

Healing Attachment Trauma: When Words Are Not Enough

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Abstract

Attachment trauma theory provides a framework for mental health clinicians to gain a deeper understanding of behavioral symptoms. This paper describes the literature review the author made with the goal of helping the reader obtain a greater understanding of the importance of the earliest relationship, that of the caregiver to child. The neurological development in the early developmental years are discussed, as well as, the influence on the brain when attachment trauma is approached from a right brain to right brain therapeutic approach - specifically, art therapy, dance therapy, mindfulness, dialectical behavioral therapy, and therapeutic attunement and transference. The author gives the reader a look at the importance and necessity of preventing attachment trauma and education with caregivers, educators, and policy makers. The author covers an Adlerian approach to understanding trauma and recovery. The paper emphasizes a clinical understanding of the client's early developmental attachment patterns directly relating to future adult relationship patterns.

Keywords: attachment, trauma, neurology, art therapy, dance therapy, mindfulness, Adlerian, prevention.

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Healing Attachment Trauma: When Words Are Not Enough

“According to the old saying, it is better to travel hopefully than to arrive. Our quest for discovery rules our creativity in all fields, not just science. If we reached the end of the line, the human spirit would shrivel and die. But I don’t think we will ever stand still: we shall increase in complexity, if not in depth, and shall always be the center of an expanding horizon of possibilities.” Stephen Hawking

Humankind is meant to be connected and not live in isolation. Yet, how is it that people find themselves alone, maybe even convinced isolation feels better? John Bowlby, a British psychologist and psychoanalyst, studied the behavior of children who were hospitalized and separated from their caregivers for periods of time (Muller, 2010). He was actually ostracized by his psychoanalytic peers because he gave strong emphasis to the mother-infant relationship instead of a psychoanalytic view with his patients. Bowlby’s attachment theory was built around the child’s need to seek proximity to the caregiver in order to feel safe and to calm distress (Schore, 2011).

Since Bowlby’s studies and discoveries from the 1950s, other researchers and mental health practitioners have become increasingly interested in how these early connections affect relationships well into adulthood. It is thought that these early attachment patterns guide the person’s interpersonal relationship expectations and how the adult strategizes for proximity (Schore, 2011). Often times, it is when relationships are no longer working and painful, people find their way to a therapist’s office. Maybe they have given up, unable to be out in public or connected to anyone. Maybe they find themselves habitually in conflicted relationships with no tools to create something different for themselves. More seriously, researchers also have connected psychopathology and personality disorders to early attachment trauma (Perrin, 2011).

Research regarding early attachment traumas as well as the clinical experiences of this reader, leads to the hypothesis that treatment must seriously address the ability to uncover attachment patterns and heal those early wounds. This paper will show the work of other practitioners who support this hypothesis. This paper will describe the early brain development, the affected nervous system, and how healing methods of attachment trauma are located in the right hemisphere of the brain. Making the connection of the right brain of the therapist to the client's right brain requires creativity, intuition, spontaneity and less reliance on the verbal, cognitive emphasis often found in traditional therapies. Hope for the client can be in the felt sense of the moment-to-moment encounter in session. As in the Stephen Hawking quote at the beginning of this paper reminds the reader, to discontinue discovery humankind will cease to exist. Hope in mental health must continue to reach for the unlimited possibilities for healing. May the reader of this paper be inspired to risk, reach for, and expand the methods used in therapeutic practice.

Early Attachment Patterns

There is a motivator for relationships deep within every person. The need for proximity to another human starts very early in life, it is primitive (Siegel, 2012). Bowlby identified styles or methods used by humans and found that according to the encounter with the major caregiver, a child would quickly figure out the pattern most likely to keep them safe and in proximity to this person (Salzman, Kunzendorf, Saunders, & Hulihan, 2013). All patterns of attachment strategies are implemented to reduce the risk of rejection and not feel the pain or distress of feeling alone (Muller, 2010). Even once the child realizes a strategy is not working to stave off rejection, the child learns to resist or repress needs so as not to feel this rejection. In addition, there are dysfunctional ways the child will continue to attempt to maintain this attachment, no matter how

harming it is to the child's self. At all costs, it is in the biological nature of humans to maintain this attachment even if it is abusive (Schoore, 2011). In their research using the Primary Attachment Style Questionnaire, Salzman, et al. (2013), found and defined six patterns of attachment styles used in response to a caregiver's attunement or lack of attunement to the child. They focused on two developmental periods, before and after the age of 12.

Six Styles of Attachment

Three attachment patterns were related to a secure attachment, meaning, the child was provided a physically and emotionally safe environment from which to venture out and return to the secure environment of the caregiver. Salzman, et al. (2013), found variations within a secure attachment style that were noteworthy. *Secure attachment* means that the caregiver provides a safe place for exploration and comfort both physically and emotionally. The *secure/ambivalent* attachment style results when the child may have felt safe and connected but is not provided with enough independent exploration. The caregiver may be anxious and over protective, leaving the child unaware of a sense of self-agency and empowerment. Because innately we are meant to explore, the child feels both positively and negatively about the encounter with the caregiver and does not understand why. The *secure/avoidant* attachment style results when the caregiver provides the opportunity for exploration but not for a safe return to comfort. After exploration, the child may feel unsupported or even criticized if an adventure goes awry. The child can then feel less inclined to connect with the caregiver when something goes wrong. The *secure/ambivalent* and *secure/avoidant* styles begin with the initial sense of safety for the child but include an element of the parent's anxiety (Diamond, Fagundes, & Butterworth, 2011).

Three attachment styles are defined by the insecure attachment category. The insecure category can be described as an inconsistent attempt by the caregiver to provide safety on a

physical or emotional level leaving the child feeling anxious and unable to figure out a way to win approval or proximity. The *insecure/ambivalent* style results when there is not a secure, encouraging base from which to explore. The child alternates from neediness and fear to anger and rejection of the unpredictable caregiver. The child cannot decide between the encounter as being positive or negative. *Insecure/avoidant* style is a result of the caregiver being so authoritarian without comfort that the child learns to avoid an encounter. This child learns quickly to rely on self and not the caregiver. The *insecure/disorganized* attachment style is a result of a caregiver being abusive, frightening, and seldom comforting. Salzman, et al. (2013) refer to this style as “fright without solution” (p. 117) because there is no positive outcome that can come from the child’s attempts at proximity.

Physical and Emotional Neglect and Attachment

All attachment styles have two elements to the child’s life that need attunement by the caregiver, the physical and the emotional (Strathearn, 2011). Allan Schore, Daniel Siegel, and Sebern Fisher in their work currently focus on how the caregiver-child relationship affects the physical and emotional wellbeing of the child due to mis-attunement and early attachment trauma. When the physical and emotional areas are neglected by the caregiver, the child cannot be assured of the caregiver’s ability or desire to care for the child. Stressors upon the caregiver and their own unresolved attachment wounding can be projected onto the child, leaving the child scrambling to implement a strategy for connection to the caregiver. Feeling neglected or a void between the child and the caregiver is confusing for the child. If proximity to the caregiver becomes threatened by an outside source, the child will try to figure out how to manipulate a connection (Fisher, 2014). If none of their attempted strategies work, withdrawal and shutdown is the final option. Turning to the only explanation left, “it must be me” (Heller & LaPierre,

2012). The sense of threat to the child's wellbeing, either physically or emotionally, needs some kind of resolution. The ultimate wounding comes when the child who now must believe that self is the cause of the disconnection, turns hatred and attack back onto the self. Shame and self-hatred are generated from the child's inability to understand self as "a good person in a bad situation" (Heller & LaPierre, 2012, p. 144). As adults, this can lead to chronically feeling unloved, unlovable, and without value (Broussard & Cassidy, 2010).

Strathearn (2011) listed necessary physical elements for the child to feel safe and attached: food, clothing, shelter, medical care, and educational provision. Plus, the necessary emotional elements for safety and attachment: contingent and sensitive responses to infant cues, touch and affection, nurturance, and attention. The physical elements may be lacking due to poverty but the emotional elements are present. When the physical elements are present, maybe even to excess, and the emotional elements are insecure, unpredictable, or lacking completely, this combination is harder to see but nonetheless still damaging.

Emotional neglect may be a result of the caregiver's inability to process affect in the self or in another (Strathearn, 2011). Also, the way in which the caregiver attached to their caregiver early in life will be the way they attach to their own child if not brought to the conscious awareness. An adult who cannot track or be present to their own affect and dismisses their own feelings will do the same to the child (Snyder, Shapiro, & Treleaven, 2012). On the opposite side of a dismissive caregiver is the preoccupied caregiver (Strathearn, 2001). Without getting their own emotional needs met, they become over-reactive to feelings such as fear, anger, and a desire for comfort. Either dismissive or preoccupied, the emotional attachment to the child is wounded, leaving the child disoriented and attempting methods to connect with the caregiver.

The brain is in a profound state of development during the early attachment years and is at risk when there is a damaging response from the caregiver toward the child's innate needs (Fisher, 2014). Therefore, it is important to have an understanding of what is happening in the brain during these developmental years. Neuron connections can become concretized, seemingly unchangeable, that cause a thought pattern that can stay in place well into adulthood (Siegel, 2012).

