Working with Disorganized/Disoriented Attachment

Dr. Ogden describes how she worked with a patient who had unresolved trauma related to an attachment figure.

**Dr. Ogden:** It’s an interesting attachment pattern in terms of the body because if an attachment figure is also the perpetrator, the child is in conflict on a somatic and biological level. The evolutionarily prepared systems of defense and proximity-seeking that go with the attachment are in conflict.

If the attachment figure is the perpetrator, a child’s body is conflicted between proximity-seeking action, seeking that attachment figure, and defending or getting away from the attachment figure. You see that later on in the organization of the body because you’ll see those conflicting patterns.

For a recent patient, one action I work with a lot is just reaching out, which is diagnostic because it’s a proximity-seeking action and you can get a lot of information by how somebody reaches out.
She would reach out and pull back at the same time instead of just a clear seeking of proximity. *(pg. 5 in your transcript)*

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**What a Client’s Body Posture Communicates**

Dr. Ogden describes how she “read” a client’s body posture in order to help him work through painful early memories.

**Dr. Ogden:** We’re watching, observing and listening to the presenting problem that the client comes in with, but the important point is to watch how the body participates in that problem, because it will. It has to.

I was working with a man recently, the son of a very famous Hollywood actor. He’s very depressed. He’s not able to find himself professionally or even in his marriage and as he talked about that, there was a collapse in his body. This tension in his rectus abdominis pulled his body down.

First, I named what I saw. I said, “As you’re talking about this, your body is collapsing. Do you sense that?” and he said, “Yeah, I can really feel it.” I asked him to go into that pattern and — although I didn’t say to use mindfulness, it was mindfulness — to notice what happens as he goes into that pattern. He started to get sad...
and memories emerged of him being alone and not having connection as a child.

The body is a quick avenue into those early memories. There’s research that says that if you embody a certain posture, you’ll start to associate with memories of when you were in that posture. There was a lot of emotional pain that we worked with; we wanted to help him find this new stance. *(pg. 7 in your transcript)*

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**How to Work with Insecure Attachment**

For an adult whose childhood needs were unmet, it can be frightening to reach out for help. The body can retain memories of reaching out, yet not finding anyone to meet the need. Dr. Ogden describes how she worked with a client with this history.

**Dr. Ogden:** I work with a young woman who cannot ask anybody for support and as soon as she thinks about it, her body tightens up.

We start to work with that through the body, very delicately, because these memories are not conscious. She hates to be a child and finds it so distasteful.

I ask her, “What happens when you just think about reaching out?” She starts to feel tightness in her body and wants to pull back and we’ve
started to explore it. I think sensorimotor psychotherapy is one of the real delights of body therapy because you don’t need the content; it’s all in the body. It all lives there and there are procedural tendencies.

**Dr. Buczynski**: Would you ask her to reach out in the hour you’re working with her?

**Dr. Ogden**: I like to work up to that. When I did ask her, she said, “Oh no, no, no” and we just slowed down and I asked what happens when she thought about reaching out. She started to get jittery and nervous and she didn’t want people to see her weakness and how weak she was deep inside. We worked with how she carries the sense that she’s weak and what that weak part needs.

**Dr. Buczynski**: Pat, can you give me a sense of what you worked on a few sessions later and how it turned out?

**Dr. Ogden**: Her homework was to go to her ex-stepdaughter’s performance. They had just gotten divorced, she was nervous to go and her homework was to reach out and ask a friend to go with her. She actually did it, which surprised me; that was a big step and she was surprised herself that her friend didn’t seem to think any less of her for that and was happy to go with her. *(pg. 9—10 in your transcript)*
A Couple’s Session Illustrating How to Work with Secure Ambivalent Attachment

Dr. Ogden shares a story of working with a couple, and the homework she assigned them, to change their postures and ways of interacting with each other.

