The Dance of Attachment: The Therapist's Use of Self and Self-Care in the Treatment of Developmental Trauma

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One of the greatest gifts is to be

the midwife of the soul in

another person.

Plato

Introduction

- EMDR therapy is an experientially-based approach
- It is about experience unfolding in a moment-to-moment way
- It's not just about what happened; it's also about what happened next and what's happening now
- In addition to reprocessing memory as the primary focus, we are also part of the client's experience
- Parallel process is memory in the making

Make what is implicit, explicit
Make what is explicit, experiential
Make the experience relational
Make it all transformative

Diana Fosha

Introduction

- The therapeutic relationship is *co-created* by therapist and client
- Creates the context for psychotherapy
- The therapeutic dyad as the primary vehicle for change
- EMDR psychotherapy within the relational context is about generating *corrective* as well as reparative experiences of self in relation to the other

Introduction

- The corrective experience of the therapeutic relationship that has a secure base allows the client to:
  - Deconstruct the attachment patterns of the **past**;
  - Construct new, adaptive patterns of attachment in the **present**;
  - Transform their sense of self, relationships in their **future**

Introduction

- As [EMDR] therapists, our exposure to trauma is much higher than for therapists who have a general practice or specialize in other modalities (Figley, 2012)
- Being in relationship with many clients who are severely traumatized puts us at risk for stress-related responses of our own

Introduction

- Our greatest asset, that is, our ability to be present to the client's experience, to empathize and attune, is also our biggest vulnerability
- Therapists who are challenged by a personal crisis or a challenging work environment are also more likely to develop symptoms

Introduction

- Therapists who have an unresolved trauma history are more vulnerable to stress-related conditions (Figley, 2012)
- Our own formative attachment experiences and our patterns of response are also a variable (Wallin, 2009)

Secondary Stress Injuries for Therapists

- Compassion Fatigue
- Secondary Traumatic Stress
- Vicarious Trauma
- Burnout
- Shared Trauma

Basics of Compassion Fatigue by Charles Figley, 2012

Compassion Fatigue

- Emotional and physical exhaustion that affects us over time
- Decrease in emotional responsiveness
- Decrease in quality of care
- More clinical errors
- Increase in anxiety and depression
- Greater difficulty empathizing

Secondary Traumatic Stress

- Where we, as therapists, are secondarily traumatized by hearing about the trauma
- Effects are the same as if you had the primary exposure yourself

Vicarious Trauma

- When we, as therapists over-identify with the client's trauma
- Results from an empathic engagement with one or more traumatized clients
- Results in loss of meaning, sense of hopelessness, powerlessness

Burnout

- Prolonged exposure to high levels of stress
- Too many clients, too heavy a workload, too many competing demands, challenging work environment

Shared Trauma

- When the same event happens to all of us
- Can have different responses to the same event
- More dialogue about the shared experience

Attachment Theory

- Internal working models of attachment, operating at non-conscious levels have encoded strategies of affect state and arousal regulation; storing critical information about the mind and body of self and other (Schore, 2004)
- This includes us as well as our clients
- Brings into play the *interplay* between our relational histories as well as the client's

Attachment Theory

- Attachment as regulation (Pipp & Harmon, 1987): Homeostatic regulation between members of a dyad is a stable aspect of all intimate relationships throughout the lifespan
- Both therapist and client are being influenced by implicit memory that is being evoked through nonverbal as well as verbal communications

Attachment Theory

- The co-constructed relationship between therapist and client is both internal and interpersonal
- The experience and behavior of both therapist and client will unavoidably be shaped unconsciously both by who we are as people independent of the relationship as well as who we are in response to that relationship

Therapist Attachment Styles

- The "all good" *objective* therapist who is a blank slate is a myth
- The client who has "everything they need" in order to move towards health is also a myth
- Relationship between therapist and client creates the context where change is possible

Therapist Attachment Styles

- As therapists, our ability to generate a secure attachment experience with our clients largely depends on our own attachment history
- Stance of the self predicts attachment security better than the *facts* of the personal history (Wallin, 2009)

Therapist Attachment Styles

- Most of us, even if we have a predominantly secure attachment have "islands" of trauma and dissociation in our history (Bromberg, 1998a)
- Working with early developmental trauma can activate our own memory networks that can inform how we respond to our clients