The Brain Development and Attachment

The History of Brain Evolution

Larry Heller and Aline LaPierre (2012), give a description of the evolutionary aspects of the brain that is helpful in first understanding the importance of the child's early attachment influence upon the brain. The human brain began as a primitive reptilian structure, meant to keep the species alert and alive because of physical threat. Therefore, the brainstem developed first and with evolution, the more complex parts of the brain came later. The brainstem regulates necessary bodily functions like heartbeat, breathing, and temperature (Heller & LaPierre, 2012). Our ability to self-soothe and understand whether we are under attack or at risk, comes from this primal source in order to keep the species alive. Under threat, the body will be given messages from the brain on how to protect itself and ready for an attack. Then when the threat is gone, the body can relax or come down from necessary, life-protecting activation. In other words, when necessary, the brain activates the sympathetic nervous system, the heart, lungs, and body temperature (Levine, 2011).

The next part of the brain to evolve was the basal ganglia that allowed us to learn a behavioral-motor response through repetition (Heller & LaPierre, 2012). You can learn a behavior if repeated over and over, like riding a bike, practicing a tennis swing, or texting at a

high rate of speed. When thinking about attachment relationships with major caregivers, a child will learn quickly what works or does not work to stay in proximity to the adult. It becomes repeated, a routine, and a pattern hard to interrupt, especially if it is working (Heller & LaPierre, 2012).

The next part of the brain to evolve was the limbic system. Here emotions are experienced and the ability to adapt to changes, as well as socialization (Heller & LaPierre, 2012). We now understand pleasurable or unpleasurable experiences and the stronger those experiences, the more likely we encode them in the memory. In the attachment relationship, the more emotional the experience, the more likely it is remembered (Siegel, 2012).

Lastly, the cortex evolved, giving us the ability to recognize a strategy, regulate affect, and become aware of voluntary movements (Heller & LaPierre, 2012). This is a higher brain function that does not fully develop until the prefrontal cortex. Our first experiences with a caregiver do not include words and conscious strategy but, instead, the more primal functions of sensory clues (Siegel, 2012).

Early Brain Development

Allan Schore is a leading researcher in neuropsychology who has written many articles on the early brain development in a healthy attachment and a dysregulated traumatic attachment. His article “Relational trauma and the developing right brain,” is found in the book *Relational Trauma in Infancy*, edited by Tessa Baradon (2010). When the infant’s early attachment to the primary caregiver is traumatizing, dysregulating, and unpredictable, the child’s brain development is interrupted and influenced especially in the right hemisphere where affect regulation, perception, visceral cues, and social connection is regulated. These are pre-verbal

aspects of communicating for the child and are possibly the most important in development for the child (Schore, 2010).

When the caregiver and child have affectively synchronized their communication, the brain produces oxytocin, catecholamines, and cortisol, all of which are necessary for brain development (Schore, 2010). These growth-producing hormones affect the hypothalamic-pituitary-adrenocortical (HPA) axis in the brain that is central to regulating stress. The infant requires assistance in managing stress, having their needs met, and feeling that sense of attunement or these hormones will either be under or over produced, leading to a less than optimum functioning of the HPA axis (Schore, 2010). In fact, these hormones affect the growth of the baby's hippocampus, the brain's portal to memory (Fisher, 2014). The right hippocampus is important for nonverbal, implicit memory and the left hippocampus is important for the explicit or verbal memory (Fisher, 2014). Memory not at the conscious level is most likely right hippocampus memory encoded in the first two years of life. So a traumatized early attachment in the adult client may at first be hard to detect verbally but as we shall see later in this paper, the therapist can become more attuned with clues, both implicitly and explicitly that can point toward the necessary healing of relational attachment trauma.

It is important to note that attachment interactions with the caregiver in the first year of life are happening when total brain growth is increasing by 101%. This growth is experience-dependent (Schore, 2010). The limbic system grows quickly in the first year and a half of life and the right hemisphere is integrated into this system by the corpus callosum. As the infant's and the caregiver's right brain communication is improving, the limbic system is properly developing as well. As we read earlier, the limbic system is where we feel emotion, adapt to change, and socialize. Housed in the limbic system are the amygdala, hippocampus, thalamus,

and hypothalamus (Creeden, 2009). The caregiver's right brain is providing emotional awareness, congruent facial expressions, ability to listen, proper intonation, and the ability to feel tactile sensations (Schore, 2010). Schore noted that if the caregiver's system is highly dysregulated from their own attachment trauma, the infant's ability to obtain clues from the caregiver is thwarted, causing the patterns first discussed in this paper, adaptation of a potentially healthy attachment to an unhealthy attachment.

Visual-facial communication is in the right hemisphere of the brain (Schore, 2010). The gaze of caregiver to child and child to caregiver is generating brain development as early as 2 months and electroencephalography (EEG) studies indicate it is the right hemisphere that is activated. If the caregiver cannot respond and mirror the infant's expressions, or is flat, fear-inducing, or incongruent with the emotional experience, the child will become fearful and turn away from the relationship (Schore, 2010). The caregiver's response then may be one of confusion and awkwardness in the misinterpretation of the infant's behaviors. The cycle continues. Causing stress for the infant's emotional wellbeing, the infant's brain is responding to this stress with ever increasing hormonal exertion and encoding in the right hemisphere what being in relationship is like. A survival strategy of some kind will become entrenched in the child's way of seeing self and the world. Most important to the infant is the emotional connection with the caregiver (Creeden, 2009).

The amygdala is focused on survival, reacting to both real and imagined threat (Fisher, 2014). The hippocampus and the amygdala become good at *kindling*. Kindling is when neuronal firings are so repetitive that finally it does not take much of an event to trigger the hippocampus and amygdala (Fisher, 2010). When the amygdala is persistently activated, this kindling effect causes the person to become hypervigilant in looking for threat and over-interprets or

misinterprets cues as threatening (Creeden, 2009). For the infant, the pattern of adapted attachment becomes their way of surviving and being. With each mis-attunement with the caregiver, it does not take much for the child to respond in a fear-driven way.

Early attachment experiences affect the development of the self over the course of the life span (Schoore, 2010). The attachment system contributes to one's survival by motivating the adult self for protective strategies in times of threat (Reizer, Dahan, & Shaver, 2013). The adult may be implementing a strategy of survival where threat may not exist. Therefore, with attachment trauma, unless the client uncovers the reason behind their easily triggered survival strategy, their adult relationships will be constantly affected by this need to protect the self (Reizer, et al., 2013). In addition, the client will desire proximity and protect any attachment to another it may have, even to their detriment (Heller & LaPierre, 2012).

Finally, the prefrontal cortex, the last to develop, works in connection with the limbic system. It monitors what the body is experiencing and makes meaning, translating sensations into emotions (Creeden, 2009). The caregiver's ability to serve as the cortex for the infant's undeveloped cortex is what Siegel (2012) describes as attunement. Abuse, neglect or mis-attunement by the caregiver can damage the infant's early synaptic development, leaving the child with less ability to regulate emotions or interpret behaviors in times of threat or perceived threat (Creeden, 2009).

Neurobiology and Attachment Patterns

The Central and Autonomic Nervous Systems

The central nervous system (CNS) regulates the social-emotional stimuli and the autonomic nervous system (ANS) regulates the somatic body sensations of emotion (Schoore, 2010). In early attachment with the caregiver, these systems are not only just beginning to form

in the infant they are forming according to the attunement with each other. If the caregiver is either over or under reacting to the infant's distress signals, the infant's nervous systems are activated for a protective response (Levine, 2010). Especially damaging is when the infant experiences abuse or neglect from the caregiver. If the caregiver does not recognize their inability to respond appropriately and continues hurtful behavior without repair, the infant is left to tolerate these highly activated states of arousal for long periods of time (Schoore, 2010).

When the infant first communicates distress, the right hemisphere of the brain is activated and the sympathetic components of the ANS are activated. This includes increased heart rate, blood pressure and rapid breathing (Schoore, 2010). The infant communicates through crying and screaming. If these distress signals do not work, then the infant goes into protest, then rage, and finally resignation. If met with anger from the parent for having a need, the child fears more danger and goes into collapse, freeze, and shut down (Heller & LaPierre, 2012). The collapse and shut down occur when the nervous system can no longer stay at such a sympathetic dominance or hyper-arousal. The only option is to engage the parasympathetic components of the ANS or hypo-arousal, resulting in a decrease in blood pressure, metabolic rate, and decreased heart rate (Schoore, 2010).

Dissociation from the unbearable stress looks like numbing, avoidance, compliance, and restricted affect (Schoore, 2010). It is the ultimate psychological escape from pain when a literal escape is not possible. The child unconsciously and biologically behaves in a way that if she is not going to be met, mirrored, and validated, then she must conserve energy from this high activation in order to survive. There is a secondary part of the parasympathetic system that helps with basic survival called the reptilian system. It will shut down during social stress, resulting in immobilization and feigning death (Levine, 2010). This is our animalistic need to survive when

under attack. When experienced for years, the adult can be dissociated from their nervous system's attempts at activation or getting the person's attention. This is the state of being that some clients come to the therapist experiencing, feeling very removed from themselves.

