Healing Attachment Trauma with Attachment (and then some!)

Diana Fosha, Ph.D.

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With attachment trauma, as Bob Dylan (1976) sings, the good news is the bad news: "what drives me to you is what drives me insane." Attachment -- wired-in and salient "from the cradle to the grave" (Bowlby, 1977, p. 203)-- is a powerful force: for good when secure, for problematic when not. While secure attachment is foundational for resilience and optimal development, disrupted attachment is wires in a vulnerability to trauma. In therapy, however *when explicitly worked with and experientially entrained*, attachment can be a powerful force for healing and repair once again.

Reflecting an understanding that moment-to-moment dyadic affect regulation and the adaptive processing of emotion are not just important to, but in fact are the very constituents of attachment (Schore, 2001, in press), my three clinical offerings are all under the aegis of an attachment informed therapy. They address and seek to re-dress the twin issues of attachment trauma: affect dysregulation and the drenching of the self in shame. What I am writing about here is best understood in the context of AEDP (Accelerated Experiential Dynamic Psychotherapy). You can learn more about AEDP in published work (e.g., Fosha, 2000, 2003, 2009a, 2009b), or by going to the AEDP website (www.aedpinstitute.com).

Part One: The Three Pearls

<u>One: Surprise the unconscious: Be a detective for transformance strivings</u>

Given that we are wired for growth, for healing, and for self-righting (Doidge, 2007), we might as well put that wiring to good use in treatment. Until recently, the

mental health field, hyper-focused on pathology, lacked concepts to guide clinical use of these powerful motivational strivings. *Transformance* is a construct that seeks to rectify that lack: "Transformance is the motivational counterpart of resistance: it is driven by hope and the search for the vitalizing positive affects that accompany all affective change processes" (Fosha, 2008).

Thus my first "offering:" be on the look-out for transformance, and make use of it when you detect it. Your job as transformance detective will be immeasurably assisted by the fact that transformance at work is visible: it is invariably accompanied by positive affective markers. By positive I do not mean necessarily happy, but rather that whatever we are feeling, even if painful or difficult, *feels* right and *feels* true, and is full of vitality (Fosha, 2008, 2009a, 2009b). As an AEDP therapist, I am an assiduous detective for evidence of transformance in glimmers --or actual rays-- of resilience, strength, courage, hope, integrity, curiosity and unsuspected capacities. Healing is a force that operates moment-to-moment, and not only the outcome of a successful therapeutic process: thus, from the get-go, , I invite my patients into a healing relationship. Compassion toward suffering, delight in the person of the patient, and empathy for his/her experience are all part of that invitation. The welcoming and valuing of emotions is another important part.

Mary Main spoke about the efficacy of the AAI, the Adult Attachment Inventory, one of the most robust research tools ever developed, as being based in "surprising the unconscious" (Main & Goldwyn, 1998). One way to get a lot of therapeutic traction is to surprise the patient's unconscious, conditioned as it is by past experience. Their resources overwhelmed, patients come into therapy prepared to have the worst in themselves exposed. To be met not only with compassion and empathy, but also delight and

appreciation of one's strengths and qualities, is the last thing that a patient -- down and out, feeling scared, overwhelmed, and defeated-- expects. To do so is disarming and rapidly undoes defenses, yielding access to more viscerally felt, right brain mediated emotional experiences, which, in my work, constitutes the stuff of therapy.

Two: Undo the patient's aloneness in the face of intense emotional experience

Aloneness --unwilled and unwanted aloneness-- in the face of unbearable emotions is central to AEDP's understanding of how psychopathology develops, and *a fortiori* to how attachment trauma comes to burrow its way in the psyche.

When the parent can support and help the child deal with the intense emotions, secure attachment is the result. Secure attachment reflects the capacity to "feel and deal" (Fosha, 2000, p. 42). If the parent is accepting and there to help, the child feels secure that his/her emotions will be met and not experienced as being "too much" or "weak" or "disgusting" or "shameful" or "evil" or "destructive." The latter is precisely the experience of kids whose attachment figures are undone by their emotions: because the parents themselves cannot feel and deal, they cannot help their kids do the same.

Kids with insecure or disorganized attachment learn that *their* emotions trigger their attachment figures' own attachment trauma, i.e., anxiety, or shame, and thus dysregulation. The child's emotions not only render the attachment figure incapable of helping, but may also sometimes lead to outright attack, rejection or neglect. If the attachment bond is to be salvaged, the child has to institute what Bowlby (1980) called "defensive exclusion:" she/he must exclude from her/his repertoire any emotions that dysregulate the attachment figure. Doing so preserves the attachment bond but at a cost.

