

# Treating Trauma Master Series

## The Neurobiology of Attachment

the Main Session with

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# The Neurobiology of Attachment

## Table of Contents

(click to go to a page)

The “Safety Miscue” That Often Comes Up with Traumatized Clients ..... 3

How Early Brain Development Is Affected by a Caregiver’s Trauma ..... 4

The Latest Developments in How a Mother’s Trauma Impacts  
the Developing Baby in Utero ..... 6

Why Connecting with the Right Brain Is Key to Regulation ..... 8

Why the Right Brain is Vital to the Client’s Core Sense of Self ..... 10

How Attachment Styles Can Become a Self-Fulfilling Prophecy  
for Future Relationships ..... 12

How Dysfunctional Interactions Are the Key to Healing ..... 15

Using the Therapeutic Relationship to Rewire the Traumatized Brain ..... 16

How Secure Attachment Is the Basis for Emotion Regulation ..... 18

How to Build Secure Attachment with a Client Who's Never Felt Safe  
with Another Person ..... 20

How to Use Choice to Create a Sense of Safety During Sessions ..... 22

How to Draw Out a Client’s Innate Intelligence for Healing ..... 23

How to Work with the Body to Reverse Feelings of Victimhood ..... 25

How Proximity-Seeking Actions Can Build Secure Attachment ..... 26

References ..... 28

About NICABM ..... 29



## The Neurobiology of Attachment

### The “Safety Miscue” That Often Comes Up with Traumatized Clients

“Most trauma we see in our offices is interpersonal trauma; it occurs in the context of attachment relationships.”

**Dr. van der Kolk:** The PTSD definition in DSM is really about car accidents and impersonal trauma. But we know — though we have never been able to convince the APA to take seriously — that most trauma we see in our offices is interpersonal trauma; it occurs in the context of attachment relationships.

And if that's the case, then actually nurturing a safe relationship is the great challenge.

**Dr. Buczynski:** That's doctor Bessel van der Kolk. He's a Professor of Psychiatry at Boston University Medical School.

And there's a fundamental misunderstanding that he thinks many practitioners have when they're working with patients who've been exposed to trauma.

**Dr. van der Kolk:** A lot of clinicians think, *if I'm just nice to this person, they'll get a feeling of safety*. I am not of that school.

Particularly because of neuroscience, we know how these elementary fear systems of the brain are continuously activated. And the notion that therapists consistently think about themselves — *I can make a person feel safe* — is really a misunderstanding.

You actually may be a major trigger for somebody if the person who molested you was smiling at you before you got molested. Or if your drunken father was sweet to you just before he exploded. Your brain is set to be very suspicious to people who are nice to you or are friendly to you.

The issue is more about *helping* people to feel safe in their own bodies and to tolerate the presence of another person rather than, *let me inflict my goodness on you*.

**Dr. Buczynski:** In just a bit, we're going to get into a specific, practical way to help clients feel safe without becoming a trigger.

But first, trauma can wreak havoc on our client's most important relationships. But there's something more to it than that, because trauma doesn't occur in a vacuum.

## How Early Brain Development Is Affected by a Caregiver's Trauma

**Dr. Buczynski:** It's important to look not only at the traumatic event a person experienced, but also at the support or attachment relationships that they have in place.

Those relationships can play a major role in how well that person heals.

Insufficient attachment relationships can predispose our clients to developing PTSD after trauma – but healthy ones can be a catalyst for healing.

I'm Dr. Ruth Buczynski, President of the National Institute for the Clinical Application of Behavioral Medicine, and a licensed psychologist in the state of Connecticut.

Today, we'll go deeper into the neurobiology of attachment and how it impacts our clients. We'll find out what part of the brain develops first, and why this matters when it comes to trauma.

We'll look at how we can work with clients to build secure attachment after trauma, even if they've never felt safe with another person before. And we'll get into how to work with the body to reverse the feeling of victimhood.

So, let's start with some of the neuroscience behind trauma and attachment relationships.

**Dr. Schore:** One of the ideas out of interpersonal neurobiology is that early in development, the brain – especially the right brain, which is the early developing brain – is being shaped by social experiences, and these are *emotional* experiences.

“Early in development, the brain is being shaped by social experiences, and these are emotional experiences.”

