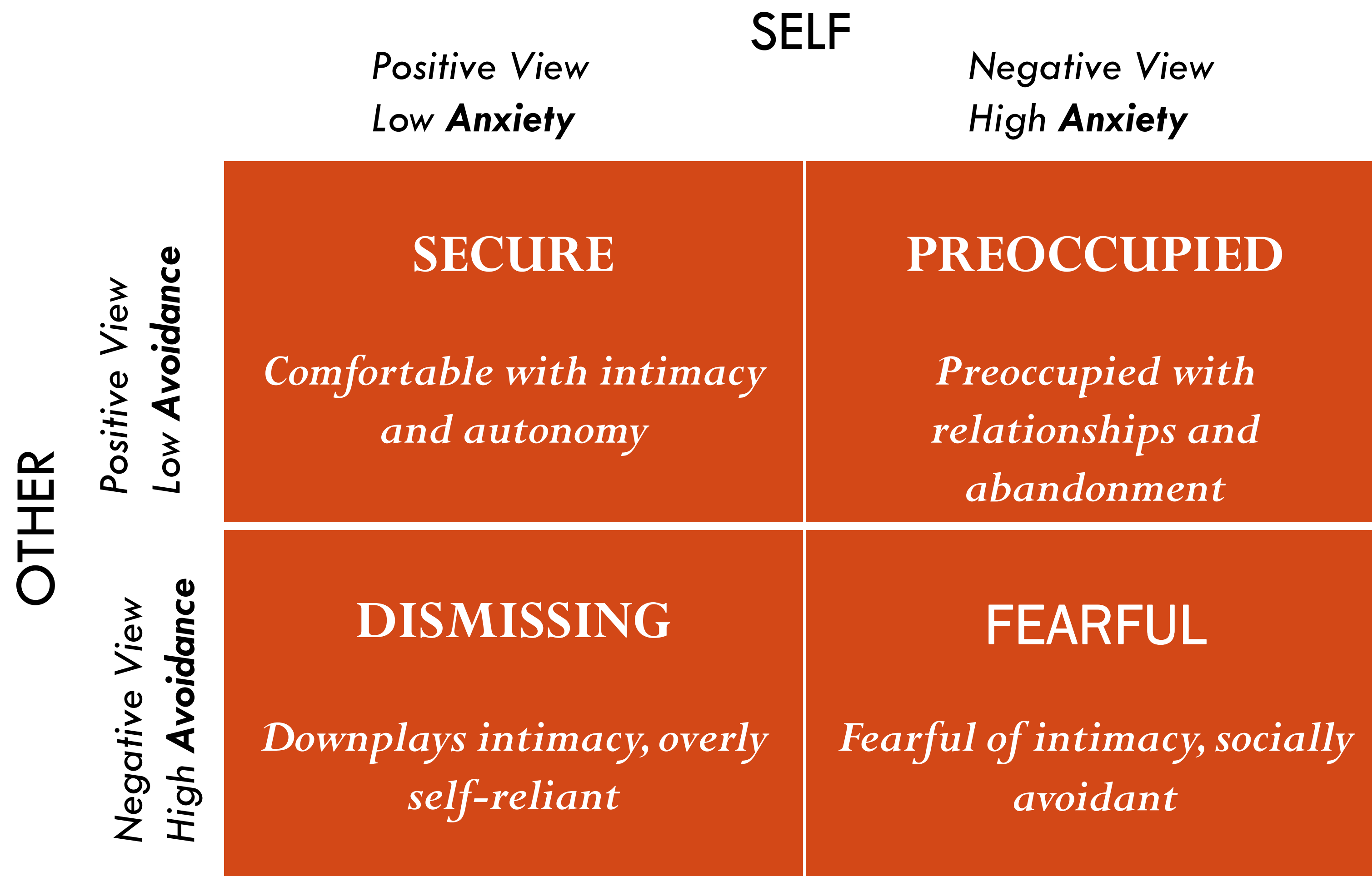


Figure 1.Bartholomew's model of self and other

Attachment and Feelings

Secure Attachment	Avoidant Attachment
➢ **Full range** ➢ **Good control** ➢ **Self-soothes** ➢ **Shares feelings** ➢ **OK with others' feelings**	➢ **Restricted affect** ➢ **Focus is on control** ➢ **Uses things to self soothe** ➢ **Keeps feelings buried** ➢ **Doesn't share feelings**
Ambivalent Attachment	Disorganized Attachment
➢ **Full range** ➢ **Poor control** ➢ **Can't self soothe** ➢ **Shares feelings too much** ➢ **Overwhelmed by others' feelings**	➢ **Full range, but few positive feelings** ➢ **Poor control** ➢ **Can't self-soothe** ➢ **Can't really share with others** ➢ **Overwhelmed by others' feelings** ➢ **Dissociates**

Complex trauma

1) Begins early in development (often within first 5 to 7 years)
2) Involves various forms of traumatic relationship experiences (physical abuse, sexual abuse, family violence, etc.)