The child is left alone with emotions that were overwhelming to begin with, and become even more so, compounded as they are by disruptive attachment experiences. Compensatory protective mechanisms emerge in the context of such affect regulatory lapses. Insecurely attached kids institute defenses that lead them to either "feel but not deal" (resistant attachment) (Fosha, 2000, p. 43), or "deal but not feel" (avoidant attachment) (Fosha, 2000, p. 43). In disorganized kids, these strategies eventually fail and "not feeling, and not dealing" (Fosha, 2000, p. 44) turns into either disorganization and/or dissociation.

Clinically, in order to render defense mechanisms no longer necessary, and to gain access to the emotions that have gone offline, it is crucial to undo the patient's unwilled and unwanted aloneness. With traumatizing experiences, *being with* is necessary but not sufficient. When it comes to the regulation and processing of heretofore feared to be unbearable emotions, active engagement, that is, sleeves rolled up feeling and dealing right along with the patient is what is required. This active engagement on the part of the therapist has two components: one is the armamentarium of experiential and emotion-processing techniques; the other has to do with the judicious, mindful use of the therapist's own affect. Dyadic affect regulation means exactly what it says: it takes two to tango. As the attachment figure partner of the therapeutic dyad, the therapist cannot do *adaptive* dyadic affect regulation with a "still face" (cf. Tronick et al., 1978). The therapist's affective engagement and affective responses to and along with the patient are integral to *dyadic* affect regulation, which in turn is central to healing attachment trauma.

Three: Promote the patient's felt sense of "existing in the heart and mind of the other"

It is not enough for you to feel empathic: for it to count, the patient must receive and *experience* that empathy.

Peter Fonagy writes eloquently of how feeling understood is a biological imperative (Fonagy et al., 1995). The child's sense of "existing in the heart and mind of the other" (Fosha, 2000, p. 57), and doing so as oneself, I might add (i.e., not as a projection) is foundational to an individual's sense of security of attachment and thus resilience in the face of adversity. The child internalizes this sense of existence when all goes well in secure attachment through dyadic affect regulation and a million shared experiences. For the sense of oneself existing in his/her heart and mind lets us respond sensitively, empathically and contingently just right to other people's needs, experiences and communication.

In individuals with attachment trauma, that felt sense can't be had: their felt sense is more that they and/or their feelings don't exist for the other (avoidant attachment), or that they exist only as a projection (disorganized attachment), or as a narcissistic extension (ambivalent attachment) of the caregiver. The recipient of such disturbing responses needs to erect defensive barriers to protect one's core from corrosive shame and from being overwhelmed. It is precisely those defensive barriers, their usefulness long gone, that need to be addressed if the security-engendering qualities of the therapist -- assuming that they are in operation-- are to be taken in by the patient and put to transformative use.

Thus my third clinical offering has to do with exploring the patient's *receptive* affective experiences of the therapist's presence, care, compassion, and love, i.e., what it

feels like to *feel* understood, cared for or delighted in. Crossing that receptive barrier requires that you challenge taboos against self-disclosure (Prenn, in press). It requires that you (a) explicitly express how the patient exists in your heart and mind, and (b) actively explore the patient's experience of you, all the more so when the experience is positive, as secure attachment engendering experiences are (Schore, 2001). A simple way of doing this is through raising the question "what is your experience of me?" and then experientially exploring that experience with the same interest, curiosity and rigor as any other emotionally laden experience.

Part Two: Case Example

The Light at the End of the Tunnel

Sally, a 35 year old single professional woman, sought treatment when her chronic depression exploded into acute feelings of pain, despair and hopelessness, accompanied by suicidal ideation. Though she had always had friends, she had never had an intimate relationship. As she put it, “I’ve never even been kissed.”

She manifested her avoidant attachment dynamics from the start. Intimate contact was fraught with danger and thus avoided. Her feelings and her yearnings for emotional connection had been met with dismissal and disgust by her parents. Wary of the pain and shame which, in her past experience, invariably accompanied emotional closeness, Sally banished her emotions and yearnings for connection. She developed a brittle self reliance which, in turn, led to the isolation and crushing loneliness which brought her to treatment. Below are some transcribed vignettes from the 9th session of psychotherapy.

Note: Nonverbal aspects of the clinical material are italicized and in parentheses; the moment-to-moment analysis of the clinical material is bracketed and highlighted.

Vignette # 1: Dyadic affect regulation of painful feelings: Not being alone

In this segment, the patient approaches very painful dark feelings, which are both expressed and defended against. The therapist's tone, affectively congruent with the experiences the patient is describing, bypasses her defenses. A deeper affect is entrained, allowing Sally greater access to right brain mediated affective experience.