And the other part of interpersonal neurobiology is that human beings will align their brain states with other human beings. They'll synchronize those brain states.

**Dr. Buczynski:** That was doctor Allan Schore. He's on the clinical faculty of the Department of Psychiatry and

Biobehavioral Sciences at the UCLA David Geffen School of Medicine.

So, we have two points there. One is that the right brain, which is the part of the brain that develops first. The right brain is shaped by social and emotional experiences.

The other point is that human beings align their brain states.

We'll come back to what Allan said about aligning brain states in a moment.

But first, let's take a look at the early developing brain – especially the right brain. How is it shaped by social experiences?

**Dr. Schore:** Essentially, what we're looking at here early in the secure attachment in an optimal situation, is that the mother is regulating the baby's states – regulating both the dysregulated, negative states, as well as upregulating the positive states.

This regulation allows for the infant to come into homeostasis – which is therefore optimal for the imprinting of the circuits, especially in the right brain.

There's stress-regulating circuits that will be used at all later periods of time, especially the circuits between the right amygdala that are being regulated by the right cingulate, the right orbital frontal, etc.

So here, what you have is an optimal situation in which these circuits can be imprinted. In cases of trauma – which is too much hyperarousal or too much hypoarousal – you're getting an inefficient imprinting of those circuits.

**Dr. Buczynski:** And in some cases, imprinting those stress-regulating circuits is not just inefficient. Early trauma can block those circuits from forming. This can harm emotional development during a critical period for a child. And that in turn can affect how they respond to stress throughout their lifetime.

“If the circuits are inefficient because there was an interference in their critical periods, you have a vulnerability later in life to the stress dysregulation that occurs from trauma.”

**Dr. Schore:** At later points in life, when stress comes up, individuals will begin to regulate in the left — mild to moderate — but then all individuals, when the affect gets intense enough, will shift right into these circuits.

If these circuits are inefficient because early on in their critical periods, there was an interference with these circuits — they are

very thin circuits — then you have a vulnerability in later life to the stress dysregulation that occurs from trauma.

But also, the interpersonal effects that will come from trauma – trauma is not only affect dysregulation, it also is

dysregulating the emotional distance with other human beings. So, for example, the individual might become too detached, etc., and not be able to be in the present moment with another human.

“Trauma can not only lead to dysregulation for the individual; it can also disrupt their emotional connection with other people.”

**Dr. Buczynski:** That’s a key point that bears repeating: Trauma can not only lead to dysregulation for the individual; it can also disrupt their emotional connection with other people. It can hurt their ability to stay in the present and to stay emotionally connected, and all the more when they get triggered.

“Then you have a vulnerability in later life to the stress dysregulation that occurs from trauma.”

## The Latest Developments in How a Mother’s Trauma Impacts the Developing Baby in Utero

**Dr. Buczynski:** But it’s not just the child’s trauma that can affect the development of their brain circuits. A mother’s experiences during pregnancy can impact her child’s developing brain as well.

**Dr. Schore:** More and more now of the work is shifting back into fetal development.

**Dr. Buczynski:** During the last trimester of pregnancy, the HPA axis – now that’s the hypothalamus, the pituitary, and the adrenal axis –is online.

And as Allan would point out, this axis sits under the right side of the brain. The amygdala is also forming during this time.

The point here is that in utero, the brain is developing. So, depending on how the mother reacts to stress, that can affect her baby’s developing brain. This stress can come from the stress that a mother experiences not only in pregnancy but also in her life time.

**Dr. Schore:** What I’m saying is it's now well established that if the caregiver is in a highly dysregulated state,

you will get cortisol literally passing through the placenta in utero, and this is now going to negatively impact whatever structures are evolving at that time, as the hypothalamic-pituitary axis is online at that point in time.

So it will sort of interfere with the optimal wiring of that axis, and it's also going to interfere with the optimal connections of the central nervous system and the limbic system into the autonomic nervous system.

In other words, the mother's dysregulated state which will be transmitted in dysregulated cortisol, etc., into the placenta.

**Dr. Buczynski:** Now obviously it's always the mother when we're talking about what's happening in utero. But once the baby is born, either parent can pass on unresolved trauma to their child. Or any other person who is a major caregiver for that matter.

