

# Somatic Treatment of Attachment Issues: Applying Neuroscientific and Experimental Research to the Clinical Situation

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“Traumatic symptoms are not caused by the event itself. They arise when residual energy from the experience is not discharged from the body. This energy remains trapped in the nervous system where it can wreak havoc on our bodies and minds.” -- Peter Levine

This paper will report on the application of three strands of research to the clinical treatment of attachment trauma. Diane Poole Heller, PhD, a senior faculty member of Somatic Experiencing, has devised body-based interventions to target and ameliorate attachment issues in adults, which can be integrated into virtually any other psychotherapeutic modality. DVD clips of demonstration sessions with workshop participants will illustrate.

We shall begin by describing the three areas of research relevant to Dr. Heller's adaptation of Somatic Experiencing to the treatment of attachment trauma: neuroscientific research, attachment research, and research on the effectiveness of Somatic Experiencing. Then, after a brief description of Somatic Experiencing, we will outline some basic principles of its utilization. The final section will describe principles of working somatically with attachment trauma and then detail specific ways of working with each of three attachment disruptions: ambivalent, avoidant, and disorganized.

There is a large body of neuroscience and attachment research supporting the importance of the early attachment process to brain development and the subsequent ability to form close relationships throughout the life span (Schorer, 2003), which we only have time to mention here. From neuroscience, summarized in many articles by Allan Schore (2001), we can see the outlines of how the infant brain develops in relationship to its caregivers. The caregiver is neuroscientifically primed to nurture: when presented with infant stimuli such as audiorecorded infant cries, parents' basal forebrain region are activated. Significant for its nurturing functions, the basal forebrain region of the brain activates the areas in the brain responsible for qualities of effective parenting, including empathy and emotion, in addition to regulating nurturing responses (Swain, 2007). The parent's cognitive abilities are so that it responds neurobiologically to infant's responses, making warm and nurturing caregiving instinctual. This design is pivotal to the development of the infant's emotional foundation. Similarly, infants are innately designed to receive these caregiving responses. When a child is born, his nervous system has not been fully developed. Schore puts forth the idea that from 0 to 18 months, the child's nervous system is essentially sculpted by the interactions he has with his mother (Schorer, 2002). Furthermore, the structures of the right brain, which are responsible for autonomic, involuntary stress regulation, and emotional regulation are designed to mature within the first two years, indicating that the child-parent relationship is crucial in this time. After birth, the baby naturally exhibits what Bowlby refers to as “proximity seeking behavior,” where the baby relies on the mother for emotional regulation (Bretherton, 2004). Because the parent is primed to respond positively to infant stimuli, in the ideal secure attachment situation, there is positive synchrony between the mother and the child. Thus, the child's nervous system is able to develop properly.

However, in less than ideal situations, **the mother induces stress within her infant child.** The neurological impacts of a insensitive parent-infant caregiving relationship can be summed up by Schore (2002): "Trauma causes biochemical alterations within the developing brain (15). **The infant's limbic system still matures according to the same schedule as that of a securely attached child, but because the emotions of the infant are not properly regulated to promote optimal organization, the right connections are not formed among limbic system structures. This results in a sub-optimally functioning limbic system, and the infant is therefore not as capable of regulating emotions in times of stress.**

**In these episodes, the infant is exposed to extreme amounts of stress, resulting in a large fluctuation in parasympathetic and sympathetic activity (Schore 2001b). An infant will react to the trauma of abuse in two stages: a hyperarousal stage mediated by an overactive sympathetic system, and a dissociative stage mediated by an overactive parasympathetic system. In the hyperaroused stage, the amygdala will initiate the stress response by signaling to the hypothalamus to increase the release of stress hormones, resulting in elevated blood pressure, and an increase in heart rate and respiratory rate. During this state, the infant's mind will attempt to repair the damage of trauma by releasing endogenous opiates, which act to decrease the sensation of physical pain by altering the perception of pain. The infant will be in a state of withdrawal.**

**The increased amount of stress will also cause hyperactivity of the parasympathetic and sympathetic nervous systems. If stress is encountered frequently, the body will adapt by selecting for connections that initiate the stress response at a lower threshold and prolonging the response. A hyperactive sympathetic nervous system will cause the stress response to be initiated when the infant encounters any type of stress. For example, the mere sight of the mother's face will cause the stress response to be enacted in an abused infant, even before she actually induces trauma in the infant. A hyperactive parasympathetic system will cause the infant to dissociate and enter into a freezing stance. Infants who are exposed to extreme levels of stress also lose their ability to regulate their shifts in state, leading to intense irregularities in development. In addition, fMRI's provide evidence of the crucial interrelationship between infant and caregiver (Swain et. al., 2007).**

Secondly, attachment research involving laboratory set-ups, interviews and self-reports of children and adults has a long history beginning with John Bowlby's groundbreaking theories (Ainsworth & Bowlby, (1991) and subsequently operationalized by Ainsworth and Main (Ainsworth & Marvin, 1995). The first body of research categorized 18-month-olds as secure, avoidant or ambivalent (a fourth category, disorganized was added later) in their response to a parent's return in what became known as the Infant Strange Situation. The research instrument was the Adult Attachment Interview (Cassidy & Shaver, 1999) in which adults were questioned about their early life and categorized into groups corresponding to those of the infants. Over the years, a number of researchers have developed self-report measures of attachment which have been used to characterize romantic and other close relationships (Collins, 1996; Griffin & Bartholemew, 1994; Fraley et. al., 2000).