Pt: (*disconnected voice, matter-of-fact tone*): Life is just empty for me... Is there more than this? And if there is no God ... that's my light at the end of the tunnel.... If you take this light away, it's pretty dark....

Th: (*soft, deep, somber tone*) It's dark...

Pt: Yeah (*slows down, despairing affect deepens but then defenses kick in, and speech speeds up, gets pressured cynical tone*)... So what's the point, you go through life proving, you go through life working, I mean this is …

Th: OK ... If for a moment, (*slowing down*).....If you let yourself stay with this feeling (*slowing down, sobering*), the sense of emptiness, this inner sense of (*deep sigh, grave tone of voice*)… having to work soooo hard to keep something away....

Pt: Yeah... (*also slowing down and sobering*) it's tiring. **[deepening experience]** I don't know... Sometimes I wonder, Is this it? Is this what life is about?.... It feels empty... (*pained tone*)

Th: In this dark moment, *(deep slow pained tone of voice)* what is that emptiness like?

Pt: It's black.... (*long pause*) **[deep affect of despair]**

Th: Black.... (*long pause*).

Pt: It's like.... I don't have to be here… If I thought of it that way. **[deep despair, references suicidal ideation]**

Vignette # 2: Transformance in action

Having bypassed the patient's defenses against these painful emotional experiences, in the vignette that follows, the therapist makes explicit that something significant has happened: Not only has the patient experienced her painful feelings, but she has shared them with another, who received them. Having touched the depths of despair, the patient is asked what it is like for her to share these feelings with another, in this case the therapist.

Immediately upon the asking, there is a transformation: Sally's affect brightens considerably as she spontaneously initiates an experiential exploration of togetherness. Little in her procedural past indicates prior experiences to support such intimate and confident relating. Nonetheless, in response to my invitation to explore, she issues an invitation of her own. She beckons me to join her in her transformational journey of sharing her darkest places with another, and affirms that it is a positive, acceptance and curiosity-filled experience. The positive affect that lights up the way is a marker of the transformance strivings in action (Fosha 2008, 2009a, 2009b). So is the initiative and creativity evident in this exploration.

Th: (*deep sigh*) .... this profound dread-filled place.... this blackness... this isolation... … what is it like to talk about it with me? What's it like for *you*? **[invitation to**

elaborate her experience of what it's like to *share* her until-now-private pain]

Pt: Well, it's sort of like… it's like we are walking through or hiking (*starts to brighten up*), and we are walking through this cave that's get darker and darker, and gets really really dark. **[accepts invitation; brightening positive affect]**

Th: Mmm huh

Pt: And … there is this little hole in the wall maybe (*makes circle shape with her hands*) and I kind of like go like this to you (*makes beckoning motion with her hand*)

Th: Uh huh

Pt: (*animated now*) And I open this door and it already feels like we are crowded in like this, and there is this tunnel with this wide opening that's getting narrower and narrower, and there is a door to that hole and I am opening this door and I am telling you like "Dr. Fosha, look inside, open the door"

Th: You're inviting me to share where you live … inside

Pt: Yeah, that's how I feel... I guess it's nice to show someone that this is how I feel.... I guess since you sort of made me think more about who I am, I feel you are a part of it too because you sort of sparked it in me … So I feel like you are part of it, part of the process of me showing you me, putting the mirror in front of my face, and me even looking at myself and examining...

Vignette # 3; The felt sense of existing in the heart and mind of another

Given how attachment trauma compromises the transfer of information between the hemispheres (Schore, in press), it is not enough just to have a new experience; the

patient needs to *know* that she has had it. That is the aim of the therapeutic work that follows. Note Sally's focus on my not only being willing to be with her and her feelings, but actually actively "wanting" to do so. The child's feeling that the parent wants to be with her is a key antidote to experiences of shame (Kaufman, 1996; Hughes, *in press*; Trevarthen, 2001).

Th: (*deep, slow tone*) Where am I? How am I in this journey?

Pt: In this whole scenario?

Th: Uh huh

Pt: You're sort of right behind me… **[she is in charge of process]**

Th: So what does that feel like? At this time when we're in this cave, going to this place that's darker and darker and darker ... You turn and I am there behind you, and you are telling me about it, and I …see it with you

Pt: Yes, it's the first time, you're the first.... And it feels like you don't mind seeing it, I feel you are not offended, you are not taken aback by it,... You *want* to see it..... And I am showing it to you, so there is an understanding I get from you that this is where I am coming from … I guess there is a nurturing understanding about my situation … you are trying to get a better understanding of who I am, so I am allowing you to look at it... [**articulation of her new experience of being with an other who wants to be with her**]

Th: Yeah

Pt: And you're a very safe person to show it to because..... Because you try to understand and you don't make light of it... It's OK for me to show you..... It makes me feel that I can show it to somebody, so it makes me feel like there is someone with me.