Most destructive is what is known as "attachment trauma"

When attachment trauma occurs repeatedly throughout childhood it sets the stage for a many psychological, emotional, spiritual, and even physical maladies

Traumatic Homes

- 1) emotionally overwhelmed caregiver. (child cannot achieve a secure base and therefore is in a constant state of hyperarousal)
- 2) with no secure base the child struggles with developing a healthy sense of self-esteem.
- 3) trauma and abuse do not occur every moment of every day, but the threat is always there
- 4) child is faced with a relational paradox (dissociation and other types of unhealthy coping behaviors manifest in this environment)

diagnostic criteria for PTSD

- Criterion A - Exposure to a traumatic stressor.
- Criterion B - Re-experiencing symptoms.
- Criterion C - Avoidance and numbing symptoms.
- Criterion D - Symptoms of increased arousal.
- Criterion E - Duration of at least one month.
- Criterion F - Significant distress or impairment of functioning.

dose-response relationship

- Severity of the trauma, in terms of its intensity, frequency, and duration, is one of the most important determinants of a stressor's potential to induce subsequent PTSD. Clinical observation and research show a "dose-response" relationship between degree of stress and the likelihood, chronicity, and severity of PTSD symptoms. Specific characteristics of the traumatic stressors are important, such as degree of violence involved and whether sexual victimization occurred.

exposure

- Type I: short term, unexpected event, limited in duration (i.e. car accident, rape, bank robbery, etc.), leads to typical PTSD with symptoms of intrusion, avoidance, hyperarousal.
  - Those with type I exposure tend to recover more quickly
  - Type I trauma can create a recapitulation of traumatic experiences from early in life.
- Type II: prolonged events (i.e. Nazi camps, Iraq war, etc.), lead to extreme stress…eventual character problems.

traumatic stressors

- Qualities of intensity, frequency and duration of stressor severity
- Unpredictability and uncontrollability of the stressor
- Presence of life threat
- Bodily injury
- Tragic loss of a significant other
- Involvement with brutality or the grotesque
- Degree of violence involved, particularly violence of a criminal nature
- Sexual victimization

caring for trauma victims

- Intrusive recollections are why people seek treatment
- Affect regulation is at core of treating PTSD and other trauma related symptoms
- Conditioned Emotional Responses (external, internal, and relational events)
- When traumatic events cannot be appropriately processed people resort to
  - Avoidance
  - Dissociation
  - Tension Reduction Behavior:

Tension Reduction Behavior

- becomes addictive (substance abuse, cutting, sexual promiscuity, self harm, etc.)
  - Releases endogenous opiods (body's equivalent to morphine)
  - Defensive behaviors become overwhelming, not flashbacks themselves
  - Right side of brain stays in the now
  - Left side of brain needs to go back and put story to it

Caring for trauma victims

- Encouraging hippocampus to activate.
- Implicit memory to explicit memory which activates left hemisphere and the prefrontal cortex.
- It's about the extinction of fear responses
- PTSD has been called the "disorder of recovery" by Shalev and Briere
- The amygdala enables the encoding of fear
- The involvement of the prefrontal cortex has been found to help the majority of individuals recover from acute trauma.

systematic desensitization

1. Exposure
2. Activation of Emotion
3. Disparity—nonreinforcement of CER (feared outcome)
4. Counterconditioning—get them to relax in event (safety)
5. Extinction of CER

"Avoidance of pain is cause of all neurotic pain" – Jung

Two core issues

- Capacity of emotion regulation
- Ability to mentalize
- Traumatized people have trouble with what they feel and why they feel that way
- They have psychodynamic conflicts –afraid of intimacy (leads to autonomy and clinginess)
- The earlier the trauma the more difficulty in skill deficits
- How you go about helping clients will be determined by where they are in their skills
- More psychoeducational for secure
- Insecure don't know how to know their deficits of intimacy when trying to find a secure base

Attachment-based Therapy

- Safety
- Education
- Containment
- Understanding
- Restructuring
- Engaging