### Somatic Experiencing

The third area is research on the effectiveness of Somatic Experiencing techniques in treating trauma.

Somatic Experiencing, originally conceptualized by Peter Levine, is a neuroscientifically based approach, which alleviates trauma by restoring the balance of the autonomic nervous system (Leitch, Miller-Karas, & Everett, 2007). Underlying the theory that humans, like animals, have a inherent capacity to heal and attain resilience, Somatic Experiencing links together the "incomplete biological patterns" that have been impaired during the traumatic incident or its

tenuous aftermath (Leitch, Miller-Karas, & Everett, 2007), “*by tracking internal changes, restoring self-regulation, re-negotiating trauma within the nervous system, and deactivating the state of hyperarousal so common in traumatized peoples*” (Britt, Napier, 2002). Somatic Experiencing utilizes bottom up processing, using increased awareness of instinctual human sensations to guide the body in healing trauma. When the body undergoes a highly stress inducing situation, the nervous system is shocked into dysregulation. The internal stress and emotion that comes from the event itself becomes locked within the body, unable to be released, leading to a multitude of trauma symptoms (Somatic Experiencing Trauma Healing Manual, 2007). Somatic Experiencing helps the physical body ground itself in the present, releasing it from its past trauma and restoring self-regulation (Leitch, Miller-Karas, & Everett, 2007, Britt & Napier, 2002) . Underlying the humanist belief that humans have the innate capacity for a rich development, Somatic Experiencing has been an invaluable *model for numerous populations, including “combat veterans, rape survivors, Holocasut survivors auto accident and post surgical trauma, chronic pain sufferers, and even to infants after suffering traumatic births.”* (What is Somatic Experiencing® (Somatic Experiencing)? n.d. Retrieved July 8<sup>th</sup>, 2009, from [Foundation for Human Enrichment – Trauma Healing](#) website). Its work has been published in peer reviewed journals such as [Traumatology](#).

The Somatic Experiencing Model has been tested for external validity on a variety of at-risk populations, with positive results. A study examining treatment effects of Somatic Experiencing after the 2004 tsunami in Thailand utilized Somatic Experiencing's early-intervention model **Trauma First Aide**. In this exploratory study, clinicians from the Foundation for Human Enrichment's Trauma Outreach Program provided individual Somatic Experiencing/Trauma First Aide treatment to 53 adults and children. Trauma First Aide treatment focused on restoring self-regulation, in order to reestablish the equilibrium of the nervous system (Leitch, 2007). This was done by tracking things such as shifts in the nervous system, resource use, titration, and pendulation (Leitch, 2007).

Immediately after the Trauma First Aide session (n = 53), 67% of patients reported either partial or complete improvement of symptoms. Table 2 delineates Leitch's results:

Table 2. Percentage of Participants Reporting Partial or Complete Improvement of Symptoms Posttreatment.

| Time of Follow-up | Immediate<br>(n = 53) | 3 to 5 Days<br>(n = 16) | 1 Year<br>(n = 22) |
|-------------------|-----------------------|-------------------------|--------------------|
| Reported symptoms | 67%                   | 90%                     | 90%                |
| Observed symptoms | 95%                   | 84%                     | 96%                |

This study offers an initial look at the effects of an early intervention model that has great potential for restoring inner equilibrium within the body and consequently, throughout the mind. Its cross-cultural flexibility makes the therapy applicable to a large range of populations, without overreliance on medication.

#### India Tsunami (Parker, Doctor, & Selvam, 2008)

Another study was conducted testing the effectiveness of Somatic Experiencing on victims of three Indian fishing villages that had been hit by a tsunami, also with favorable results.

The participants (n = 150) were assessed four times: before treatment, immediately after treatment, 4 weeks later, and then 8 months after treatment.

Overall, application of Somatic Experiencing principles resulted in significant improvement in patients. Post-treatment assessments indicated that 85.2% of participants experienced improvement from their initial trauma induced symptoms. Approximately 68.8% of total participants reported noticing symptom reduction in the 8 month assessment. As results show,

Somatic Experiencing has proven effective in short term treatment in traumatized populations, demonstrating great potential as not only a short term intervention model but also a healing therapy that can have lasting effects.

These studies have been published in the peer reviewed journal, *Traumatology*, confirming the external validity of the Somatic Experiencing methodology.