..... Maybe you don't quite understand what's happening when I open the door, but.... I am sharing with someone "this is what I have to live with, this is how I *really* feel"... And I never show people that side of me so… I don't know, it just feels … (*moved, tears in her voice*) comforting ... It feels like a little bit of a relief too.... Like maybe there is somebody else in this world (*fighting back tears*) that might have an understanding of who I am (*cries*) **[aloneness undone]**

Th: You are telling me..... that what is developing is the sense that though, in a way, this is your journey, but in a way it's our journey and I am there with you in some way.

Pt: *(nods through tears) (moved)* Yeah, definitely... I couldn't put it into words but .... it's like you just said, that we going through this thing together.

Th: I wonder what you see.... what you see in my face, what you see in my eyes in response to what you are telling me [**crossing the receptive barrier of the patient's perception and experience of the other**]

Pt: (*the patient looks very carefully at the therapist's face, much like a baby surveying the mother's face*) Oh, it's like we are in this trip together so.... I feel like there is a connection, you know… connection, and there is an understanding… mmm… compassion... I feel like a certain amount of… the feeling of trust. … Because honestly, your face, you know, like every time I talk to you, you look like you're *really* feeling it (*laughing, scrunches up her face in imitation of therapist's expression*)... Like you *really* get a good feeling for where I am coming from, it's like you almost got a pained look on your face …**[the negative affect becomes transformed into positive affect]** .... It's funny though, but it makes me feel like someone out there understands (*upbeat tone, smiling*) so I don't have to dwell on it...

Th: Mmmm (*matches mood, smile in voice*)

Pt: It's a relief, thinking that there is another someone in this world that understands where I am coming from... It feels good (*energetic voice, increasingly brightening mood*). I don't feel all alone in that world, someone's looked at it, so that I am not by myself. When I discovered that this is how it made me feel, I told my friend, it's weird, but I was all happy after last session... Because it's like "oh, someone knows, I don't have to hide it all the time, someone else knows out there" (*big sigh of relief, bright smile*) .... And I can move on... It's nice that I can be real with you, I don't have to be anything I don't want to be. I can be me. I can be myself. That's nice … I can be myself.

Th: I know what you mean

Pt: I can be my self and it makes me feel… It feel a little like when you show people this side of you, this private part of yourself it makes you feel a little bit lighter, (t*akes a deep breath*), you know, I can breathe a little bit better too...

This session proved to be pivotal. The patient's new experiences with the therapist, marked by the positive affects associated with transformance strivings, led to a more consistent willingness to be open, which enabled us to stay connected and endure the emotional storms associated with working on the painful aspects of her past. It also inspired her to work hard to overcome her fears of rejection and have the courage to risk being in a relationship.

Reflecting the consequences of an avoidant attachment style, Sally was isolated, lonely, depressed and intimacy-phobic when she started therapy. She developed a secure

and resilient therapeutic relationship early in the treatment which deepened over time. At termination, the patient was involved in a loving, committed relationship.

One of the last pieces of therapeutic work involved helping Sally share with her partner the nature of her struggles and enlist her partner's help in countering her avoidant tendencies. Her partner was not only willing to lend a hand, but felt moved and honored by the trust. At follow-up, one year after the termination of treatment, Sally continued to be free of chronic depression; the occasional bout of depressive feelings was short-lived. She continued to be deeply involved in her relationship where emotional communication and closeness was valued by both partners. The sharing of emotional experiences to deepen intimacy and solve problems, initially a new experience with the therapist, became an ongoing aspect of her everyday interpersonal life.

Part Three: Concluding Comments

Transformance strivings are everywhere: a theory informed by transformance allows a knowledge of and sensitivity to markers of health and healing, and thus making the most of them. In my work with Sally, her explorations and in her positive feelings were taken to be substantive and important markers of healing and self-righting, and not avoidance of the darker side.

The pivotal moment that captures the healing mechanism is when the patient, despite a life-long avoidant attachment style, *initiates* close emotional contact, and actually beckons her companion to accompany her on a journey where she will share the darkness that she lives with. In that moment, transformance in full operation: confident that she exists in the heart and mind of the therapist as herself, the patient's aloneness in

the face of unbearable emotions is undone. The therapeutic relationship acquires the features of security that allows us to do the hard work of processing her previously unbearable emotions until they too are transformed and yield their gifts of adaptive action and resilience for the patient to make use of moment-to-moment, day-to-day in her life.

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