Dissociation can result in Dissociative Identity Disorder (DID). It can be difficult to recognize and treat symptoms of dissociation (Biswas, Chu, Pere, & Gutheil, 2013). Biswas, et al., propose that DID results from the child's inability to develop a unified sense of self because of early attachment trauma (2013). If clinicians are not trained to recognize dissociative behaviors and the client cannot self-report symptoms, the condition may get misdiagnosed and become difficult to treat.

Dis-associating from the physical and psychic experience involves altering consciousness, memories, personal information and identity (Pierce, 2014). These dissociated states allow the child and subsequently as an adult, to tolerate traumatic memories, affects, sensations, beliefs, and behaviors. Identities may develop in a protective stance through early development, adolescence and adulthood (Biswas, et al., 2013). Dissociation can become hard-wired into the brain as a strategy for regulation. There is a high correlation between chronic childhood trauma and complex presentations of posttraumatic stress symptoms, including depression, dissociation, unrealistic self-perception and identity, impulse control, interpersonal problems, and behavioral and affect dysregulation (Pierce, 2014). The wounded right brain cannot cohere the external with the internal. During chronic attachment trauma, right brain regulatory functions are not integrated to serve as a protector against high emotional activation (Pierce, 2014). It is important that DSM-5 diagnoses take into consideration the incoherence of the external to the internal experience.

Other Diagnoses Related to Attachment Trauma

Attention Deficit and Hyperactivity Disorder (ADHD)

ADHD symptoms, inattention, hyperactivity, and impulsivity, are the most frequently found disorders in childhood and adolescence. Adults are also being diagnosed more readily now with ADHD. (Roskam, Stievenart, Tessier, Muntean, Escobar, Santelices, Juffer, Van Ijzendoorn, & Pierrehumbert, 2014). In a study conducted by Roskam, et al. (2014), they predicted a relationship between early attachment deprivation and ADHD. Their results show that an increase in ADHD symptoms can be predicted by the duration of exposure to early attachment trauma. Cognitive theories explain ADHD symptoms in terms of a low level of executive functioning such as, interference of behavior control, cognitive flexibility, and a motivational deficit. The research shows that environmental conditions affect the resulting characteristics of ADHD. Within one month of life, the lack of stable care, nurturance, and emotional attunement has an impact on the development of attachment relationships, contributing to an increase in ADHD symptoms for years to come (Roskam, et al., 2014).

Personality Disorders

Bowlby theorized that early attachment issues are often at the core of many personality disorders (Levy, Johnson, Clouthier, Scala, & Temes, 2015). A child whose physical and emotional needs are met by a caregiver will develop a sense of others as reliable and supportive. A child who is unsupported or ignored often sees people as inaccessible, uncaring, not trustworthy and may continue this schema well into adulthood. These assumptions of the other become components of a person's personality and can remain over time especially if unable to connect with a support system. This results in an attachment style identified in adulthood that

relates to personality disorders. Levy, et al. (2015), identify three attachment adaptations in adulthood.

Preoccupied adults appear overwhelmed by anxiety and negative emotions in close relationships. Neurologically, they have greater activation in the posterior cingulate cortex and inferior parietal lobe, areas of the brain that experience emotion regulation. They have difficulty down regulating intense affect. *Dismissing/avoidant* adults distance themselves from people to defend against painful feelings related to early attachment relationships. The amygdala and insula are highly activated when processing emotions. These adults are hypersensitive to emotional cues. *Unresolved/disorganized* adults have less ability to monitor their reasoning or speech especially when talking about events such as loss or trauma, reflecting their contradicting sense of trust and mistrust of others (Levy, et al., 2015).

More specifically, Levy, et al. (2015), suggest personality disorders related to these adaptations. Preoccupied adults fall along a continuum of high adaptation or non-disordered to Borderline Personality Disorder with Histrionic and Dependent Personality Disorders between these two adaptations. Dismissing adults fall along a continuum of high adaptation or non-disordered to Obsessive Compulsive and Avoidant to Borderline or Anti-social Disorders.

In Borderline Personality Disorder (BPD), the negative emotions are linked to a decreased prefrontal activation and increased amygdala activity. Insecure attachment is common in BPD. This leads to an inability to mentalize, the “ability to conceptualize the mental states of self and others” (Levy, et al., 2015, p. 201). Insecure attachment formed in early childhood often results from traumatic experiences common to BPD, leading to difficulty with emotional regulation and self-identity. In order to be relieved of the intensity of affect, the individual creates coping mechanisms that result in symptoms of a personality disorder. It is important that

clinicians stay curious about early attachment trauma with clients who exhibit personality disorder characteristics and be willing to treat the early trauma. Recognizing the presenting behaviors indicative of attachment trauma is critical.

Presenting Behaviors of Attachment Trauma

Emotional Detachment

A client may appear reluctant to describe their emotions about an event, or even as if no emotion exists. This can feel like what has been typically called the resistant client. The client actually cannot reflect upon their emotion (Muller, 2014). If emotions were not mirrored or met by the caregiver, emotional experiences then felt like rejection. The child learns quickly to detach from or disassociate from their emotions. As an adult, the client directs the attention in session away from their internal emotional states. If pushed in therapy to express emotion, the client may prematurely quit. Only after attunement and therapeutic alliance is established can the client risk allowing the emotion (Muller, 2014).

Inability to Regulate Affect

Developmental trauma has the capacity to limit the ability to regulate the response to emotion. Physically, the client will feel a dysregulation in their breathing, heart rate, blood pressure, digestion, and sleep (Heller & LaPierre, 2013). The client's emotions may present as being out of congruence with the content. When fear, shame, and rage are activated in the amygdala, at least for a period of time, the client gets relief from numbness (Fisher, 2014). Even desirable emotions can seem extreme or frightening for the client. The extreme response may be frightening for the person, feeling out of control, even having the sense of "blinking out" for a moment. Without self-awareness, this can be the onset of personality disorder (Levy, et al., 2015).

Misreading Emotional Cues

A client with attachment trauma also can have difficulty reading other people's facial expressions or states of being (Schore, 2010). They may misread another's intentions. Their interpretation is informed by the need to protect themselves, therefore reading a situation has the probability of being inaccurate. In addition, the client may have an inability to accurately identify one's own internal states, called desomatization (Schore, 2010). Early attachment experiences also contribute to beliefs about worthiness of love and expectations about how others are responding or will respond to their expressions of distress (Monti, and Rudolph, 2014).

Overly Self-Reliant

A client may implement the strategy of not needing anyone else and appears very strong, independent, and uses mostly cognitive communication. All people are seen as unreliable, even the therapist. The client might even be watching for signs of the therapist's rejection in some way to confirm their belief (Muller, 2014). The client may have become most comfortable in the left-brain, rationalizing strength and pursued a career that protected them from reflecting upon their need for another. This strategy helps to keep the client from feeling the anxiety and pain from the possibility of not having their needs acknowledged by another person. Also described as the *cutoff*, this technique pushes away others in hopes of not facing the distress of attachment related issues. The underlying feelings are just too frightening (Muller, 2014).

Internalizing Reactions

It is common with attachment trauma that the client believes undoubtedly that another's reactions to an encounter with the client are "my fault." This became the child's conclusion with early neglect or abuse by the caregiver and carries on into adult life. The client works hard to not cause a negative reaction in another but is unable to be successful. Nonetheless, the client will

keep trying. When a client is convinced of this strategy for even the slightest connection, it leads to feeling very empty, lost, dead, faulty, and non-existent (Schore, 2010). A client in session may even remark, “I feel like I do not exist.” Heller and LaPierre (2013) called this internalization of hatred as *acting in*, believing that a negative response to self is deserved and serves to protect the idea of a potential attachment to caregiver or anyone.

Dissociation and Splitting

During times of dissociation, the right hemisphere is not functioning properly. It cannot organize the expression of emotion and stay present to the current environment. It is as if something in the brain gets switched off (Schore, 2010). The emotional functions within the right brain that could help with external coping are not available to the person. That which is related to a healthy early attachment is shut down, such as, nurturance, play, joy, affection, sexuality, fear, and anger. The client must withdraw from what could leave them open for rejection and the anguish of expecting those states of being to not be accepted (Schore, 2010).

“Dissociation is a splitting or separating of different aspects of experience and its representation” that is too difficult for the psyche to process (Carter, et al., 2011, p. 348). Splitting off from one’s unbearable emotion or circumstance is an attempt at self-agency (Carter, et al., 2011). The child, in trying to maintain safety and proximity, learns to split off from the self any emotion or response that created internal and external dissonance, leading to future dissociation (Stewart, et al., 2011). The inability to allow negative emotion toward the caregiver is a life-saving strategy that can manifest in self-hatred and a freeze response, appearing as frozen in the therapeutic office. (Heller & LaPierre, 2013). If the client is unconscious to one’s own anger or rage, they may project the split-off emotion onto another and be terribly frightened

by someone else's aggression. This strategy worked in early development to protect the attachment or proximity but at great cost to connection to the self (Heller & LaPierre, 2013).