“A pilot project was recently conducted to determine the effectiveness of the Dynamic RePatterning Experience (DARE) workshop in shifting people's attachment styles. Conducted by

<sup>1</sup>  
Dr. Diane Poole-Heller, DARE is a five part series which integrates Somatic Experiencing in the exploration of Attachment Styles within personal, interpersonal and trans-personal relationships. The pilot project analyzed DARE Module 3, which took place during July 2009 in New York City. DARE Module 3 focuses on sexuality and relationship dynamics. As with the other DARE Modules, one goal of the workshop is to guide participants toward more secure attachments in their personal lives in order to most effectively apply it to their clinical practices. Participants were therapists and other helping professionals interested in learning about healing attachment disruptions using Somatic Experiencing. For each participant, attachment scores were recorded before and after the workshop using the Relationship Scales Questionnaire (RSQ), an empirically supported self-report measure of attachment. Participants rate the extent to which thirty statements describe their characteristic style in close relationships. Responses are scored to obtain continuous measures of four attachment patterns: secure, dismissing, fearful, and preoccupied. Data analysis of the pilot program seems to suggest that all of the participants experienced a change within one or more attachment patterns (N=17). Most notably, 94% of participants expressed a change in Secure attachment scores (N=16). Secure attachment scores increased in more than half of participants (N=9) at an average of 0.48. The greatest shift of Secure Attachment Score was an increase of 1.4. Considering scores are assessed along a five-point scale ranging from 1 (Not at all like me) to 5 (Very much like me), the magnitude of these shifts is substantial. The figures below illustrate the results of the pilot project, which suggest an SE workshop is effective in shifting attachment styles.”

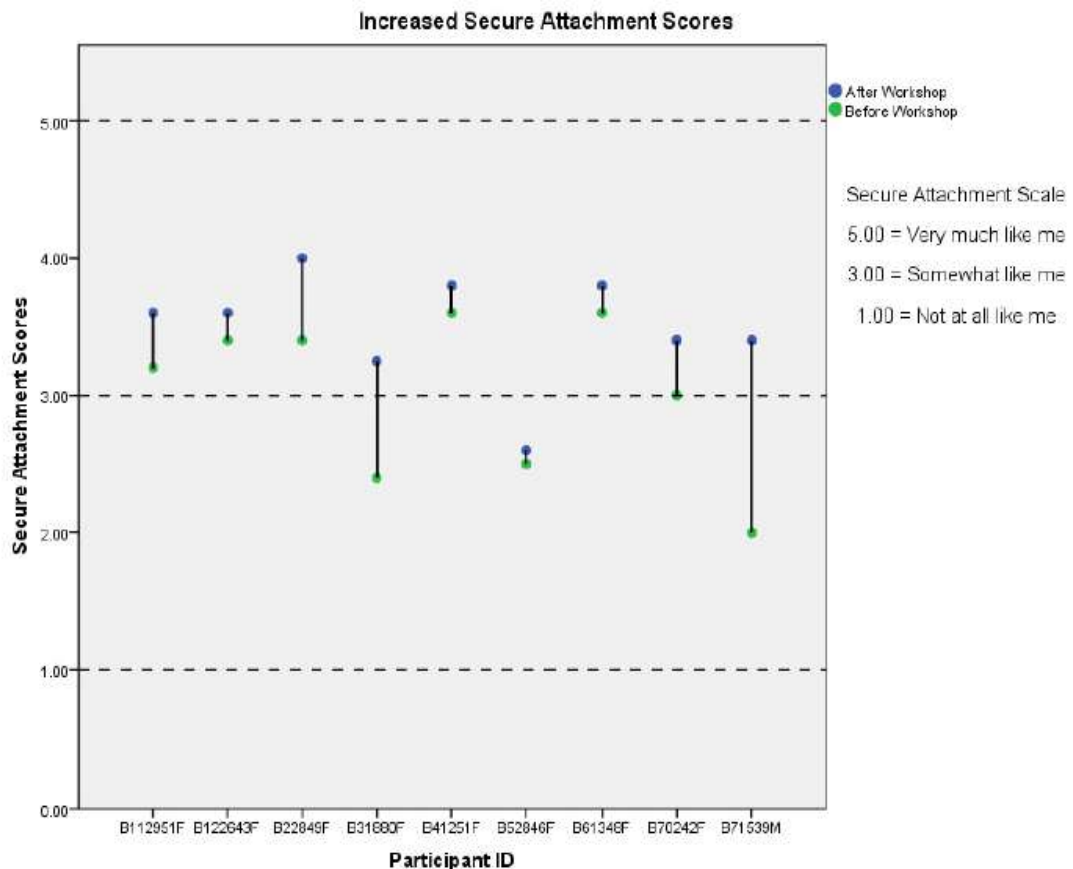
It is also important to note that secure attachment scores decreased for some participants (N=7), at a higher average (-0.56) than that of the increase group. Interestingly, these participants tend to have higher pre-workshop secure attachment scores, as depicted in the tables below.