**Dr. Schore:** The mother, the primary caregiver – the dysregulated caregiver – is also imprinting that internal working model into the baby itself. And the baby is not only impacted by these situations of going into hyperarousal or going into hypoarousal.

“The key to affect regulation is not only the perfect attunement, but there are ruptures. And it's the repair after the ruptures that really teach how to tolerate negative affect.”

The key here is not only that, but then there is no interactive repair afterwards because, remember – the key to affect regulation is not only the perfect attunement, but there are ruptures. And then it's the repair *after* the ruptures that really teaches the child how to tolerate negative affect instead of to banish it out by defenses, etc.

But I want to point out here that what is transmitted here is not only the trauma itself but the defenses against the trauma. So now you have an individual who will be highly prone to dissociation at later points in life, and that is one of the great indicators of whether a person will go on to traumatic stress at later points in life if they habitually, characterologically dissociate here.

**Dr. Buczynski:** What Allan said just now is so important. The infant is not just absorbing the caregiver's reaction to stress and trauma. The infant is also learning how to defend against rupture.

“If the caregiver is in a highly dysregulated state, you will get cortisol passing through the placenta in utero, and this is now going to negatively impact whatever structures are evolving at that time.”

That might be the most critical point of all, because rupture will happen frequently in life. Some of it can be prevented with learning and growth, but not all the time.

Rupture is common, even for people who come from secure and loving homes. It's how we deal with rupture that affects so much of our lives.

## Why Connecting with the Right Brain Is Key to Regulation

**Dr. Buczynski:** Now a few minutes ago, we heard how during a traumatic event, our clients switch over from the left to the right brain. Let's take a moment to review a few basics about the brain.

We think of the left side as the more logical, verbal side. When we think left, we're usually talking about the conscious mind.

On the other hand, the right side is more emotional and nonverbal. The unconscious mind is associated with the right side.

"The right side of the brain can be affected by early life trauma. Since the right side is the more emotional side, it can have an impact on our ability to form social connections and relationships."

And according to Allan, it's the right side of the brain that can be affected by early life trauma. Since the right side is the more emotional side, it can have an impact on our ability to form social connections and relationships.

**Dr. Schore:** So here we have the right brain, which is dominant for processing both emotional and social information. And incidentally, all trauma, early trauma, will interfere not only with the processing of emotions but also the processing of information, social information — voices, faces, gestures, etc.; they're

"Early trauma will interfere not only with the processing of emotions but also the processing of information."

linked together. These are not separate situations.

There has been a shift in trauma theory from the one-person psychology to the interpersonal, the relational — which, as you know, is now part of just about all psychotherapeutic models.

**Dr. Buczynski:** So trauma can particularly hurt our clients' ability to process information that's social and emotional. That's because it disrupts the circuits in the right side of brain, the more emotional side of the brain.

So how can we work directly with the right brain of a traumatized client?

**Dr. Schore:** Essentially, I've come to the idea here that when we're with a patient, we're not only listening to the words, and we're processing their explicit communications about themselves, but we're also listening at another level.

“When we're with a patient, we're not only listening to the words, but we're also listening at another level.”

At another level, just as the left is communicating to another left right now, my Broca to your Wernicke, we're also communicating our right-brain states to other right brains that are attuned to those communications.

**Dr. Buczynski:** For those of you who don't remember this from your licensing exam, Broca's area of the brain is the part that's associated with producing speech. Wernicke's area is the part that helps us understand speech.

So, Allan just said his Broca to your Wernicke as you were listening. This is what's going on as I'm talking. My Broca is connecting to your Wernicke.

Now, we often tend to focus on verbal communication in the therapy hour. That's a bias toward the left side of the brain. But in the last few minutes we've learned how much trauma disrupts the right brain. So, it's critical to think about how we're communicating not just with our client's left brain but also with their right brain as well.

With that in mind, let's look at how a misattunement in the relationship between practitioner and patient can sometimes occur.

**Dr. Schore:** Usually it's because when the patient is going down right into their body, the therapist is going up left into some kind of abstraction. So, they're in different hemispheres.

So how do we get to these affects that are underneath the surface? How do we pick up these communications? How does the person literally know that in our felt experience, we also picked up these communications, which are being transmitted by our voice, by our facial expressions, and also by our body gestures?

Now, that's not a theory. That is literally the way that human beings work. It starts in the attachment relationship. Those attachment relationships are there at later points in time.