Maintains Favorable Caregiver Image

The client may want to make excuses for the caregivers or even idealize them. In the therapeutic discussion, the client will leave out important early relational events. This is a desperate attempt to believe the caregiver was or even is, still trustworthy. It is too frightening to think there was no one there to protect or meet the client when it was most needed. In some cases, to realize the caregiver as perpetrator is terrifying. Muller (2014) called this *deactivation*. The client is disabling the feelings, memories, and ideas that threaten the real or perceived relationship with the caregiver, no matter whether it is healthy or damaging.

When clients with early attachment trauma appear in the therapist's office, they most likely will come with a diversion as a way of keeping an emotional distance from the therapist (Muller, 2014). Yet, the presenting symptom, especially a relationship conflict, may actually be unconsciously guiding them to the deeper early attachment issues (Brandell, 2010). Defense systems have broken down in work, relationships, and living a meaningful life. Distancing and avoiding the emotional life is an indirect expression of discomfort with closeness, an early attachment trauma symptom (Muller, 2014). Detaching any felt sense of desire for authentic connection is a survival mechanism (Rappoport, 2012). It would be tempting for the therapist to stay on the surface and not see the deeper symptomology but ultimately not serve the client.

Limitation of Therapeutic Models and DSM-5 Diagnoses Uninformed by Trauma History

Currently, the DSM-5 supports a diagnosis for Reactive Attachment Disorder that is diagnosable for children only. However, these symptoms are similar to what an adult with attachment trauma presents. Some examples are: rarely or minimally seeking comfort when

distressed or responding to comfort; limited positive affect, minimal social and emotional responsiveness to others, and a history of insufficient physical and emotional care (American Psychiatric Association, 2013).

Post-Traumatic Stress Disorder has some similar symptoms that could relate to early attachment trauma: intrusive distressing memories, distressing dreams, dissociative behaviors, avoiding external reminders and emotions, inability to remember, and persistent negative beliefs about self, others, and the world, feelings of detachment from others, hypervigilance, angry outbursts, problems with concentration, and sleep disturbance (American Psychiatric Association, 2013).

Most traditional therapeutic models focus on the need to process language. This may be the least affective model due to the pre-verbal nature and brain development of early attachment trauma (Creeden, 2009). The left hemisphere of the brain is responsible for analytic thought, logic, remembering detail, language, reasoning, and conscious thought or the domain of the explicit. While the right hemisphere is responsible for empathy, non-verbal information, awareness of voice tones, imagination, intuition, insight, metaphor, and the domain of the implicit (Quillman, 2012). Attachment trauma is imprinted into the right hemisphere systems and encodes disorganized and disoriented insecure, non-conscious early attachment encounters and information (Schoore, 2014). Relational processing and dysregulation caused by early attachment trauma can be associated with most, if not all, psychiatric disorders (Schoore, 2014).

The Sitko study, done in 2014, examined and found insecure attachment styles having links between childhood trauma and positive psychotic illness (Sheinbaum, Kwapil, & Barrantes-Vidal, 2014). Sheinbaum, et al. (2014), studied similar connections and found support for attachment traumas being a contributor to psychosis. They found that “adverse relational

experiences on the attachment system is what carries most risk for developing psychotic phenomena” (Sheinbaum, et al., 2014, p. 2). Bowlby believed that integrating the non-conscious material of attachment trauma is a goal of all psychotherapy (Schore, 2014).

Unfortunately, behavior management approaches begin from the standpoint that the client lacks motivation and the therapist hopes that the right combination of award and consequence will change the behavior, therefore, changing the thought process (Creeden, 2009). As we have seen, in actuality the attachment trauma has neurological damage that impacts the child, and later adult, from functioning within the necessary prefrontal cortex or left hemisphere. As therapists, we cannot only be interested in changed behavior even if the treatment plan and insurance company is measuring such behavior modification. Creeden (2009) boldly suggests that with adults caught in abusive behaviors of their own, they must be approached from their own trauma histories of abandonment. Their early attachment trauma is also a likely influence on memory loss, cognitive inability, and not being able to integrate their emotion or even seem lacking of emotion (Creeden, 2009).

A New Diagnosis for Attachment/Developmental Trauma and Possible Interventions

There is movement toward reviewing a possible diagnosis that would be informed by early developmental attachment trauma. Ford, Grasso, Green, Levine, Spinazzola, and van der Kolk (2012) surveyed child-serving professionals to assess the clinical utility of a possible new diagnosis. These professionals included psychologists, social workers, counselors, marriage and family therapists, psychiatrists, educators, child protective services, case managers, and pediatricians. Ford, et al. (2012) proposed that a diagnosis of Developmental Trauma Disorder would result in more effective treatment than the current evidenced-based treatments that are used for regularized DSM-5 anxiety, ADHD, or PTSD disorders. They hypothesized that

“Maltreatment, family violence, and disruption in primary caregiver attachment in childhood may constitute a developmental form of trauma that places children at risk for multiple psychiatric and medical diagnoses that often are refractory to well-established evidence-based mental health treatments” (Ford, et al., 2012, p. 841).

Seven symptoms were identified as not being accounted for by any other psychiatric disorder. They were 1) beliefs about self as permanently damaged, 2) expects irresolvable attachment loss, 3) expects betrayal, 4) believes self was damaged by trauma, 5) expects to be victimized, 6) over-identifies with others’ distress, and 7) cannot self-soothe (Ford, et al., 2012). There were more symptoms identified as potentially not accounted for by other diagnoses. Some of these included reactive aggression, impaired attention due to perceived threat, aversion to touch yet seeking physical contact, impaired ability to express emotion or avoidance of emotion, somatoform pain that is medically unexplainable, extreme risk taking, and inability to experience positive affect or recover from a dysphoric state (Ford, et al., 2012).

The professionals surveyed indicated that a developmental trauma disorder diagnosis may have clinical usefulness and may be discriminable from other diagnoses. They also rated developmental trauma disorder symptoms only partially addressed by evidence-based treatments (Ford, et al., 2012). This study of professionals encourages more research to be performed. We have only just begun to bring greater awareness to the needs of attachment trauma or developmental trauma and to approached it from a unique standpoint of its own diagnosis. Without an Attachment Trauma diagnosis, we will continue to misdiagnose and use treatment plans meant for other disorders. A neurological perspective on diagnosing and treatment is essential to understanding and exploring different healing modalities.

The Polyvagal System and Feeling Safe in Therapy

One of the indicators of attachment trauma is seen in the polyvagal system. This system responds to threat, perceived or imagined, experienced by the client. Stephen Porges, a neuroscientist at the University of North Carolina, has studied the polyvagal system and its importance in revealing automatic, physical responses in the therapeutic process (Quillman, 2012). Therapy that relies only on left hemisphere functioning, talking and reasoning, will miss the cues being given by the polyvagal system. The vagus nerve, emerging from the tenth cranial nerve, supplies the nerve movement to the muscles around the eyes, ears, larynx, pharynx, and the heart (Quillman, 2012). Being able to remain socially engaged in therapy is revealed in voice tone, facial expression, and inner ear balance. It allows for rapid adjustments in facial muscles and the larynx, communicating beyond words in the therapeutic session.

When under threat during the retelling of a story or the therapist's questioning, this system goes into two possible responses. These are 1) hyperarousal: a fight or rage where the pupils dilate, hearts races, respiration increases (Quillman, 2012); arising out of fear and anxiety (Hass-Cohen, Findlay, Carr, & Vanderlan, 2014), or hypoarousal: a freeze or dissociation because the client cannot flee (Quillman, 2012); causing deactivation of the brain regions responsible for verbalization and cognitive function (Hass-Cohen, et al., 2014).

The polyvagal system has two branches, the dorsal (top) and the ventral (lower). The dorsal branch signals the stress response, activating the heart, liver, and the gut and can become conditioned over long periods of trauma. The ventral branch has a calming influence on the heart, breathing, and speaking, generating oxytocin. This allows for greater curiosity, disclosure of emotions, and social bonding (Hass-Cohen, et al., 2014). If a history of early childhood trauma activates the conditioned stress response, it lingers into adulthood, trapped in anxiety that

feels as if it cannot be modified. Under this conditioned response, therapy can be negatively affected if the client feels misunderstood. It stimulates old feelings from previous mis-attunement.

Behavioral change or therapeutic influence is, therefore, reliant on skilled sensory watchfulness on the therapist's part. Little can be accomplished when the client is in either hyper or hypo arousal. If the therapist is only trying to use talk therapy, she may unintentionally be activating either of these two responses without understanding the client's window of tolerance (Quillman, 2012). The therapist must also be tracking her own sensory experience and be willing to share her present-centered experience in the therapeutic moment. Porges states therapist self-disclosure, or right brain experience, is one of the most effective ways to access the client's vagal system and right brain healing. It uses left-brain language to describe right-brain somatic or affective experience (Quillman, 2012). "The conscious left brain is far less skilled than the unconscious right at perceiving the implicit communications of others. . . . attachment communications are implicit, affective, and nonverbal" (Quillman, 2012, p. 3). There are therapeutic methods that emphasize the implicit communication and memories. This focus has been part of analytical psychotherapy for years.

Using the Therapeutic Relationship

Traumatic memory involves a layering of different memory systems and the last system to develop is the episodic (Pickering, 2012). When traumatic memories are felt through the senses, they are implicit, lacking reflective opportunities until triggered by a relational encounter or episode. Jung's practice and early psychoanalysis emphasized that the psyche's complexes were best understood in relationship (Knox, 2011). In addition, Bowlby affected the utilization of relationship with his studies on communication, attachment, and trauma (Carter, et al., 2011).