| Participant ID   | Pre-Workshop | Post-Workshop | Increase Amount |
|------------------|--------------|---------------|-----------------|
| B41251F          | 3.6          | 3.8           | 0.2             |
| B61348F          | 3.6          | 3.8           | 0.2             |
| B22849F          | 3.4          | 4             | 0.6             |
| B122643F         | 3.4          | 3.6           | 0.2             |
| B11295F          | 3.2          | 3.6           | 0.4             |
| B70242F          | 3            | 3.4           | 0.4             |
| B31880F          | 2.4          | 3.25          | 0.85            |
| B52846F          | 2.5          | 2.6           | 0.1             |
| B71539M          | 2            | 3.4           | 1.4             |
| <b>Average =</b> | 3            | 3.49          | 0.48            |

| Participant ID | Pre-Workshop | Post-Workshop | Decrease Amount |
|----------------|--------------|---------------|-----------------|
| B112736F       | 4.6          | 3.6           | -1              |
| B51047F        | 4.5          | 3.4           | -1.1            |

|                  |            |             |              |
|------------------|------------|-------------|--------------|
| B61752F          | 4          | 3.8         | -0.2         |
| B51553F          | 3.8        | 3.2         | -0.6         |
| B80957M          | 3.4        | 3           | -0.4         |
| B12142F          | 3.4        | 3           | -0.4         |
| B11265M          | 2.2        | 2           | -0.2         |
| <b>Average =</b> | <b>3.7</b> | <b>3.14</b> | <b>-0.56</b> |

It is suggested that the workshop experience increased awareness and caused participants to reflect more precisely on the subtleties of their attachment style. Perceived secure attachment scores may have been inflated prior to the workshop due to a more general idea of attachment patterns. Quite logically, increasing understanding of attachment may be pivotal in the process of strengthening “earned” secure attachments and is essential for clinicians seeking to apply the material to their work with clients. It can be argued from the results of the pilot study that DARE Module 3 fostered a more refined perspective of attachment through SE integration in the promotion of secure attachments. The findings of this study are limited due to the small sample size. However, additional data collection and analyses are currently underway, and greater support for the effectiveness of SE integrated workshops is anticipated.



## Principles of Somatic Experiencing

The body-mind is designed to heal intense, extreme experience: utilizing the brain's unlimited neural plasticity. Interactive regulation and self regulation, evident in mother-infant relationship are a part of any intimate relationship and are called upon constantly in psychotherapy.

[From Istanbul 2008 paper]

1. **Resources** are identified and alluded to throughout the treatment. They are whatever is positive in patient's life or imagination: can be sensations, images, behaviors, affects or meanings. They are reparative and they aid titration.
2. **Narrative** is used to track activation, not search for memories.
3. Therapist must work within range of resilience: don't push through resistance or promote catharsis.

**4. Pendulation and titration** are concepts easy to apply to psychodynamic sessions.

Psychotherapists have been trained to allow the patient to complete a horrific narrative in the hopes that the neocortex will make sense of it and thereby lessen its ramifications in the person's present life. The autonomic nervous system, however, is hard-wired, in its optimal state, to pendulate between sympathetic and parasympathetic modes. Extrapolating, we have learned that the energy locked into the system by trauma is most effectively released in small increments. Therefore, pausing in the account to allow the nervous system to "recycle" avoids iatrogenic retraumatization. This can be done in a number of ways: by resourcing at the beginning and as it unfolds, by asking the patient to focus in the present, and by any one of a number of grounding and stabilizing exercises. An analogy would be folding in dry ingredients to a wet batter to avoid lumps.

**a. Titration** involves introducing traumatic material in small amounts. It keeps the nervous system activation within the "window of tolerance."

To resolve the trauma more effectively, we have to touch into the resource and then go back, alternate between a piece of the trauma and a piece of the resource. You're working with a trauma vortex. Just as if you were kayaking in a river, if you come up to an eddy, there's always a spin off to the other direction. We are working with a polarity so sometimes the counter vortex, the healing vortex, is small. We try to strengthen the ability to stabilize. When you are going back and forth, you are disabling the pull of the trauma vortex; you are disorganizing it. [Edited from Transcript p.7]

5. SIBAM is an acronym for the elements of experience. We want to work on as many elements of experience as possible. It is necessary to work in as many channels as possible to enlarge the experience, making it wider and deeper. (Discharge can occur through awareness of any element of SIBAM.)

- a. **Sensation** involves any of 5 senses
- b. **Image** can be internal or external (red ball in chest vs. sunset)
- c. **Behavior** can be verbal/nonverbal, voluntary/involuntary conscious, unconscious.
- d. **Affects** are emotions, actually patterns of sensations
- e. **Meaning** is explicit linguistic concept or statement

6. Allow lots of time for the nervous system to re-organize itself. We don't want to rush the session.

7. Discharge: It is important to be able to recognize signs of discharge without inhibiting them in both self and patient.