**Dr. Buczynski:** When we're thinking about communicating right brain to right brain, we have to think *physically*. We communicate with our facial expressions, the tone of our voice, and our gestures.

So, before we get back to Allan's point, I want you to think back to a recent session with a client. What were you saying with your face and tone? How do you think your client's right brain responded to that?

## Why the Right Brain is Vital to the Client's Core Sense of Self

**Dr. Buczynski:** Now, Allan finished on an interesting point. The impact of attachment relationships can reappear throughout a person's life. We're going to get more into that in a moment – but first, there's one more thing we need to talk about when it comes to how trauma can impact the brain.

**Dr. Schore:** Usually when we're thinking about trauma, we're thinking about under-regulation disorders

“We're talking about more than under-regulation; we're also talking about over-regulation and the use of dissociation.”

where the person now is in sympathetic hyperarousal, and they cannot downregulate the sympathetic, which is dominant for the right.

But also, we're looking at over-inhibition in disorders, whereby the person literally is living in the left - all of the affect is blocked down, and there's no access to them. Incidentally, there's more recent

evidence that men have more of a tendency towards that and towards externalizing psychopathologies, women more towards the other.

So we're also talking about more than under-regulation; we're also talking about over-regulation and the use of dissociation, which just packs these down underneath consciousness.

**Dr. Buczynski:** So, let's look at that for a moment.

What happens to a child when their caregiver responds to their own trauma in a left-brain, over-regulated manner?

When the parent is responding predominantly in an overinhibited way, it's likely to be registering in the left brain. So how does that affect the child?

**Dr. Schore:** So children who have been more or less raised by a left brain and not by an attuned right brain,

usually cannot get a sense of their own core self – and how their core self literally be can activated in intimate human relationships with another human being.

**Dr. Buczynski:** Now we've talked about how a traumatized mother can affect a child's developing brain. But here's the thing, when we're talking about attachment, the focus is too often ONLY on the mother.

All children start with two parents, and it's extremely important that we think about the father or partner's contribution here as well. Good parenting can and should ideally come from both parents.

But when one parent isn't able to provide that attuned, right brain presence, the other parent can compensate for that.

Not only that, but other people *besides* the parents can be important caregivers as well. Families come in all configurations. It's *love* that makes a family.

“The key thing is that there's an adult in the child's life who is an attuned, right brain presence. That can help the child develop a sense of their core self.”

The key thing is that there's an adult in the child's life who is an attuned, right brain presence. That can help the child develop a sense of their core self.

This matters, because attachment relationships that are developed in infancy can stay with a person for a lifetime.

But how does that happen? Well, here's an idea:

**Dr. Siegel:** What you can see in developmental trauma is people will evoke from people around them unhelpful responses that reinforce the stress and the vigilance for danger and the feeling that people don't really trust you.

Well, no, they don't trust you because you're doing stuff to evoke these hostile reactions from them.

Then you go, *Ah, they're hostile. The whole world is hostile.*

“You convince yourself of your own worst nightmare.”

So, in other words, you convince yourself of your own worst nightmare. Now, sometimes it's because you selected people who are actually people who you shouldn't be around and sometimes

there are people you can be around but you're participating, in an active way, to create a nightmare.

**Dr. Buczynski:** That was Dr. Dan Siegel. Dan is a clinical professor of psychiatry at the UCLA School of Medicine.

There are times when a person with developmental trauma might provoke certain reactions from other people. Those reactions will end up reinforcing their childhood experience.

It's like your client's childhood attachment styles can become a self-fulfilling prophecy throughout their life.

## How Attachment Styles Can Become a Self-Fulfilling Prophecy for Future Relationships

**Dr. Siegel:** Alan Sroufe and I wrote a little teeny paper called "The Verdict Is In", that you can get from my website, where we wanted to summarize all of his 40-year longitudinal study of attachment in just four pages.

But the key thing there was kids who have certain experiences in the first 12-18 months of life evoke from their teachers in the early years of elementary school and in summer camp from their friends, their peers, exact ways that their parents were treating them.

But the baby didn't create that, you see?

They just adapted to it at 12 months – but then at seven years, they're evoking it from people who never met those parents. And so, then the response of their peers and the teachers then reinforces the very strategies they developed as a one-year-old.