Repeated patterns of unhealthy interaction can be altered when something new is introduced into a relational encounter, otherwise known by Jung as the transcendent function (Carter, et al., 2011). If trauma is prolonged, Connolly (2011) quotes Jung, “whole tracts of our being can plunge back into unconsciousness and vanish from the surface for years and decades” (p. 609). The modalities described below all hinge on introducing something new, something felt on the implicit sensory level in the therapeutic approach.

Right Brain Hemisphere Healing

Right brain-to-right brain therapy is a present centered approach between the therapist and the client. Here the nonverbal communication happens, such as, facial expressions, tone of voice and gestures. In the present moment, transference and countertransference can activate implicit memories of either being met or not being met by the attachment figure (Schoore, 2014). The unconscious communications between the inner worlds of therapist and client can express dissociated affects connected to early attachment trauma. What could not be shared with or regulated by the caregiver now has potential of being healed with the transference toward the therapist.

This transference makes it all the more necessary for the therapist to be internally regulated themselves. What the child did not get from a regulated parent who was either over or under reacting, can be accessed through the therapist. Non-judgmental, availability to the client is what was missing in early attachment but is now felt from a right brain sensory experience. Evelyn Rappoport (2012) describes through a helpful case study, her experience with transference and counter-transference. Working with a client with severe attachment trauma can trigger the therapist’s dissociation and possible resentments. Because building trust is critical and complicated, the therapist can feel dread, despair, and guilt in not “reaching” the client

(Rappoport, 2012). Healing of the symptoms of attachment trauma are affective focused, relationally oriented encounters through the right brain (Schore, 2014). The implicit experience is not a result of cognitive self-reflection or starting with behavioral change goals. In fact, the therapist needs skills in feeling their physical, emotional, and implicit response to the client and be willing to seek supervision (Rappoport, 2012).

Right brain-to-right brain therapeutic skills include empathically receiving and expressing bodily based nonverbal communication, tracking slight changes in another's expression or emotion, an awareness of one's own subjective experience, and the regulation of one's own affect while inquiring about the client's affective clues (Schore, 2014). In addition, the skills necessary in therapist self-disclosure are affective in the therapeutic process. Self-disclosure is not a telling of the therapist's own story to relate to the client. Instead, it is the therapist's ability to speak to her own current felt experience in the session. It uses language to describe the right brain experience either somatically or emotionally. An example would be, "I feel my chest tighten as you talk about your grandmother. I sense my own emotion of sadness right now."

The therapist must not be afraid to turn toward trauma-related material. Instead, take the risk to listen for it, notice it, ask about it, and facilitate the topic (Muller, 2009). To not take the risk is to repeat the client's caregiver reaction as discounting, minimizing, or being unable to regulate one's own activation to difficult information (Muller, 2009). It is important to remember that with implicit memories and a right brain focused therapy, two stories can be told at the same time: what the client is saying verbally and what the client's body is doing (Quillman, 2012). It takes training, skill, practice, and courage to track the client and self as the therapist.

As the client feels more and more seen by the therapist, trust is built and a larger window of tolerance is created for the client to hold charged emotion and sensation. A mirroring of the client's experience is reparative for the client. They begin to accept their own deep reactions as being valid and necessary to express. This mirroring was missing in the early attachment process and takes a while to trust it from the therapist. "Just as infants learn about themselves through the reflection of a caregiver, clients can also learn self-awareness by being mirrored in the therapeutic relationship" (Pierce, 2014, p. 13).

A therapeutic alliance also makes psycho-education a possibility. Talking about why and how many people implemented a way of surviving attachment issues helps the client know that she did what she needed to do in order to survive. In fact, the client brilliantly created a strategy at a very young age.

Art and Dream Work: Healing and the Right Brain

The impact of making emotional contact through right brain methodologies helps to ground the client and allows the brain to fire different neurons than the repeated pattern of hyperarousal (Quillman, 2012). Some of the most powerful and effective right brain methods are found in creative expression, such as, visual art, music, and the performing arts (Richman, 2013). Art can serve as the witnessing function for the client. Witnessing one's own experience along with the therapist helps to integrate the emotional response. Because the right brain houses creative expression, the images generated through visual art mend the stuck trauma response of dissociation, allowing for greater tolerance of the emotions associated with the experience (Richman, 2013).

When trauma from the past is put aside, out of one's conscious awareness, symbol, metaphor, and dreams can serve to open a pathway to that which is at first, unknown or even

unthinkable (Pickering, (2012). A child may unconsciously internalize parental or intergenerational trauma that does not belong to him or her, leaving the child to feel alien to self. Accessing the right brain's ability for implicit memory through sensory images and symbol, one can begin to peel away that which does not belong to the self.

Analyzing dreams in a therapeutic session is another way to access early childhood trauma, communicating from the unconscious of the client to the unconscious of the therapist. Thus, accessing the effect of both parties is an element of healing, using right brain functioning (Sands, 2010). In a treatment session, dreams bring up processes when the patient is engaged in two overwhelming pieces of work: 1) dissociated childhood trauma and 2) the dissolving of a dissociative structure once implemented for safety but now not useful as the client begins to "come alive" (Sands, 2010, p. 358). Brain research shows that image or metaphor lights up more brain centers than any other form of communication, integrating and moving affective material from the right-brain implicit memory to left-brain explicit reasoning (Sands, 2010).

Sands (2012) also emphasizes that the visual and sensory nature of dreams makes them affective when working with early trauma that is too overwhelming to be stored in the left brain as narrative or verbally encoded memory. Dreams allow a certain amount of safety in the healing of trauma as they are the link between conscious and unconscious, repression and expression. Dreams are "a voice from a dissociated part of the patient's self that is ready to be heard" (Sands, 2010, p. 360-361).

Musical art forms are the most direct ways of self-expression and the closest to the experience of pure feeling. Music most connects to grief and loss. Slow rhythmic counting or rocking along to the rhythm is associated with early trauma and self-soothing (Richman, 2013). Therapeutic goals include transforming the hyperarousal, the overwhelmed feelings, and the

dissociation into manageable and coherent memories and verbal narratives. It is possible to integrate the left brain reasoning and the right brain healing. Art helps to cross the two sides of the brain for greater wholeness (Shore, 2014).

Another art form that has right brain healing affects is that of Dance Movement Therapy (DMT). Its definition is the psychotherapeutic use of movement that furthers the emotional, physical, and cognitive integration of traumatic, dissociated experience (Pierce, 2014). When a client is dissociated, movement can provide a healing path and improve the capacity to stay connected to the emotional experience (Manford, 2014). The therapist and client attunement is enhanced through mirrored movement. This causes neural networks to fire that serve to give cohesiveness to the clients felt experience from the external to the internal worlds (Pierce, 2014). If mirroring in early attachment by the caregiver was absent or incongruent, the child and then adult, believes their internal world cannot be trusted.

Specifically in Borderline Personality Disorder, motor and sensory functions are split off in order to numb the emotions associated with trauma (Manford, 2015). The sympathetic nervous system is over-stimulated and the fight-flight response is heightened. Clients with BPD enter therapy with dissociative feelings towards their bodies. Dance Movement Therapists can provide containment through mirroring, embodiment, and flexible improvisation, helping the client begin to have access to and greater tolerance for affect or inner conflicts (Manford, 2015).

DMT can serve in right brain affect regulation and provide a secure sense of self, bringing into coordination the limbic system with the client's present moment experience with the therapist. Mirror neurons become activated through watching another's movement, voice, touch, and other sensory experiences (Manford, 2014). Pierce (2014) organized the DMT

treatment into three phases. These three phases can incorporate all artistic forms depending upon to which one(s) the client feels a connection.

Phase one: safety and stabilization. Orienting to the space is important as the dysregulated system needs to look around from side to side, assessing what the present moment in time and space is like. In phase one, the goal is to mirror back to the client the implicit and non-verbal capacity for emotional bonding and self-regulation (Pierce, 2014). This is filling in the void from a lack of mirroring in early attachment. The right brain process is called implicit relational knowing and governs the sense of safety. The client feels felt (Pierce, 2014). A therapist trained in using the right brain arts in therapy becomes skilled in nonverbal attunement to support the client in developing this sense of feeling felt. “This simple function may facilitate the basic, essential, and often unconscious foundation of a secure attachment relationship” (Pierce, 2014, p. 9).

Phase two: integration of traumatic memories. Emotional processing of grief, mourning, shame, and rage can emerge in this phase. Creative expression can support clients in their attempts to understand the physical and emotional consequence of early attachment trauma. Movement can bring awareness to physical sensations, thoughts, images, and story. It is important to track this awareness without the inner self-judgment that can accompany this phase (Pierce, 2014). Strong self-criticism can serve to assist the client in exiting their healing process as if to say, “I am not deserving of being well.”

In addition, strong sensations and affect were not tolerable or acceptable at one time for the client and so accessing and expressing them verbally can feel overwhelming. Artistic expression allows for a transitional space, or just enough distance to begin increasing tolerance.