Therapist Attachment Styles

- It is not necessarily that our formative attachment experiences are painful per se, it is the *lack of resolution*
- Consistent with EMDR AIP theory that our *perceptions a*s well as our *conclusions* about ourselves, others and relationships organize our experience of self in the present

Therapist Attachment Styles

- How did we *self-select* into becoming professional "helpers?"
- Our own formative attachment experiences set the template for becoming a therapist
- Intergenerational transmission of trauma
- Developed controlling-caregiving strategies (Wallin, 2009)
- These adaptations/strategies are both our strengths and our vulnerabilities

Therapists Attachment Styles

- Attachment patterns are known but not necessarily remembered
- What we think, how we feel, what is "real" for us versus what is true in the present
- To the extent that we know ourselves determines to what extent we can know the other
- Therapeutic impasses often related to the interplay between the client's and the therapist's attachment patterns

EMDR Therapy Case Conceptualization

- Client is engaged in reenactments of familial relationships with significant others in the present
- Have significant developmental deficits
- Unmet dependency needs from childhood that can manifest as extreme dependency and counter-dependency

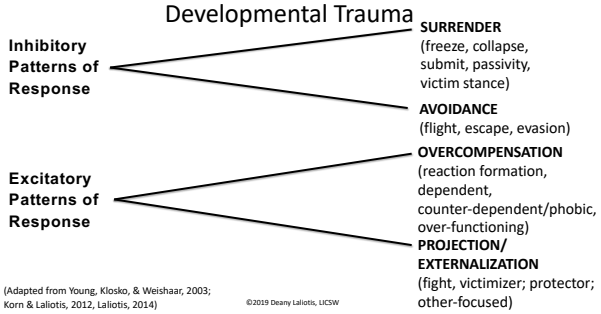
EMDR Therapy Case Conceptualization

- Developed adaptations in childhood that helped them survive their situation
- Adaptations are now overdeveloped, habituated and often problematic
- Need to identify and process formative attachment experiences where the client learned to apply these adaptations

It's not just about what happened;
it's also about what happened next.

DL

Maladaptive Coping Styles in Response to Developmental Trauma



(Adapted from Young, Klosko, & Weishaar, 2003; Korn & Liliotis, 2012, Laliotis, 2014)

Adult Attachment Styles

- Secure Attachment
- Anxious-Preoccupied Attachment
- Avoidant-Dismissive Attachment
- Disorganized Attachment
- Earned, Secure Attachment

(Siegel, 2001, 2007; Fosha, 2000)

- Predominant attachment style
- Attachment as a *state of mind*

Secure Attachment

- Affective Competence
- Feeling and dealing while relating
- Able to feel and process emotions in dyad
- Flexible strategies in relational experiences of affect
- Capable of intimacy and reflective self-functioning; ability to repair

Secure Attachment

- Often results in rich, intimate exchanges
- Able to maintain integrity of self and other
- Able to tolerate separation and reunion w/o being overwhelmed
- Capable of self and interpersonal regulation
- Has clear emotional boundaries and assumes responsibility for their own well-being in the context of relationships

Secure Attachment State of Mind

- Client strengths
  - Acknowledges and has empathy for his/her own dependency needs and wishes
  - Higher integrative capacity
  - Accepts limitations of therapy and the therapist
  - Willing to grieve their early attachment losses

Secure Attachment State of Mind

- Has capacity for co-consciousness and willing to take on the role of primary caretaker of the Self
- Has empathy for the younger parts of self that are both dependent and counter-dependent
- Can manage their unmet dependency needs and behaviors within their window of tolerance most of the time

Secure Attachment State of Mind

- Understands and allows for dependency on the therapist while working on improving functioning in daily life
- Able to approach intimacy in relationships
- Greater capacity to manage emotional systems and defensive systems

Secure Attachment State of Mind

- Therapist's strengths:
  - Noticing, observing
  - Present to the client
  - Grounded in our own experience
  - Can use our felt sense of the client to track their experience without merging
  - Sense of safety and trust in the process, even when it's unclear how to proceed

Secure Attachment State of Mind

- Detached compassion
- Responsive versus reactive
- Questioning, challenging
- Relational, authentic in our emotional response
- Have flexible strategies in response to what is needed clinically
- Seek support and case consultation

Anxious – Preoccupied Attachment

- Feeling but not dealing; easily hyperaroused under stress
- Insecure, resistant; Core experience is uncertainty
- Can't let go at separation, difficulty being soothed upon reunion;
- Unable to resume independent or exploratory functioning