**Dr. Buczynski:** So Dan's saying that your clients might evoke their childhood attachment pattern from the people around them. That's not only true when their attachment relationship is healthy, but unfortunately, that's also true when their attachment relationship is unhealthy.

So it might be best to think about what secure attachment looks like to start with.

**Dr. Siegel:** Like someone with **secure attachment** does, basically says, "I'm worthy of being seen. My emotions are worthwhile."

I can take what I feel and communicate them to you, Ruth.

You will say, "Oh yeah, Dan. I hear what you have to say."

And I have a right to reasonably expect that certain people – not everybody – will respect what I say, hear what I say, and provide me with what I need. Not in an entitled way, but in just a human way.

**Dr. Buczynski:** OK, so that's secure attachment. But what about avoidant or ambivalent attachment?

**Dr. Siegel:** Whereas **avoidant attachment** – in about 20% of the population – is, "I haven't gotten what I need early in life from my primary caregiver, so the way I'm going to survive is, I'm not going to need anything from anybody."

So now I comport myself as is a five-year-old in camp or a seven-year-old in school, and I don't ask my teacher for anything I need because I don't need anybody for anything.

Let's say I'm in a romance later on and my partner feels like I don't need her. Well, guess what? I don't.

So, then she acts in this kind of cold way which proves, *see? I don't need her.*

So, you're saying, I call it a *nightmare* – but in this case, it's a strategy of avoidance.

In **ambivalence attachment** it's, *I'd better rev things up because my parent wasn't disconnected (as in avoidance), now they're inconsistent.*

Sometimes they're there and sometimes not. Sometimes there, sometimes not, and they're intrusive at times. So, what I do with that strategy is I say, "I don't know if you're my friend, Ruth. I don't know if you're really going to be there for me."

But if I really amp things up and say, "Come on, let's go to this party, let's go here, let's go there, let's go there, there."

You go, "That's too much!"

"Oh, see? You're not there. You said yes before. You're just like..."

And so, it's like this, it's like this. I can evoke a look in you like, *I don't know if I can still be your friend.*

I go, "See? You don't know if you're going to be my friend or not, right?"

Well, I pulled that from you because I'm a nudnick like this, and I don't mean to be. It's just what my whole

limbic area does when it comes to important people like a friend like you. So, there's that.

**Dr. Buczynski:** Take a moment to think of your clients. Does something Dan said remind you of one of them?

Or let me take a risk here and say that maybe it reminds you of yourself sometimes.

Now we've talked about three types of attachment - secure, avoidant, and ambivalent. But there's one other that's distinct from all the rest.

**Dr. Siegel:** Now, in **disorganized attachment**, it's very different. In disorganization, whatever the background attachment is – secure, avoidant, ambivalent – the research shows it doesn't matter. Which is kind of startling, actually.

If I have disorganized attachment, I can't regulate my emotions, and I fragment my internal sense of self. Under stress, I cannot think clearly. Mutuality in relationships is really strained, and so I feel like I don't really get much from relationships, so I'd better try to get something from you. It's not a give and take, give and take, like that.

“If I have disorganized attachment, I can't regulate my emotions, and I fragment my internal sense of self.”

Of course, I'm going to pull from you, if you're my friend or if you're my therapist, I'm going to pull from you all these things.

**Dr. Buczynski:** While disorganized attachment is often associated with abuse and neglect, it isn't always the case.

Now you've had a run-down of the different attachment styles, and how they can play out throughout a person's life.

That's a lot of information, so before we move on, take a moment to jot down your biggest takeaway so far.

“The whole idea of psychotherapy is to engage the process by connecting with the person in front of me in the here and now.”

Ok, so how does this all impact our interactions with clients?

**Dr. Siegel:** So, for me, the whole idea of psychotherapy, as a therapist, is to engage the process by connecting with the person in front of me, realizing that it will be the things happening in the here and now. *This is what happened this morning, this happened last night.* An interaction

the person is telling me about. Fine, but at the same time, there's all the things that are happening right now in the moment that are echoes of strategies that were developed from the time – not just when this person was a one-year-old. Now we know with epigenetic things we've acquired from experiences that this person's grandparents had.

**Dr. Buczynski:** Dan mentioned epigenetics. We looked at epigenetics a bit last week, but let's take a moment for a quick review.