Dr. Ogden: This was actually a couple’s session where [the woman’s] husband was complaining about her neediness. When we worked with them, as she spoke to him, she was leaning forward and clinging with her eyes and her energy. He found himself moving back away from her because there was too much intensity for him, but that was unconscious for her.

We played with it and had her back off a little bit and we saw how he reacted as she talked from a leaning back stance; he didn’t feel the need to defend against her. We do little experiments like that.

Dr. Buczynski: Did you send them home with any homework?

Dr. Ogden: She was to practice not leaning forward and living in her body when she spoke; she was to practice living in her back, being aware of her back and resting back in her own body. He was to practice not automatically
defending. They had developed that pattern over the years. *(pg. 10—11 in your transcript)*

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**How to Help Clients**

**Bring Their Level of Arousal into the Window of Tolerance**

According to Dr. Ogden, the first step in the treatment of trauma is to help patients learn how to bring their arousal into the window of tolerance. Here, she illustrates how she helps patients understand this concept and gives an example of how she helped a client bring down her level of arousal.

**Dr. Ogden:** I always think of connecting the treatment and interventions into the goals they have. If a patient comes in with panic attacks and says that they’re revved up all the time — they can’t sleep and they’re anxious — their arousal is over the edge of the window.

So I’ll often draw the window for them and say, “It seems like your arousal is up here.” And if they say yes, then I say, “Let’s see how we can bring it back down into the window.” Here again, we have to look at how their body participates in that high arousal.

There are so many ways to work with them, such as helping a person learn to stay grounded or helping someone who goes into panic or
hyper-arousal to learn to breathe or relax their shoulders. All those interventions have to be particularly tailored to that individual. To me, there’s no one size fits all; it has to be particularly tailored for that person.

I worked with one woman and I never would’ve come up with this. She tended to get very hyper-aroused and as we started exploring that in her body, I was tracking ways that her body would automatically try to calm her. If you see that in the body, you can capitalize on it and they can have meaning for the person.

Her hands kept coming together; I asked her about that and it was so touching because as she felt her hands and experienced that, she was reminded of her mother who had passed away. It was a terrible death from alcoholism, alone in a slum, but her hands took her to a very positive experience of her mother.

She loved her mother’s hands; her mother had very beautiful hands and she remembered her mother’s hands holding hers. This became a gesture that she could do consciously to calm her down and implicitly trigger those positive attachment memories of her mother. I mean, who would’ve thought of that? (pg. 11—12 and 14 in your transcript)
How Movement Can
Reverse Hypo-Arousal

Hypo-arousal, or feigned death, is an immobilizing response in which a person has given up all movement. Dr. Ogden shares an account that illustrates how stimulating some kind of movement – even just standing up – can mitigate that response.

Dr. Ogden: I worked with a woman who had suffered very early sexual abuse and although she didn’t remember it, she’d never had a sexual relationship in her life or really dated.

She was in her 40s when I saw her, and she remembered being attracted to a boy when she was in high school but she kept thinking, “What would happen in the dark afterwards?” She didn’t know where it came from, but the more she talked, the more she went into this response and she said she couldn’t feel her body and she wasn’t present.

I asked her if she’d stand up and when she stood up, that was more of a resource position for her body. You have your legs under you and it stimulates being in the world and then from that posture, everything started to emerge. She felt an impulse to push, which of course she couldn’t have executed as a young child.

The instinctual animal defense of protection
came up for her and I think that’s so important to remember because we want to find those defensive pattern responses that a person has given up on, and we want to elicit them from the body.

With this hypo-arousal, she had not been able to push away, but to bring that response back to her body was very empowering for her. It came from her body and I didn’t even have to suggest it; she just felt it. (*pg. 15 – 16 in your transcript*)

**How to Stimulate the Social Engagement System to Help a Client Feel Safe**

Dr. Ogden explains how she applies Polyvagal Theory in her work. In this case, she worked with a client to stimulate social engagement, bring her ventral vagal complex online, and regulate arousal.