1. Exhale, yawn (Yawning is a parasympathetic response)
2. Burping
3. Tingling/Numbing depending on context
4. Sense of flow
5. Warmth/heat, can also be mobilization
6. Sweating
7. Crying
8. Shaking and trembling (trembling may have fear mixed in)
9. Coughing

## **8. Dosing and Pacing to Discharge Arousal**

### **Why Tears and Trembling Are Good**

Self-regulation of the nervous system automatically discharges periodic arousal. It facilitates resilience regardless of the chaotic outside environment. If a person did not have a loving, nurturing caregiver, was not taught how to self-soothe as a part of early attachment, it will be difficult to have a steadily regulated nervous system. Regulation fosters a capacity to experience and stay in contact with highly charged positive states. Unresolved trauma makes it difficult to stay in contact even with highly charged positive states without flipping to the familiar negative.. So the ability to experience joy, bliss, expansion, compassion, gratitude, sexuality, and all these things are related to having regulation in a place that can tolerate higher charged positive feeling.

Attachment trauma survivors often have hyperaroused bodies. The nervous system hasn't been able to discharge it, so the sympathetic nervous system remains activated. After having excess arousal trapped within the nervous system for prolonged periods of time, the body/mind interprets the hyperaroused nervous system as normal. The threat response becomes internalized. When this happens, the person does not need a tiger or an oncoming car or a fire breaking out to trigger the threat response: the bottled up arousal within the nervous system triggers triggers the threat response. To bring the arousal level down, the body needs to complete incomplete physiological sequences related to threat [Somatic Experiencing Trauma Healing Manual, 2007). When the arousal level is down, it is much easier for the person to maintain contact with resources, relaxation, and expansion.

Traumatized people who have undergone harrowing experiences have a lot of energy built up within their systems, adding extra weight onto their emotional and physical frame. If the body has been in a state of hyperarousal for an extended period of time, it most likely will have forgotten how to discharge excess arousal, either through crying or shaking or otherwise letting go of the profusion of energy. We want to encourage the signs of discharge: "Oh, you're trembling and shaking. That's really good – that's how the nervous system discharges excess arousal, so just let that happen." We want to encourage the body to feel comfortable discharging. The intent is to facilitate subtler levels of discharge, such as implicit movement. Subtler levels are easier to manage and integrate. While it's still therapeutic when someone's nervous system discharges excess arousal in high dosages, he may feel vulnerable and out of control: "I don't know what my body's doing!" You need to normalize it so that they don't constrict against the discharge process and stop it. You need to encourage them to let it happen. When we encounter tears, we can say: "Oh, that's really good, your tears are coming, leave space for that, that's wonderful." Tears are another way. You are normalizing the situation for them so that patients feel safe enough to release previously held trauma.

Therapists need to constantly access their patients' arousal states. Their energy is often unintegrated, fragmented, and very highly charged: It is a bit like walking through a minefield. When someone's nervous system becomes highly activated, they can be swept away and lose themselves. The energy has a magnetic pull – hence, the term vortex – and it takes the client out of his integrated sense of self.

From chaos theory, we learn that in non-linear, self-organizing systems (Bloom, 2000), the right amount of perturbation (disturbance) allows a system to reorganize to a higher level. Excess perturbation results in traumatized clients at a lower level of functioning. If you introduce just the right amount of perturbation, it leads to a tolerable activation of the nervous system, and

can proceed to a higher level of organization. Subsequently, the person can tolerate more expansion, more flexibility, and more happening in the nervous system.

After a small amount of expansion, the next step is stabilization. Stabilization involves allowing the person to have time to get used to increased energy in their system. If they don't, they may revert to old patterns of dysregulation. One of us worked in a workshop with a woman in Sweden who had a near-death experience, and was quite dissociated for 30 years. She didn't realize that she had been gone that long until she came back and she had the awareness that she had missed her kids growing up, she had missed all these things because of something that happened during a surgery. So she was really amazed and happy to come back. For the first time, she was present. The day after that session, I asked her how she was and I found out she went out and got drunk that night. It was too hard to orient to a less dissociated present. It is very important to give people time to stabilize changes in the session, to really develop the container to hold all that aliveness and energy that's been trapped in the trauma.

## **9. Creating Continuity through Language**

Utilizing specific types of language, the therapist can facilitate successful movement, make the client cognizant of physiological and emotional discharge, and continue movement through and past trauma.