Anxious – Preoccupied Attachment

- Too much anxiety mixed in with affect due to caregiver's unreliability (less affective competence)
- High emotionality (vs. access to core affective experiences) that interfere w/ functioning; child parts (exiles)
- Confusion about the integrity of relationships in the present

Anxious – Preoccupied Attachment

EMDR challenge is to:

- Bring awareness to the underlying uncertainty
- Tolerate the anxiety/fear/shame within the context of the dyad/ present moment
- Observe the anxiety vs. being in it

Anxious – Preoccupied Attachment

- Utilize the therapeutic dyad to tolerate negative affects about the self that resulted from these formative experiences
- Differentiate past versus present
- Explore client choices now and in the future

Anxious-Preoccupied Attachment

- Client strengths:
  - Is more relational
  - Greater access to emotions
  - Is generally unafraid of difficult affects
  - Responsive to co-regulation of affect with the therapist
  - Can approach their internal experience and can make sense of it
  - Can track self and other with guidance

Anxious-Preoccupied Attachment

- Client vulnerabilities:
  - Greater emotional instability in and out of sessions
  - Affect dysregulation
  - Lower integrative capacity
  - Confused about how they really feel or what they really need
  - Other-focused; co-dependent, caretaking
  - Emotional boundaries blurred (enmeshed)

Anxious-Preoccupied Attachment

- Confused about integrity of self; more often defined by perceived expectations of others
- Can have sense of entitlement to be taken care of (may or may not be in awareness)
- Can express extreme dependency needs by overreliance on the therapist
- Struggles to accept limitations of the therapy and therapist
- It's all about attachment

Anxious-Preoccupied State of Mind

- Therapist strengths:
  - Focused on the client
  - Greater access to feelings
  - Highly intuitive
  - Greater capacity for warmth and empathic connection
  - Can easily track somatically the client's experience
  - Can use information in the resonance to track subtleties in the client's experience

Anxious-Preoccupied State of Mind

- Therapist vulnerabilities:
  - Tendency to merge; to over-identify; difficulty offering alternative perspectives
  - Too much emphasis on feelings; not enough accountability; trouble with boundaries and difficulty setting limits
  - Tendency towards over-activity in our role as a therapist driven by anxiety and the need to fix it
  - May intervene or treat without permission

Anxious-Preoccupied State of Mind

- Tendency to over-focus on the client's experience not tracking their own
- Can submit to the client's need to be taken care of
- Can become over-active in their interpretations or interventions
- Shame and self-blame when it's not working well
- Preoccupied with our own effectiveness

Dismissive-Avoidant Attachment

- Dealing but not feeling
- Sacrifices his/her internal life in order to function
- Uninterrupted self-engagement; hypo-aroused under stress
- Shows neither distress at separation nor joy at reunion

Dismissive-Avoidant Attachment

- Relationship is maintained through minimizing its importance & suppressing emotional experience ("as if" indifferent); well-developed "manager" parts
- Minimal relational engagement (doesn't feel, therefore doesn't engage); good at self-regulation versus interpersonal regulation

Dismissive- Avoidant Attachment

EMDR challenge is to:

- Access memories; often experiences of neglect or absence of care or attunement
- Access their experience of emotion and soma ("felt sense")
- Access their sense of relationship with self/other in the moment

Dismissive-Avoidant Attachment

- Challenge their minimizing of relationships as important; counter-dependency stance
- Differentiate past relationships from present
- Generate reparative experiences where the client is "allowed" to feel his feelings and express them to the "other"

Dismissive-Avoidant Attachment

- Client strengths:
  - Is more task-focused and behaviorally oriented
  - Tends to be compliant with homework and other clinical interventions

Dismissive-Avoidant Attachment

- Highly self-regulated; wants to be in charge
- More cognitive; greater need to know and understand
- Greater capacity to develop coping strategies to manage challenge situations
- Respond to what is expected of them

Dismissive-Avoidant Attachment

- Client vulnerabilities:
  - Limited access to emotions; can be affect phobic or over-regulated
  - Difficulty with interpersonal regulation of affect

Dismissive-Avoidant Attachment

- Limited memory recall due to denial or minimization of experience
- Minimizes importance of attachment bond; can be dismissive
- Denies dependency needs and wishes