**Dr. Ogden:** When I asked the woman with early trauma to stand up, she wanted me to sit very close to her because as soon as I backed away, she experienced that I wasn’t there. Our chairs were close in that case, but with another client I had to be across the room before she felt safe and the social engagement system could kick in.

In therapy, one of the first things we work with is simple proximity and what helps the social
engagement system kick in. When a traumatized person is in control of how close or far you sit, that immediately gives them a sense of safety.

**Dr. Buczynski:** Do you have people sit in a chair that has wheels on it? How do you do that?

**Dr. Ogden:** Wheels are a nice idea because you can slide in and out, but you don’t have to have wheels. You can use a chair that moves and you can scoot forward or back.

**Dr. Buczynski:** Do you move or do you have the patient move?

**Dr. Ogden:** It really depends on the patient. We might experiment with both ways. Traumatized people are so sensitive to your movements that just leaning forward can raise anxiety and being too far away or breaking eye contact can make some people feel you’re not really with them.

*(pg. 17—18 in your transcript)*

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**Practical Strategies for Working with Disorganized Attachment**

According to Dr. Ron Siegel, clients with disorganized attachment are often prone to behavioral issues, difficulty in school, substance abuse, aggression, and even incarceration. He identifies the challenge in working with this particular type of attachment issue and suggests approaches that can be helpful.
**Dr. Siegel:** These are the folks who it's really, really hard to work with because they don't soothe easily, and you can't get close to them at all.

It starts with the therapy relationship. A lot of these folks seem to be amenable to the kinds of things that work for borderline people, whether or not they fit the diagnostic category.

It's the kinds of things Marsha Linehan would do for distress tolerance, learning how to be with discomfort — maybe holding an ice cube or something to learn how to do that; mindfulness practices to begin to observe one's responses to things, and to try to choose more appropriate behaviors; and a lot of psychoeducation around, *this is what's going on for you here*, and, *no wonder you're having difficulty* — some kind of compassionate holding and mapping that out.

*(pg. 5 in your Talkback transcript)*

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**How to Apply Mindfulness in the Treatment of Trauma**

According to Dr. Ruth Lanius, mindfulness practice is relevant in the treatment of trauma. However, she believes it needs to be titrated and paced in a way that feels safe for the client. Here, she describes how she introduces mindfulness in working with clients who have experienced trauma.
Dr. Lanius: The way I introduce it is, we need to come to the present, both in the external environment and also in the body. This, of course, can be very frightening especially because the body holds so much pain. I always give the control back to the client, and I say, "We're going to work at a pace that feels safe to you. I'm always going to look to your feedback about how we should be progressing. You need to let me know any time if that doesn't feel safe."

Grounding the client in the present brings them into the external environment of the present using senses: using what they hear; what they see; what they feel; what they smell; what they taste — Some people bring a certain smell they love, or strong mints to help them ground to the present. Others bring clothes.

And so, we usually create their own grounding kit using the five senses that they really like to use. This could be bringing a picture of a child that they can take out or bringing their favorite smell, and really helping them to reorient to the present with that.

And then, of course, somatic mindfulness: becoming aware of all of these sensations that we've talked about. Again, that needs to be titrated and really done at a pace that feels safe with the client.
We adapt body scans used by Kabat-Zinn and others at a very slow pace. In less severely traumatized clients, that can be done very quickly — but in people who are very disconnected from their bodies, it often takes a while. I think it’s really helpful both for client and therapist, because it really helps us to gain a much greater understanding of what people experience in their bodies.

I’ve learned it’s amazing how often people feel like their hands or their feet are disconnected, how they have certain painful parts of their bodies, or numb parts of their body, and how that relates to the trauma and how we can use that then in the trauma therapy.

So, I think mindfulness is always helpful but really needs to be adapted to the traumatized client. (pg. 6—7 in your Talkback transcript)