Connecting words and phrases often provide a sense of continuity within the patient, allowing them to fill in the blanks of their trauma. We can think of our attempts to bridge their discontinuity if we think of their memory as a film strip: a lot of people blank out in the middle of the film strip when the arousal is high. So you just start to add one frame at a time. Often, that's manageable, just concentrating on what happens in the next frame. We start with connecting phrases such as, "And as you feel that resource in your legs, what do you notice in your upper body?" We keep things moving. We often start sentences with "And..." and "As you..." to obtain that sense of continuity. The prompt, "What happens next?" is invariably useful for trying to move someone through time. You may say, "So you're noticing some emotion coming up and it's related to this particulate event, this person did something that was upsetting, just let yourself stay with that, let that have some space. What do you notice happening next?" The prompt serves two purposes: to move the experience along, or to move along a story that actually was interrupted in the past, and a story we want to continue and finish to help release the trauma.

Signs of discharge (see above) are positive indications the session is moving in the right direction. To maintain the focus, our language must focus on the physiology of the client. The individual might rapidly go to a next thought, or another memory, but we need to help them move through their own physiology in tandem with what they're experiencing emotionally. An example: "After discharge, what do you notice next? After that strong movement, what do you notice next in your legs

When someone experiences too much arousal, language needs to become much more directive. You may have to say firmly: "Open your eyes, look at the carpet, look at the colors," etc.

Language, in short, is used to support the unfolding of the process. One of the hallmarks of trauma is that it stops the experience, and the person spins in the arousal. We want to tap into that and resource enough so that the individual feels safe enough to move forward. The experience could be sensation, could be image, a picture, a sound, a smell—trying to bring elements of the experience back in a soft enough way. The goal, always, is to help move towards integration instead of disintegration.

## **10. Maintaining Stable Arousal in Therapy**

The therapist needs to carefully gauge the level of arousal of the patient. The term arousal manager comes to mind in a quite literal sense: it is the therapist's job to manage the arousal so the person doesn't experience unnecessary suffering. With some clients it's more difficult because they have so much arousal, and with others, they're reasonably regulated so it's



easier to bring them back. The higher the arousal, the more difficult it is for the patient to utilize resources. But if the resources have been encoded physiologically at the beginning of therapy, utilizing the felt sense and in their own body, patients can always revert to those resources when they start to feel hyperaroused. That's why we prefer to work with trauma after there's something solid and stable to come back to: once the person is highly activated, they lose their capacity for creative self-regulation.

In states of high arousal, focusing on the lower parts of the body facilitates the later discharge of energy. To feel, for example, five molecules moving down your legs, helps neural pathways become remembered. Then, when patients are trying to discharge activation, the body has a path of which client is aware. Of course, discharge can happen in other parts of the body, but the lower body is the most frequent locus.

## **Working with Attachment Trauma**

### **Core Intactness**

This work assumes that inherent in all of us is a healthy core intactness. If we can recreate the right situation in therapy, friendship, or marriage, we are able to reconstellate it. In the corrective experience, when we really focus on safety, attunement, presence, we start to feel a shift. We do not want to ignore the wounds; we want to be able to work with them. We want to facilitate what healthy attachment would feel like. Sometimes we try to bring out a secure attachment through corrective experience by looking at what was missing, and asking what difference it would make if the client had had an ideal kind of experience.

### **Using Therapist or Other to Create Earned Secure Attachment: Repairing Trust**

It is important to remember that the bonding of secure attachment can occur at any time in a person's life, even if it did not happen initially. It can return any time someone has a consistent, present, safe relationship: with neighbor, child, partner, friend. Therapy offices are just one place to achieve that stability. Though people may have experienced disruptions, the research is quite hopeful about the capacity of people to bring back healthy attachment and effective relationship skills. Neuroscience research suggests that neural plasticity is a lifelong possibility (Rakic, 2002).

### **Creating a Secure Base**

There is a quality of relaxation about moving in and out of contact when the child knows that the parent will be there. When that holding environment is intact, there is a feeling of basic trust. The person has a sense that things will work out, a natural optimism, unflappability, even in the face of difficulty. We often cannot correct people's attachment systems with what actually happened. If they have a disrupted attachment, what actually happened was very painful. We want to let patients understand what they did not have and expose them to the possibility of having it. We want to acknowledge what they did not have, but also introduce the antidote (Jaffe, 2007). Mirror neurons, which are activated by perception and action alike, allow traumatized individuals to visualize a solution so powerfully that it acts upon their neurological and biological systems. People will come up with what that correction would be, but because they do not have it on their physiological menu, we have to introduce the healthy experience into their physiological frame of reference. If you do not have it in your physiology, then you will not see it in the world. If someone is very supportive and a generally positive resource, and a person had been brought up in a damaging environment, they will not know what to do (Bollas, 1987): "that doesn't fit with the original puzzle pieces." "You're being kind all the time?" You have to make sure you are introducing healthy attachment into their experience (Seligman, 2002). If someone has never felt safe, then they do not have a physiological awareness of what safety feels like. In session, the therapist has to work to help the client's body experience what it would feel like if it were in adequate safety. (You can never be 100% safe because that is not possible, but you can be safe enough.) How does your body tell you something, like art or nature or animals, is safe? How do you feel that physically? What happens? For some people their stomachs may relax, their

shoulders may drop. For other people, their eyes sink back into their eye sockets a little bit. (By the way, that is a very quick way to trigger the parasympathetic.)