Dismissive-Avoidant Attachment

- Shame and disgust towards self and others who acknowledge dependency needs
- Pseudo-autonomous
- Unable to allow for dependency needs to be met in therapy or by therapist (any attachment triggers dependency needs)
- Engage in behaviors that are usually attachment-related but w/o attachment (e.g., sex addiction)

Avoidant-Dismissive State of Mind

- Therapist's strengths:
  - Ability to focus; particularly on the task at hand
  - Good at offering suggestions, advice;
  - Cognitive; strategic
  - Analytic
  - Ability to set boundaries and limits

Avoidant-Dismissive State of Mind

- Therapist's vulnerabilities:
  - Over-focused on the task at the expense of the relationship
  - Difficulty tracking the client's experience, especially with compliance
  - Tendency to analyze experience or give direction, rather than to explore or deepen the client's experience

Avoidant-Dismissive State of Mind

- Focus on thinking rather than feeling
- Focus on behavior (i.e., to externalize) rather than on internal states
- Can move towards emotional withdrawal rather than intimacy
- Can over-function as a reaction to uncertainty
- Can respond to the client's minimizing stance by being angry and dismissive

Insecure-Disorganized Attachment

- Not feeling and not dealing
- Psychic equivalent of the body going into shock
- Momentary emotional loss produces intense anxiety and overwhelming affect; oscillates between hyper and hypoarousal
- Attachment bond itself is threatened
- Experiences simultaneously the impulse to move toward as well as move away from the caregiver

Insecure-Disorganized Attachment

- Often experiences caregiver as alternately frightening and frightened; lack of holding environment
- Primary affect is fear which leads to splitting and dissociation in order to cope
- Tremendous difficulty in self and interpersonal regulation

Insecure-Disorganized Attachment

EMDR challenge is to:

- Access dissociative states without prefrontal cortex shutdown
- Manage the processing demands so as not to overshoot the therapeutic window of tolerance
- Manage defenses that will invariably arise to protect the client

Insecure-Disorganized Attachment

- Balance the need for dyadic support for emotional regulation vs. inadvertently meeting unmet dependency needs
- Address transference reactions to the therapist when the client becomes frightened or confused about the integrity of the relationship

Insecure-Disorganized State of Mind

- Client strengths:
  - Well-developed survival strategies
  - Come into therapy with an appreciation of their developmental trauma history
  - Can respond well to therapeutic interventions when offered incrementally
  - Can be extremely attuned to the therapist's state of mind

Insecure-Disorganized State of Mind

- Client vulnerabilities:
  - Can easily oscillate between states of dependency and counter-dependency
  - Survival strategies of fight, flight, freeze and submission can be easily triggered in a therapeutic context
  - Can become frightened or confused about the integrity of the relationship with the therapist
  - Lower integrative capacity

Insecure-Disorganized State of Mind

- Can easily dissociate and become disoriented; has difficulty with co-consciousness
- Difficulty assuming role of primary caretaker due to oscillation between hyper and hypoactive states and severity of abuse and neglect of needs

Insecure-Disorganized State of Mind

- Has difficulty not acting out of these extreme states; pervasive difficulty with dual awareness
- Has difficulty with safety and trust
- Difficulty asking for appropriate help

Insecure-Disorganized State of Mind

- Therapist strengths:
  - Greater sensitivity to the experience of trauma
  - Understands it through their own experience/identification with it
  - Great capacity for empathy
  - Understands Victim/Victimizer/Rescuer dynamics

Insecure-Disorganized State of Mind

- Therapist vulnerabilities:
  - Can be over-focused on the traumatic history and get into it prematurely, OR
  - Avoid addressing trauma history altogether for fear of it becoming overwhelming to the client
  - Can oscillate in and out of positions of Victim, Victimizer or Rescuer due to collision or collusion between the client's history and our own

Insecure-Disorganized Attachment

- Countertransference reactions we can have to the client's disorganized state:
  - Feeling lost and overwhelmed
  - Checking out or dissociating
  - Feeling incompetent
  - Feeling anxious that you will be rejected by the client
  - Fearful the client will hurt themselves

Earned-Secure Attachment

- Develop a new, more adaptive pattern of attachment and relatedness
- Feel secure about ourselves/themselves/others
- Develop an integrated narrative about themselves and the caregiver(s) that includes a recognition of the impact of past history

Earned-Secure Attachment

- Ability to self-regulate; greater access to authentic experiences (core affects) and insights
- Ability to deal and feel within the context of relatedness; attuned communication
- Greater resiliency to navigate emotional needs and communicate them effectively within the context of being in relationship

Our capacity for compassion is limited only by the compassion we have for ourselves.

