

# Attachment, Trauma, and the Therapeutic Relationship

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## **AS HEALTH CARE PROVIDERS AND THERAPISTS,**

psychologists are a compassionate and highly empathic group of practitioners. From at least graduate school forward we are taught about, and appreciate, the importance of creating a good “therapeutic alliance” with our clients. However, we are not often offered much guidance on how to create this relationship, other than through a Rogerian, open and attuned stance. Navigating the possible vicissitudes of this relationship, and how to engage in effective repair of relationship ruptures is a challenge for the most seasoned of clinicians.

Schore (2005) maintains that the “principles of regulation theory” (p. 211) that apply to the significant attachment figure-infant relationship are also operative in the therapeutic alliance. We now understand that the development of the capacity for affective self-regulation occurs during the very early, preverbal years. Observing a “good enough” attachment figure (usually the mother) with her baby brings this point home. One observes lots of “stimulating up” (Josephs & Zettl), what Heller (2014) calls the “gleam beam”, and a titration of eye contact as too much “gaze” can be highly activating to the nervous system.

Research has informed us of early, very rapid right brain development. Schore (2005) indicates: “The neurobiology of attachment...is an interpersonal neurobiology of right brain-to-right brain communications” (p. 208). Fisher (2016) has said that the brain at birth is such that a major function of these early interactions is to prune and sculpt the forming synaptic connections. This occurs very significantly during the first years of life, as morphometric work by Huttenlocher (1990) on the developmental aspects of synaptic density has shown. In short, we evidence a “high sensitivity to initial conditions” (Josephs & Zettl): both brain structure and brain function develop in the context of relationship and affective co-regulation.

At the same time that early brain development is taking place, the attachment system is activated and we develop templates for later social and intimate relationships, as Bowlby and later attachment theorists and researchers have demonstrated. Early attachment ruptures or failures can dramatically influence the development of the attachment system. Examples include war, parental unavailability due to hospitalization, depression or substance abuse, as well as neglect, abuse, and violence. Schore (2002) suggests “traumatic attachments, expressed in episodes of hyperarousal and dissociation, are imprinted into the developing limbic and autonomic nervous systems of the early maturing right brain” (p. 9). As such, trauma is perhaps best considered as not inherent to the event(s), but in terms of its effects on the nervous system.

The mother-infant relationship is a helpful model for understanding what transpires between therapist and client. Many of our clients come to therapy because of affective dysregulation, and the therapeutic relationship can serve as a crucible within which initially learning to co-

regulate can occur. It is often asked whether we can increase our capacity to self-regulate on our own. My sense is that this occurs best initially in the relational field, that is, in interaction with a well-regulated other. This emphasizes the critical importance of therapists doing their own trauma-related healing.

We are taught to attend to the non-verbal aspects of our interactions with clients. We can only observe behaviour, but we can also develop the skills to better intuit what a client's behaviour in the moment is telling us about the state of their nervous system and what they have learned to do in order to survive. A client's physical posture is one component of this — how does the client carry his/her body, is there evidence of “bracing”, do we see “collapse” or a lengthened spine? There are studies on procedural learning which have found that our meaning-making appears to be influenced by our physical posture (Fisher, 2016). What is the client's tolerance for eye contact, and how much do we need to titrate that? What do we observe about voice volume and prosody and what does this tell us about the degree of safety the client is experiencing? Heller (2016) recently indicated that when stressed, women's voices tend to become shriller and men's become lower and more booming, carry-overs from our evolutionary heritage of needing to signal danger to the tribe.

Stephen Porges has contributed tremendously to our understanding of the autonomic nervous system and trauma. His concept of “neuroception” is particularly important here. Porges (2013) has said that our nervous system functions similarly to a body scan at the airport, scanning and appraising whether another person is safe. Heller (2016) indicates that we do this approximately once every four seconds. Therapist voice prosody or modulation is essential in therapy, as it signals much to the client about the state of our own nervous system.