## **Working with Each Attachment Style**

### **Secure Attachment Summary**

Secure attachment thrives when the holding environment is safe and engenders basic trust, parents are present and consistent, communication is predictable, sensitive, and attuned, parent shows interest in and aligns with states of mind of those of the child. Securely attached adults show realistic optimism in their worldview, have a capacity for attunement and clear communications, have resiliency in recovering from stress, especially in relationships, demonstrate the capacity to initiate and receive repair attempts, tend to be unflappable and levelheaded and give others the benefit of the doubt when appropriate.

### **Avoidant Attachment**

Avoidant people tend to be relatively disconnected from their physiology and/or their emotions. With parents who were emotionally distant, the child does not receive the mirroring, or the exchange, and the development of the prefrontal cortex around emotional connectedness is truncated. In therapy, then, we have to set up conditions to allow those impulses to resurface. The therapist can embody the correction in the relational field, and can then highlight a particular aspect of presence, quality of being, or attunement.

Even memories, perceptions of the past, are biologically detached in avoidant people. Felt sense depends on limbic exchange: there needs to be an emotional connection for our brains to configure a personal memory. There needs to be a limbic connection for a “feeling” memory to imprint. Avoidant people may recall their childhood: “Yes, I went to that red brick school and my teacher’s name was Mrs. Harris and there was a playground and I played ball”. They can describe the fact of it, but there is not a felt sense memory of the experience: “I was there.” Avoidantly attached people describe their history the same way they approach relationships: the narrative is detached and impersonal. They may have large gaps in their memory: memory was not consolidated due to a lack of emotional connectedness.

### **Avoidant Style in Adult Relationships**

One of the primary characteristics of avoidantly attached people is to be solely self-reliant. It is a self-reliance based on deficiency, an autonomy that is driven by fear and self-deprivation. It is an unhealthy, fear-driven autonomy.

The criticized child grows up to be the critical adult, and the roles are flipped. The person acts out both sides, in line with the projection experienced: criticism, excess pessimism, a cold and distant demeanor. The avoidant person is either the rejected or rejecting one. But either one of those is an ultimately uncomfortable place to be.

### **Repairing Avoidant Attachment**

Avoidantly attached people tend to be somewhat dissociated, and not fully present in their bodies.

In trying to help clients repair their disrupted attachment, the therapy must emphasize seeking other people out as resources. They must resurrect the need to connect and see the positive experience of the connection, instead of the strained connections they experienced in the past. The optimal condition for attachment to thrive is a connection in which communication is predictable, sensitive, and attuned.

Avoidantly attached people view connection as something dark and dangerous, to be deeply feared. When you invite someone to open up again, you have to have a strong focus on loving-kindness, on compassion, on acceptance, on safety, on attunement, because you’re asking someone to challenge the whole foundation of how they experience the world, and to take a chance again. So it’s very important that you understand and can say to the person, “I know

that what I'm suggesting to you feels like a huge risk." You must validate that because it is true.  
[transcript 11-13 all avoidant]

### **Ambivalent/Insecure** [Transcript 15-17]

In this attachment model, infants at 18 months return to parents on reunion but are not easily soothed and do not return to play quickly. They exhibit crying, then relief, and then cry again, so appear not to trust consistent availability of the parent.

The child simultaneously feels hunger for closeness and a debilitating fear of losing the closeness. Even as the individual hungers for emotional closeness, new relationships may be unfairly viewed as inconsistent and unreliable. Anxious adults may experience chronic anxiety, frustration and despair in relationships, expecting the worst of their partners. They have difficulty trusting themselves, their partner and the relationship. They will accept what they are given instead of asking clearly for what they want. They may "give in order to get" and wonder why their partners sometimes feel angry instead of appreciative. They feel they have to please their partners all the time in order to keep them.

### **Repairing Ambivalent/Anxious Attachment**

There are a number of ways to help ambivalent/anxious people repair anxious attachment. One is to help them experience having something, versus wanting and not having. Anxiously attached people can easily identify with wanting, and yet are almost dazed when they receive, and don't know what to do. We want to see what happens when they are confronted with the possibility of having what they want, whether it is having support, or receiving love.

Anxiously attached people say they want pleasure, but their life experience has taught them to be more comfortable with pain because it's familiar. In identifying with deprivation, ambivalently attached people reject love when it truly manifests because it feels unfamiliar and disorienting

Another option is to provide corrective imaginal experiences around the themes of:

#### **"Consistent Relationship" Meditation**

#### **"Giving and Receiving" Exercise (3 parts)**

##### Part One: What Happens When You Attempt to Receive

Track in your body and your emotional self what your responses are when others are available and you have the opportunity to receive. What happens?