## How Dysfunctional Interactions Are the Key to Healing

**Dr. Buczynski:** Epigenetics is about what makes certain genes active for some people and dormant for others. So even though you've inherited a certain gene, it might stay dormant for your entire life.

What's more, we can pass not only our DNA, but also these changes in gene expression to future generations.

So how does this affect our work with clients?

Well, let's look at how Dan works with his clients.

**Dr. Siegel:** So, if I'm working with someone who's African American whose ancestors were slaves, or someone whose grandparents were in the Holocaust, or all sorts of traumas we have – I've worked with people from Rwanda – we have epigenetic things passed through sperm and egg that affect and skip a generation.

So, as I'm sitting with a person, I realize, there's a ton of stuff that's influenced this person's brain. The mind is not the same as the brain but one aspect of the mind is the brain and the whole body and our sociality.

“The mind is not the same as the brain, but one aspect of the mind is the brain and the whole body and our sociality.”

So, what I do then is I try to keep a space inside of me to know that my job is to allow these dysfunctional interactions to arise. Not to see them as, *oh, this is such a hard job*, but see them as, *yay, an opportunity to do some work. How fun is that?*

“My job is to allow these dysfunctional interactions to arise.”

What a glorious profession we have that we can help people. I mean, I literally feel that way. So, I see those hard things as invitations to explore.

I don't see them as difficult.

I remember once when I was in training, I remember a peer of mine in our same year in training. We were both doing family sessions, two rooms next to each other. The families left, and I could hear his family screaming and my family screaming whatever.

I was so used to that, I thought that's why we're there to work on that. He's like literally pulling his hair out and going, "I'm going to become a researcher, I can't stand this clinical work stuff. Why would I ever want to be with people who talk about killing themselves?"

It's like, *what?* That's what you're there *to do*.

So, he became a researcher. But listen, it's part of our job to immerse ourselves in the chaos and the rigidity. That's where the suffering is.

As our wonderful poet, Leonard Cohen said, "Everything has a crack in it and that's where the light gets in." So, I see these chaos and rigidity moments as cracks that literally let you illuminate the path forward.

"It's part of our job to immerse ourselves in the chaos and the rigidity. That's where the suffering is."

**Dr. Buczynski:** It's the dysfunctional interactions that give us an opportunity to help people. But those can be the times when it's most challenging for our clients to stay connected, to stay in the moment with us.

## Using the Therapeutic Relationship to Rewire the Traumatized Brain

**Dr. Buczynski:** Now, back at the beginning, both Bessel van der Kolk and Allan Schore talked about how trauma disrupts relationships – particularly the ability to stay present and connected with another person.

So how can we, as practitioners, help people remain emotionally connected – especially when they're dysregulated?

Well, the answer could lie in the right brain.

You see, it's the right brain circuits that are particularly disrupted by trauma. They are also the seat of emotion in the brain. So to best serve our patients, connecting with the right brain is critical. For many of us, this is a bit different from our training in grad school.

**Dr. Schore:** The idea that comes out of left-hemispheric models, purely top-down models, is that changing thinking will ultimately change feeling.

“Attachment is the interactive regulation of emotion and the interactive regulation of the biological synchronicity between and within organisms.”

But there's a limitation to that, especially with intense affect, which is why insight – which used to be thought to be the key – is *not* the key.

The *relationship* is the key, and the relational interactive regulation, because essentially, attachment is the interactive

regulation of emotion and the interactive regulation of the biological synchronicity between and within organisms.

This means that we are using our own subjectivity in this situation.

The old idea about being neutral and detached is problematic at this point in time. We are using our own subjectivity to feel into the subjectivity of the others.

“We are using our own subjectivity to feel into the subjectivity of the others.”

And when another person has that experience, they change – just by the nature of knowing that someone else is resonating with that state. And that in itself can have a regulatory mechanism, an effect there.

**Dr. Buczynski:** So, here's the thing – our relationship with our clients can be part of what helps them realize that they can regulate. It's part of what helps them change. The experience itself is rewiring their brain.

**Dr. Schore:** More and more, we are learning how to regulate, how to form an attachment bond of emotional communication with a wide variety of patients and states. Not only how to downregulate *fear* but also how to downregulate *rage*, how to downregulate *shame*, etc.