What needed to be “given up” in order to preserve the attachment relationship to a parent(s) gets played out in the therapeutic relationship, as it does in other areas of the client's life. It is more helpful to think of how the client's nervous system presents as a survival or “creative” (Heller, website) adaptation rather than in terms of pathology. Under early conditions, what there was no room for tends to get split-off and dissociated, including in ourselves as therapists. Such survival strategies develop as the brain and nervous system adapt to whatever the initial conditions happen to be. Survival adaptations can be considered in many terms, including enduring cognitive schemas and ways of being-in-

the-world, such as the commonly used attachment pattern descriptions of secure/secure-autonomous, avoidant/dismissing, ambivalent/preoccupied, and disorganized/unresolved (the initial term is used to describe infants and the second to describe adults; Wallin, 2014). While we are generally a mix of these styles, we tend to “favour one style as our default relational blueprint” (Heller, 2014).

Wallin (2007, 2014) outlines Lyons-Ruth's (1999) “key” aspects of parental communication which facilitates “positive developmental outcomes” or the development of a secure attachment style and subsequent increased resiliency and flexibility. I believe that these components can inform our understanding of the factors which contribute to the development of a secure and safe therapeutic alliance.

The first component Wallin terms “make the dialogue inclusive”. Again, it is helpful to be curious about what the client had to give up or how she/he “had” to be in their family in order to survive in their early developmental context. These strategies ensured that we did not threaten, given our prolonged human dependency, our significant attachment relationships. Thus, we need to make room in the therapy, through conveying how our own nervous system presents to the client, for those split-off and dissociated thoughts, feelings, and sensations. This includes the capacity for therapist and client to examine the therapeutic relationship, in the here-and-now, moment-by-moment flow. If there has been relational trauma, then the therapeutic relationship may well be a “trigger”.

The second component is the capacity of the therapist to initiate the repair of ruptures in the relationship, as these will inevitably occur. For a client with little experience of repair, the capacity to transparently discuss and resolve issues that arise in the therapy contributes to the client's sense that “the secure base is, in fact, secure” (Wallin, 2007, p. 197).

The third aspect Wallin (2007) refers to is “upgrading” the communication with the client as his/her capacity for affect regulation and what Fonagy calls “mentalizing” (referenced in Wallin, 2007) develops. Wallin sees this part of the therapeutic work as contributing to “deeper, more emotionally involved reflection” (Wallin, 2007, p.199), with clients who initially present as very “embedded” in their experience and relatively unable to reflect on it.

The fourth component refers to a willingness to “engage and struggle”. Wallin (2007) uses the example of a therapist confronting the client’s destructive tendencies. Appropriate limit setting further conveys that this is an authentic relationship and that the therapist is actively engaged, present, and not dissociated or uninterested.

There are similarities here to what Ogden and Fisher (2015) term “embedded relational mindfulness skills” (p. 61). These include “tracking” the client’s experience in the present, making “contact statements”, and framing or deciding together which aspects of experience to attend to and explore. As these authors indicate, “Otherwise, the focus of the therapy returns to having a conversation rather than mindful exploration” (p. 62).

### **REPAIRING THE THERAPIST’S ATTACHMENT-RELATED DYSREGULATION**

An essential consideration in terms of our thinking about the therapeutic alliance is how the attachment “state of

mind” (Wallin, 2007) of the therapist interacts with that of the client. Understanding our own predominant attachment style and how this is likely to intersect with that of the client can contribute towards eliminating those “blind spots” that may lead us into unconscious (re)enactments. As a simple example, if anger has been something in the therapist’s family background that needed to be dissociated, he or she may unknowingly collude with a client to avoid intense emotion in the therapy. Viewing attachment patterning as a survival strategy enables us to compassionately appreciate its salience in the therapeutic relationship and assists in navigating the challenges of what arises in this context.

What does having a good therapeutic “alliance” truly mean? A brief article can only highlight some of the more salient aspects of what we need to consider in our therapeutic relationships. The considerations discussed above, together with practicing the language of secure attachment, which is really the “language of love” (Heller, 2014), may aid therapists in nurturing the client’s shift towards an earned secure attachment. ■

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