##### Part Two: Building Resiliency Around Receiving

Corrective Experience Options

##### Part Three : What is your experience when giving?

### **Disorganized Attachment** [transcript 18-20]

The disorganized infant displays chaotic and disoriented behavior. The child may run toward and abruptly away from parent because he simultaneously needs and is terrified of the parent, who is frightening and/or deeply frightened (Mikulincer & Shaver, 2007). Two major biological drives are in constant conflict: the innate drive to attach and the instinctual drive to survive.

### **Repair of disorganized attachment**

Children learn to override their instinctive self protective instincts as their survival depends on entering an unsafe environment on a regular basis. Ultimately, they cannot distinguish between safe and unsafe circumstances. Their self protective alarms no longer sound. As adults, they may

be attracted to danger or unaware they are walking straight into it. They may not find options that are actually available to increase their safety. For example, abuse survivors often ignore the early signals of inappropriate behavior from others, such as off color jokes, invasive touch and “bad vibes.”. As facilitators, we may need to help bring these original survival instincts back into awareness and “reactivate” this early radar system.

### **Competent Protector Exercise is one technique to Repair Disorganized Attachment**

In disorganized attachment, the patient's sense of safety has often been so disrupted that there are no safe relationships the person can fall back on. If someone has been abused from very early, their holding environment will have been so fractured that they won't know what safety or relaxation is. It will be immensely difficult for them to contact resources. The therapist may have to resurrect and build that physiological experience of safety that the patient had been lacking in his life.

To offset the disorganized influence on the attachment system, a possible exercise is to construct a competent protector, in order to give the client an imagined experience of physiological safety. The goal is to help clients have the physiological sense of what it would be like to be protected.

The source of the competent protector can be a person from any time in the client's life, in the past or in the present. Some people feel it more with animals: some people report feeling it with black panthers or tigers. If it's easier, the protector can be imaginary. You can extend it to movies that you've seen or books you've read. For example, a person who had a lot of violence in her childhood really enjoys watching Mel Gibson in Braveheart. Every time she saw Mel Gibson in the role, she would put his protector role into her childhood story. You could try Xena the warrior woman, or Arnold Schwarzenegger. The Mahakala on a spiritual level. Deities and Tibetan deities. The client needs to know that competent protection does exist, even if they haven't previously experienced it themselves.

Another method is to design one's own competent protector. Visualize the perfect protector: what qualities would they have? What would be the archetype? As clients describe the qualities that would facilitate their process of feeling safe, the therapist might say, “And as you talk about the possibilities of those qualities, what happens in your body?” What would be a competent protector for you be in the ideal scenario? What would they do? Say?

Another way of accessing the competent protector is to help the client to undertake an adult role in being a competent protector and to compare it with the less-than-ideal protectors they may have had as a child. Many people have had lousy protectors as a child but are great protectors as adults. “My parents didn't do it,” or “My adults in my life didn't do it. So when I see a kid getting bounced around, I'm going to show up.” Often they can use the rightness of how it feels to be the protective mother bear or the father bear and protect their child. So you ask them to visualize: you might say, “imagine how the child around you feels knowing you're going to give them space to do their own protecting, but that if they need you, you're going to be there and take care of them. What do you imagine they'd feel?”

When feeling protected becomes a tangible possibility, the attachment system will start reorganizing. Parts of the body will start to relax, and the person will start to feel more present. Basically, the patient is coming back to secure attachment. As facilitators, the goal is to help someone have that energy surface, so that they feel relief or relaxation. The therapist wants to anchor their capacity to feel safe.

What happens in the body when they start to feel safer? They might notice their breathing gets deeper, they might get warmer in temperature, they might feel more aliveness, they might feel calmer, and become really deeply connected to themselves. They might be in a relational field and more able to interact.

There are times when the person cannot physiologically access safety. It means their childhood was so tumultuous and fragmented that you have to start from the beginning and rebuild that connection to possible safety: usually human relational trauma.. If the therapist can be present enough to embody some of the missing resources, the client can experience a presence of protection, compassion, or kindness. The therapist is the antidote as well as the facilitator of corrective experiences.

## Conclusion

The effective principles in the Somatic Experiencing modality have great potential as a cross-modality approach to attachment trauma. Attachment trauma occurs when the precarious mother-infant relationship is disrupted and the child grows up with attachment wounds. When left untreated, attachment wounds worsen, drastically diminishing and reducing quality of subsequent relationships the individual will have with others. Somatic Experiencing allows an individual to pendulate effectively between states of resource and states of highly charged traumatic energy. This allows for the negative energy locked in the nervous system to be safely released, while giving the individual space to explore resourced states of safety. As the therapy operates under an assumption that within all of us is an innate secure attachment, it simply works to bring out our secure attachment, freeing us the emotionally heavy obstructions within our nervous system that hinder our potential for a healthy, thriving, and generative development.

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