Processing symbols uses the right brain that stimulates connections between the content and emotion.

Phase three: relational self and rehabilitation. In this third phase, the client embraces the movement forward into the future. Because attachment trauma affects interpersonal adult relationships, the concepts of differentiation and self-to-self attachment are explored. The creative self can imagine and be free to design how they want to engage life. In DMT, group opportunities are a way to experiment with merging and differentiating with others, using the right brain awareness of how one is experienced by others and how one is experiencing those in the group (Pierce, 2014).

Just as movement gains greater access to internal awareness and neuron connections, the imagination is another useful tool for trauma recovery. Mental imagery refers to internal images that can be created by combining actual event memories with a modification of what would have been more helpful (Lusebrink, 2014). The process of art therapy or re-imagining in the mind, involves reconstructing current images that engage new neuron connections. Seeing a different outcome or the sense of optimistic options has been linked neurologically to the release of dopamine and increased serotonin, causing the amygdala reactivity to decrease (Hass-Cohen, et al., 2014). *Check*, is an art therapy protocol with five steps that rely on the creative, intuitive right side of the brain to re-image one's traumatic past. Hass-Cohen, et al., (2014), describe them as follows:

Step one: draw the timeline of the traumatic past. This allows the client to begin placing traumatic events in the past and differentiating from the present. In addition, it bridges memory gaps caused by the early trauma. With early attachment trauma, there may only be a felt sense and not a clear memory.

Step two: draw an aspect of what it felt like at the time. This possibly exposes more memories and activates more of the right brain where the memory is stored.

Step three: title your drawing. This begins to integrate emotion and cognitive processing.

Step four: check and change it. Here, the client gets to change one aspect of the picture to become what they want it to look like now, or what would have been more preferable in the past.

Step five: title the new picture. The client notices the difference between the two images and increases their internal sense of control. Greater access to an optimistic response may generate more emotional expression that is healing to the client.

Self-Attachment Repair

Daniel Siegel (2012) describes a secure attachment as one that includes a repair. It does not mean that mistakes between caregiver and child are never made or that attunement is perfect. However, the awareness of mis-attunement, along with an encounter that includes a repair or safe re-engagement, is necessary. While early attachment trauma can affect one's life well into adulthood, everyone has the capacity to experience what Siegel calls *earned security* (Snyder, Shapiro, & Treleaven, 2012). One of the ways an insecure attachment can be healed is through a secure attachment to the self, the self that is more deeply understood and supported. Through self-awareness and self-attunement, the client can begin to find compassion for self and the history they survived. Appreciation for the self that once was and is now becoming, replaces self-disdain and abandoning self as a way of coping.

Mindfulness

Mindfulness is one of the practices associated with repairing attachment to the self. Mindfulness actually strengthens the areas of the brain already identified as being associated

with healthy, secure relating. Engaging in a mindfulness practice may be the way an individual develops a secure attachment with the self, noticing the moment-to-moment experiences with compassion (Snyder, et al., 2012). Mindfulness, as defined by Kabat Zinn is paying attention to the present-moment, one's current experience, without judgment, so as to integrate acceptance, openness, and discernment (Snyder, et al., 2012). Mindfulness differentiates from cognitive functioning that relies on the prefrontal cortex in that the client does not try to reappraise or rationally control a response to an experience but implements two important aspects: 1) present moment sensory experience and 2) suspending judgment or evaluating one's current response as right or wrong (Farb, Anderson, & Segal, 2012). Mindfulness helps to reduce the cognitive ruminations and self-critical evaluations linked to the prefrontal cortex of a traumatized person. Rumination will only serve to activate the limbic system and keep the client stuck in the trauma (Farb, et al., 2012).

Mindfulness does not have an agenda to calm the self or meditate on the potential positive intent, or reappraisal. Instead, the one practicing mindfulness stays with even that which seems painful. In so doing, one is becoming more self-attuned and befriending one's experience. Therefore, what was missing in the attachment process early in life can now be healed with self-attunement, self-attachment, and self-compassion. With a more secure attachment to self, the client has greater capacity for intimate relationship, resilience, and overall wellbeing (Snyder, et. al., 2012). With a secure sense of self-attachment, the triggers of threat to the amygdala decrease, new neuron connections form, and, as said earlier, optimism increases the dopamine and serotonin levels.

Dialectical Behavioral Therapy

Bliss and McCardle (2014), make a case for what they are calling technical eclecticism or an integration of several treatment approaches when working with Borderline Personality Disorders (BPD) or attachment trauma. One of the therapies they support in an integrative approach is Dialectical Behavioral Therapy (DBT). Many clients with BPD had an invalidating environment growing up and present with an instability of interpersonal relationships, poor self-image, inability to regulate affect, and impulsivity. DBT is a structured treatment that incorporates cognitive behavioral therapy and Eastern meditative philosophies as well as mindfulness. It can be used in individual therapy, group therapy, coaching, and within a team of treatments (Bliss & McCardle, 2014).

Included with DBT is the practice of mentalizing, the ability to understand the mental states of self and others (Levy, et al., 2015). Because BPD is a disorder of attachment, separation tolerance, and mentalization, it is critical to incorporate the skill of exploring how the client is interpreting self, other, and the world. Its focus is helping people to differentiate and separate out their own thoughts and feelings from those around them.

Eye Movement Desensitization and Reprocessing (EMDR)

Traumatic memories are stored in the implicit, right brain, not always accessible through verbal communication and insight. Yet, these memories are reached through sensory and imaginal methods, making EMDR one of the treatment modalities that can process traumatic memories. EMDR uses a systematic and gradual exposure to the trauma through sensory and affect culminating with the integration of insight and reflection (Ringel, 2014). Symbolic thinking generated through sensory processing is the earliest mode of memory. The therapist uses a directive approach to help desensitize the memory through an imaginal exposure

technique, a bilateral stimulation through visual stimuli, sound, or tapping. The client is encouraged to re-experience part of the traumatic past and is then taught to integrate these experiences into a new cognitive structure (Ringel, 2014).

Adlerian Perspective and Healing

Attachment needs that are met or unmet are fundamental in creating the way an individual sees others and the world. When these early needs for secure proximity to the caregiver are not met or even rejected or disdained by the caregiver, a patterned lifestyle will be developed in order to survive. Adler believed that all behavior serves a purpose whether or not the need the behavior is fulfilling is conscious or unconscious (Ansbacher & Ansbacher, 1956).

One way an adult who has experienced attachment trauma tries to self-regulate is through *setting up a rescue*. Proximity to a potential rescuer will temporarily meet a need the individual has for attachment outside of self (Carter, Knox, McFadden, & West, 2011). Instead of meeting one's own emotional need, the individual requires that others take over the task of regulating one's experience. Interpersonal relationships are manipulated by the individual and unfulfilling for both parties. In addition, the individual is unaware of this dysfunction, misreads social cues, and feels intense shame when relationships discontinue. When interpersonal relationships mimic the same dysregulation associated with early attachment trauma, shame is used against the self as a reminder that she/he is the cause of rejection (van Assen & Vingerhoets, 2012).

Early patterns of attachment shape the individual's predisposition to shame, intensifying the inferiority feeling common for everyone. Yet shame is not useful in moving through life (Smith, 2009). "Shame is an earlier occurring affect than guilt. It is the painful state of self-consciousness that results from someone else's negative appraisal" (Smith, 2009, p. 242). It causes the unwanted feelings of separation from the caregiver and later in life, alienation from

others. These early interactions with a caregiver unable to meet attachment needs become internalized for the child and form a belief system about being disapproved of by everyone (Smith, 2009).

It is important to clarify the difference between inferiority or the striving forward, and shame. Inferiority serves to assist people in movement toward greater wholeness or completeness, striving to step into their innate skills, talents, and strengths (Ansbacher & Ansbacher, 1956). Shame leaves people feeling immobilized, frozen out of fear of being discovered as innately faulty. Therefore, the inability to move toward goals, toward social interest, toward interpersonal relationships is used as self-protection or *safeguarding*. Adler defined safeguarding as a strategy used against dangers, which in feeling shame, are expected and avoided at all costs (Ansbacher & Ansbacher, 1956).

In addition, the client may manifest excessive anger and aggression as a way to safeguard against deeper feelings of shame with the consequence of successfully preventing the possibility of attachment or closeness to another (Carter, et al., 2011). The fear of love is a defense against relationship in adults who became the recipient or carriers of the caregiver's own relational trauma. With negative reactions of withdrawal, anger, or despair the child believes, unconsciously at first, her very being and own agency is the cause of this reaction. Consequently, avoidance of self-agency is programmed in from early attachment trauma and must also be explored in treatment.

Treatment of Attachment Trauma through Adlerian Lens

While there are not a lot of current writings about Adlerian psychotherapy and attachment theory and trauma, Adler's and Dreikurs' focus on parenting styles certainly generated an emphasis on the parent-child relationship in its early stages as being one of, if not

the major contributor, for later mental health. Adlerian psychotherapy is a method based upon understanding the context from which the client has experienced self and the world (Ansbacher & Ansbacher, 1956). The earliest context for anyone is held within the relationship between child and caregiver(s), establishing a concrete set of beliefs. This set of beliefs can rule the life of someone for years as long as insight into the self is missing. Specifically related to early attachment trauma, Adler emphasized that the neglected child is one who will not find trust in another until a greater understanding of one's set of beliefs is examined (Ansbacher & Ansbacher, 1956).