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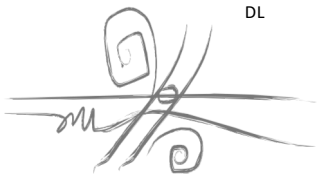


THE MINDFUL THERAPIST:
WHAT SKILLS ARE NEEDED?

Therapist Mindfulness Skills

- **Ability to be present:** tracking sensory aspects of our own and the client's experience in the moment
- **Ability to be non-reactive:** the rate and ability to achieve equanimity under stress

Therapist Mindfulness Skills

- **Ability to be humble:** cross-check impressions and applying discernment in one's judgment
- **Ability to label and describe:** To put into words one's internal experience (Siegel, 2009)

Therapist Mindfulness Skills

- **Capacity to self-observe:** the ability to observe one's own responses
- **Check our intentions:** whose needs are being met?
- **Capacity for interoception:** To ask oneself, "What is going on inside of me?"

Therapist Mindfulness Skills

- **Capacity to remain curious:** what is happening or what is needed in the moment; mental flexibility
- **Tolerate not knowing:** space for greater clarity
- **Practice attunement:** engaged and detached with compassion

Therapist Mindfulness Skills

- Being mindful that there is a parallel process that you're co-creating memory together
- As you're having an effect on them, the client is having an effect on you and your responses
- The intersubjective field co-constructed by two individuals includes not just two minds, but two bodies. (Schore, 1994, 2003a,b).

Therapist Mindfulness Skills

- The experience of being felt by another giving the person a sense of stability and safety in the present moment
- Creates a neural state of integration
- How does it feel to the client to be known by you?

Therapist Mindfulness Skills

- How do you know the difference between "holding in awareness" versus "helping"?
- "Being" state versus "doing" state
- Feeling "felt" or "perceived" by the other –"neuroception" of safety (Porges, 1998)

Therapist Mindfulness Skills

- From interoception (inside our own minds) to neuroception
- The coordination of input from another mind with the activity of one's own mind
- Being aware of the present moment tracking simultaneously inner and outer experience w/o judging and evaluating (oneness versus merging)

NEXT STEPS:

Make an executive decision to adopt self-care strategies!

WHY???

Standards of Self- Care (Figley, 2012)

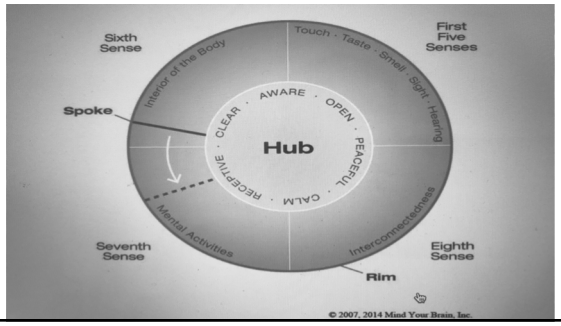
- First, do no harm to oneself
- Take care of physical, social, emotional and spiritual needs
- Ensures the highest quality of care to others when we care at the same level for ourselves
- We model self-care, self-esteem, self-compassion
- Our ethical responsibility to keep our instrument finely tuned

Daily Mindfulness Practice (Laliotis & Merlis, 2015)

2-3 times a day:

- Close your eyes and feel into your body
- Assess level of activation (0-10)
- Ask, is your level of activation appropriate to the task or situation? If yes, ok.
- If level of activation is out of proportion, give a self-command to apply a state-shift strategy of your choosing

Wheel of Awareness Meditation (AWARE, Dan Siegel, 2019, in press)



Six things to do for ongoing therapist self-care:

- Be in an ongoing case consultation group
- 10-20 minutes of meditation every morning
- Make transition time between practice and home
- Be present to one's experience in the moment; check in!
- Maintain physical and emotional health to include restorative practices
- Slow down your "YES" responses and say "NO" more often!

About Deany Laliotis

- Senior Trainer, Director of Training, EMDR Institute
- Co-Director of EMDR of Greater Washington, DC
- Web-based ongoing case consultation and in-depth interactive case studies
- Specializes in the application of EMDR Therapy to developmental trauma and attachment disorders
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- References available upon request

"And the day came when the risk it took to remain tight in the bud was more painful than the risk it took to blossom."

Anais Nin