An Adlerian definition of trauma is any experience that interrupts the system of care that gives a person a sense of control, connection, and meaning. In addition, the experience shatters one's sense of identity, worth, and belonging (Millar, 2013). Betty Lou Bettner and Amy Lew (1996), Adlerian therapists, developed a series for educators and parents on raising children who are secure, encouraged, and capable. They focused on what is termed the Crucial Cs. These Cs are: connection, capableness, to count, and courage (Millar, 2013).

1. Connection: the strategies developed to connect with the family will set the stage for later connections with others. Positive connections establish security (Bettner & Lew, 1996).
2. Capableness: security, self-respect, and self-esteem are directly related to the belief and reassurance that one can take care of self and handle life's issues. Testing one's competencies in a safe, non-humiliating environment leads to believing one is capable (Bettner & Lew, 1996).

3. To Count: feeling as though one truly makes a difference in the family and the world. If one feels appreciated and necessary, confidence and future contributions are possible (Bettner & Lew, 1996).
4. Courage: allows one to face failure and begin again, risk, and try new things. The first 3 Cs set the stage for courage (Bettner & Lew, 1996).

When a child experiences attachment trauma, these Crucial Cs are threatened, leaving the child disorganized, overwhelmed and the sympathetic nervous system on high alert. Millar (2013) noted that research in neuroscience over the last two decades offers evidence of Adler's concept of the social embeddedness of humankind and the brain as a social organ. Therefore, when the child compensates on a neurological level for not being connected, held capable, sensing that they count, and courageous, "the superstructure of the central nervous system the mind, as part of the entire organism, will play its part in the process of compensation or maintenance of equilibrium" (Ansbacher & Ansbacher 1956, p. 23).

The discovery of mirror neurons supports this Adlerian concept. fMRI scans show that observing disgust on another person's face activates the same part of the brain as a disgusting smell. This happens in the insula part of the cerebral cortex where cognitive self-awareness and perception are linked (Carter, et al., 2011). This insular pathway gives a child the message that the caregiver's expression is in response to the child, positive or negative. The brain of the child, in critical stages of development, is programmed with neuron connections to experience disgust or fear at one's core self due to the functioning of mirror neurons (Carter, et al., 2011). Research on the young developing brain has shown a correlation between perceptions of a positive sense of belonging as children and the increased capacity to handle adult life stress (Millar, 2013). Therefore, Adler was correct in understanding the brain as a social organ with the potential of

disability if not met with attunement from the caregiver. Adler hypothesized that every organ was capable of expressing emotions and physical symptoms, a holistic view that was new in 1934 but a common understanding in this current century (Millar, 2013).

Care then is taken in the analytic relationship to provide the client opportunity to express his or her self-agency without a perceived negative response from the therapist. In addition, a cooperative meaning-making process, not a passive activity for the client, provides empowerment and encouragement to the client, holding the client capable for their own process. If the client has little experience with believing in one's capableness, this cooperative effort will take time but is well worth the patience. Adler stated the treatment takes on the once lost functions of the mother or caregiver: 1) to join with the client to give him the experience of trustworthiness, and 2) increase the client's social interest in order to strengthen their self-agency, independence, and courage (Ansbacher & Ansbacher, 1956).

Phases of Healing Trauma

Millar (2013) notes that Adler integrated 3 phases of healing trauma that are applicable today. The fourth is a necessary component when working with a family system wounded by attachment trauma.

Stabilization and safety. The therapist must assess whether or not the client feels safe in one's present life and has the basic needs met of food, housing, and money. In addition, it is important to identify the client's current social support, what the client is already doing for self-agency, and identify simple ways to regulate the nervous system when feeling distress. Finally, in this first phase, the therapist must be building upon trust and attunement in the therapeutic relationship. With early attachment trauma, it will most likely be a current relational trauma,

break, or abuse that brings the client in initially for therapy. One's sense of safety has been shattered which triggers the deeper suffering felt in early life (Millar, 2013).

Remembering and processing memories. With attachment trauma, there may be implicit memory (or body memory) without explicit memory, or there may be a distorted memory and a perception of how the events unfolded with a caregiver. Adler would commit to the current life-style the client is exploring and not the past (Millar, 2013). Early Recollections, an Adlerian therapeutic technique, should not be used with the agenda of bringing up trauma but instead, how the client sees the world and one's sense of impact or belonging. There are techniques available to work with trauma symptoms using the observing self that allow for a window of tolerance and dual awareness. Some of those are EMDR and Somatic Experiencing (Levine, 2010), a nervous system regulating type of trauma therapy.

Integration with family and culture and daily life. Adler felt therapy should focus on the present with how the client is handling the tasks of life now. He was committed to rebuilding healthy personal and community connections, regaining a sense of capability, experiencing making a difference, and utilizing one's courage (Millar, 2013). Change can occur from fear and pain, more accurately called *post-traumatic growth*. Becoming conscious of early attachment trauma is normalizing for the client's experience, bringing to light what may have been hidden in the unconscious where it held too much influencing power. Once the healing process has begun, the client will make even greater strides when held to their own capableness, realizing the impact possible upon the community and world.

Caregiver awareness of their own attachment. Daniel Siegel (2014), emphasizes in his writing and work with families that in order for children to not unconsciously hold the parent's early attachment interruptions, the parent/caregiver must first make sense of their own history

with their caregivers. We work out our own wounding or our complexes in relationships but children should not be the barriers of this projection. Siegel (2014) lists three adult attachment patterns that can be present when unresolved issues interfere.

1. Dismissing: identified by the inability to be emotionally close to another adult or their child.
2. Preoccupied: identified by the anxiety, uncertainty, and ambivalence surrounding relationships.
3. Unresolved: identified by abrupt shifts in the caregiver's state of mind that are alarming or disorienting to their child.

A secure attachment pattern is experienced as flexibility and objectivity when engaging relationships. These caregivers have integrated their past with the present and are more fully conscious of any unresolved early attachment traumas of their own (Siegel, 2014).

The level of integration a caregiver has done will affect their parenting styles and beliefs. Holding the child capable and encouraging the child are two necessary elements of parenting (Dreikurs, 1964). The major task of any caregiver is to prepare the child for life, not protect the child from suffering. Preparing involves supporting the environment in which the child feels a sense of belonging. A healthy sense of self, understanding one's history, and believing in the child's innate ability to thrive contribute greatly to the caregiver's skill in attachment that is secure.

Prevention and Family Support

The National Scientific Council on the Developing Child is housed at Harvard University. It is designed to bring the science of early childhood and early brain development to the awareness on public decision-making concerning the health and emotional wellbeing of

children. The Council uses an evidence-based approach to bring public awareness to the necessity of integrating the responsibilities of family, community, workplace, and government to succeed in greater wellbeing of all young children. Their website is www.developingchild.net. Their articles and research layout ideas on what forms of action are necessary to protect and support children so that they can live their lives less affected by early attachment trauma and maltreatment.

In addition, the Centers for Disease Control and Prevention (CDC) study on Adverse Childhood Experiences (ACE), one of the largest investigations conducted to assess associations between childhood maltreatment and later-life health and wellbeing, is useful data when addressing the prevention of trauma. Their passion and work created the public awareness necessary to understand how some of the worst health and social problems in our nation can arise as a result of adverse childhood experience. Realizing these connections can improve the efforts made toward prevention and support (<http://www.cdc.gov/violenceprevention/acestudy>).

Early Childhood Trauma and the Lifespan

The CDC identifies toxic stress as a result of intense, adverse experiences that are sustained over a long period of time (Middlebrooks & Audage, 2009). Childhood maltreatment, abuse and neglect, are examples of long term toxic stress that children cannot manage alone. This leads to permanent changes in their developing brain as we have discussed already. The ACE study was a collaboration between the Center for Disease Control and Kaiser Permanente's Health Appraisal Clinic in San Diego. It took place from 1995 – 1997. Approximately 17,000 adults participated in the research. Each participant completed a questionnaire that asked for past history of abuse, neglect, and family dysfunction, as well as current behaviors and health.

The ACE findings were that childhood abuse, neglect, and exposure to adverse experiences is common. Two-thirds of study participants reported at least one ACE and one in five participants reported three or more. The categories on the survey included emotional, physical, and sexual abuse, emotional and physical neglect, and household dysfunction. Household dysfunction categories were mother treated violently, substance abuse, mental illness, separation or divorce, and member of family incarcerated. The CDC concluded that too many people in the US are exposed early on to violence and other childhood stressors (Middlebrooks & Audage, 2009).

Many symptoms are created because of early childhood neglect, abuse, and witnessing trauma and violence. A child cannot differentiate affectively from what is externally happening to what they are internally feeling. Therefore, long-term health related issues arise. They risk the following health issues identified by the CDC that then persist and perpetuate a system of dysfunction if not addressed (Middlebrooks & Audage, 2009).

Increased unhealthy outcomes from ACE.

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease
- Depression
- Fetal death
- Illicit drug use
- Ischemic heart disease
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners

- Sexually transmitted diseases
- Smoking
- Suicide attempts
- Unintended pregnancies

Symptoms in Children

The National Scientific Council on the Developing Child, in a 2004 working paper entitled *Children's Emotional Development Is Built into the Architecture of Their Brains*, discusses the child's emotional development and what we can find in children who are in abusive or neglectful environments. The parts of the brain that are identified with affect regulation and also interacting with the prefrontal cortex associated with planning, judgment, decision-making, and problem solving. In other words, emotions support linear, left-brain function when the child is regulated but if not, the dysregulation interferes with these functions (2011). We have been quick to medicate children's behaviors that appear to lack focus and regulation. Instead, we must be educating caregivers and teachers on how to evaluate behaviors that are as a result of trauma, not simply a phase or attention deficit. A suggested book from The National Scientific Council on the Developing Child is *Improving the Odds for American's Children* (2014), edited by Kathleen McCartney, Hirokazu Yoshikawa, and Laurie B. Forcier. The book examines critical issues – prenatal and infant health and development, early child care and education, school reform, vulnerable children, and policy measure to consider to better serve children.

Children can have serious mental-health issues affecting the brain development. Studies have shown that the same kind of brain changes in an adult with depression and anxiety are also happening in a child with the same symptoms (National Scientific Council on the Developing Child, 2004). When these symptoms are prolonged, the affected neurological developments will

remain well into adulthood. The Council noted that even with all of our current knowledge about brain development, the early childhood policies focus mainly on cognition, language, and literacy. “Policies addressing children’s emotional and behavioral needs have been the exception, not the rule” (National Scientific Council on the Developing Child, 2011, p. 3). Further training on attachment trauma for educators can be obtained through Professional Educators Systems, Inc. (PESI), specifically Bessell van der Kolk’s workshops on Early Attachment Trauma (www.pesi.com).

Understanding Neglect

Child neglect can come in many forms. If the caregiver is mentally and emotionally unable to meet the child’s initiation for proximity and attunement, this can lead to attachment trauma. The Council on the Developing Child issued a paper to help policymakers and practitioners understand the forms of neglect by defining it in terms of biological reactions to unresponsive care. Neglect can cause more harm to a young child’s development than physical abuse. This affect includes cognitive delays, executive prefrontal cortex functioning, and the body’s stress response. The biological stress response leads to chemical and hormonal over activation that corresponds to academic attention or struggles, social miscues and maladjustment, mental health diagnoses, and chronic disease (National Scientific Council on the Developing Child, 2004). The Council identified four types of neglect and the consequences.

- 1) Occasional Inattention: If inattention happens intermittently in a loving and responsive environment, there is often no need for concern. It may be that variation in responsiveness helps establish the child’s sense of capableness.
- 2) Chronic Under-Stimulation: If caregivers do not understand the necessity of child interactions, inattention may become chronic. This can occur from leaving the child alone

for hours without stimulation from the caregiver. Risk factors for this response are caregiver depression, social isolation, poverty, or family illness. Under chronic inattention, the child risks developmental delay in language, social, and emotional engagement, making school difficult.

- 3) **Severe Neglect in a Family:** This environment is missing basic nutritional, medical, and educational needs. The child does not have an adult who can provide care, protection, and may be absent for such long periods of time that the child is in danger. The child must learn coping mechanisms that could ultimately harm their physical health as well as behavioral health. The child's survival is at risk and intervention must occur.
- 4) **Severe Neglect in an Institution:** If a large childcare institution with little one-on-one stimulation and where children are ignored is the only place for children to live, no meaningful relationships are likely. Even if basic nutritional needs and housing needs are met, these children suffer psychosocial deprivation causing long-term psychological damage.

Children who have suffered severe neglect have a decreased ability to interpret emotional cues and cannot integrate complex cognitive and social information. The prefrontal cortex is less able to solve problems and self-regulate. In this sensitive developmental stage of early life, the brain is not wiring and encoding the proper connections for healthy interactions that can cause attention, emotional, cognitive, and behavioral disorders well into adulthood.

Potential Effects on Policies and Community Programming

The National Council on the Developing Child (2004) suggests ways that public programming must consider addressing early attachment trauma and support of the caregivers

who may themselves be suffering from early trauma. The Council focused on five areas that need attention.

- 1) **Balance:** All early childhood programs must include focusing on social and emotional health that can help the child to sit in a classroom and pay attention. If only focusing on measurable results of cognitive skills, the social and emotional health is disregarded and the cognitive skills suffer. Teaching children ways to notice their bodies and begin feeling a sensation of grounding is an effective method for regulation. If the child feels under threat and dysregulated all day, attention in the classroom is impossible.
- 2) **Educate Parents:** Early emotional and social development education must be part of the support services to parents. We must help parents understand the young developmental brain and why the child may be acting out. Too often the child is seen as noncompliant or defiant. Using judgmental, disciplinary actions that only cause more dysregulation in the nervous system simply keep the child in a state of fear/threat/protection response. In addition, teaching the caregiver regulation skills through mindfulness and body awareness will benefit the child. There is a correlation between a mother's capacity for self-regulation and attunement with the child's ability to regulate (Snyder, et al., 2012). Teaching parents mindfulness can assist in their own personal self-compassion, in turn, making it safer for the child to notice their own experience, even if it feels large. Thus, the parent and the child can hold the child's state of being with compassion instead of fear.
- 3) **Educate Public Providers:** All providers, including daycare providers, must be educated in skills to help children with behavioral dysregulated symptoms to begin feeling safe in their environments. This includes teaching basic regulation skills and mindfulness for

these public providers. In addition, all early childhood programs must have access to mental health services to meet more complex needs.

- 4) Identification and Assessment: Early childhood educational and childcare providers must be trained to identify and assess for early intervention programs that can address the complexities and unmet needs of young children. A basic assessment for depression, anxiety, or antisocial behaviors should be used in public early childhood programs. Included in this assessment would be knowing the difference between a short-term phase and a possible diagnosis.
- 5) Accountability: All child-welfare agencies must be investigating suspected abuse or neglect. A closer collaboration between child-protective services and early intervention programs that have identified developmental delays would assist in accountability to children.

Additionally, mental health providers also need to be trained to skillfully identify early attachment trauma and if capable, write educational materials on symptoms and prevention for distribution to public schools, church youth programs, and daycare providers. Adolescent, teenage programming leaders must also be trained in recognizing attachment trauma and hold educational weekends or programming for parents, especially within adolescent treatment programs.

Conclusion

Humankind is meant to be in relationship. When trust in the primary caregiver is broken in our earliest development, we now know that survival feels threatened. It is our basic need to survive emotionally, psychologically, and physically. We implement brilliant strategies in order to do so. Unfortunately, those very strategies have the potential to prevent us from fully living in

proximity to others as we accommodate for the early trauma of broken attachment, broken, wounded relationships.

We now know enough about neuroscience and brain development to take seriously the effects of early attachment trauma. “Brain processes cause behavior, and experiences affect the brain . . . [changing] the synaptic connections that are the material basis for our beliefs, attitudes, memories, personality” (Walter, Berger, & Schnell, 2009, p. 174). As therapists, we are obligated to understand the happenings in the brain due to chronic threat of losing the attachment to the primary, trusted caregiver.

Being trained in the ability to watch for signs in the body of early trauma is critical for healing. Peter Levine, a doctor of medical biophysics and psychology has spent 40 years developing a trauma recovery therapy called Somatic Experience, a body-awareness approach to healing (Levine, 2010). The body, the brain, the nervous system are all wired for survival. If our therapeutic techniques rely only on the verbal, analytical, and linear functioning, we will miss important cues and wonder when the client cannot change behavior, maintain healthy relationships, or relapses into self-destruction.

Early attachment trauma can cause intense disdain for the self. If this is never understood or healed, it will only perpetuate a cycle of trauma for the next generation. Whenever we are with what might be labeled a “resistant” client, we may be uncovering this chronic self-attack that is too much for the client to bear. Fear of rejection or mis-attunement yet again from a therapist can cause a wall of protection. Most damaging is when a client believes they deserve rejection, being so accustomed to mis-attunement. Left brain emphases of language, analysis, and cognitive strategies that try to make logical sense of the client’s contributing behaviors may only keep the client stuck in destructive anxiety.

Instead, using the right hemisphere of the brain can bring the client back to the original felt sense of self, what was too painful to bear and from which the client had to dissociate in order to survive. When we feel stuck in the chatter of words or become too interested in the details of trauma, we (the client and therapist) stay frozen in self-defense. As therapists, we can unleash the senses, the imagination, and the intuition with which the client comes to us. We must continue to use our creativity to discover new, affective healing techniques. Humankind can heal even from the most profound mental, spiritual, and emotional atrocities. We must continue to explore the possible modalities that include neuroscience, the body, the integration of the right hemisphere of the brain, and the felt sense once more of our innate wholeness.

Finally, teaching and training educators, caregivers, and leaders in the field for child advocacy, will lead to greater understanding, awareness, and affective treatment for children who suffer from the effects of early attachment trauma. Children and adults alike have a need for connection, belonging, and safety. Without the felt sensation of these necessary life requirements, words of their definition will remain empty and never enough to truly heal attachment trauma.

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