But also, just for the record, how to *upregulate* positive emotions, interest, and excitement – because as you're well aware, trauma, what you have in the early history, there's very little play behavior there. So, the person is now going to be more sensitive to depression.

**Dr. Buczynski:** I think that's a really important idea. When we talk about trauma, we are often talking about how to help clients tolerate difficult emotions. We have strategies for teaching self-regulation and for managing HYPERregulation.

But that's only half of the equation. People also cope with trauma through HYPOregulation – dissociation,

and shut down. So as practitioners, we also need to think about how to help clients tolerate positive emotions. We need strategies to encourage interest, excitement, and even play.

“We also need to think about how to help clients tolerate positive emotions.”

We'll get more into that in a few minutes.

But right now, let's get back to the practitioner-patient relationship.

Why can it be so hard for people to co-regulate after trauma?

**Dr. Schore:** The problem in trauma is that, literally, the person will sever the interactive regulation and literally go inside and disengage in order to regulate without really remaining emotionally connected.

How can the patient remain emotionally connected with another human being while they are in these dysregulated states?

Because part of the problem with trauma is the inability to take in interactive regulation, to take in comfort also by the other. You've got a closed system.

The question is how can we open that system? It takes some openness of our own systems.

**Dr. Buczynski:** So, relationship is paramount. Especially forming attachment bonds with clients. A secure attachment figure can be so healing for our clients. There are many reasons here, but a big one is that it can help a person regulate their emotions.

## How Secure Attachment Is the Basis for Emotion Regulation

**Dr. Lanius:** Having a secure attachment figure is the basis of emotion regulation. If you have that, your capacity to regulate your emotions is going to be much greater. I think you'll see much less of the emotional rollercoaster that you would see *without* a secure attachment figure.

**Dr. Buczynski:** That was Dr. Ruth Lanius. She's a Professor of Psychiatry and director of the posttraumatic stress disorder research unit at the University of Western Ontario.

A secure attachment figure can help a person regulate their emotions. But beyond that, a secure attachment figure can help a person manage fear.

**Dr. Lanius:** I think this takes us right back to the work of Bowlby, who really stressed the importance of having that secure base in the emotional development.

**Dr. Buczynski:** She's referring to John Bowlby. He was one of those very smart guys who was both a psychologist and psychiatrist. He was notable for his work in child development and attachment theory.

**Dr. Lanius:** If you have a secure attachment figure who's there when the infant is first born, they soothe the nervous system of the infant. For example, when the infant gets hungry or when the infant has a wet diaper. Over time, that nervous system learns how to regulate itself.

When the infant then becomes a toddler, and has a secure base or secure attachment figure, it can then explore. Because it knows that secure base is going to be there and it can come back to that secure base.

So that whole system of curiosity can be stimulated which is so important, and often lost in trauma. Because, in trauma, people just focus on *survival* and *fear*. They don't have time to be curious and to explore.

““In trauma, people just focus on *survival* and *fear*. They don't have time to be curious

**Dr. Buczynski:** Again, we are looking at not only down-regulating negative emotions, but also upregulating positive ones.

Experiencing secure attachment can make a huge difference for a person who's just been through a traumatic event.

So much so that Dr. Arieh Shalev incorporated this into his treatment protocols. He practiced at a major hospital in Jerusalem.

**Dr. Ogden:** At his hospital, when people are injured in a terrorist attack, he said the first thing he does is get the person's family there. And that, I thought, was so striking.

It has to do with attachment – if you have your support and your attachment figures there, that's going to prevent the escalation of the PTSD symptoms.

It gets back to our attachment history and the support that we experience from our attachment figures.

There's a lot of literature written about, say, sexual abuse – the first trauma is the actual abuse. The secondary trauma is not having a parent to support you through it. So really, that is almost as traumatizing as

“The first trauma is the actual abuse. The secondary trauma is not having support.”

the trauma itself.

**Dr. Buczynski:** That was Dr. Pat Ogden. She’s a psychotherapist who specializes in somatic psychology.

Her story illustrates a powerful point. Attachment relationships can actually protect people from some of the harmful aftermath of trauma. So much so that the lack of a secure attachment figure is like a secondary kind of trauma.

## How to Build Secure Attachment with a Client Who's Never Felt Safe with Another Person

**Dr. Buczynski:** So, what do we do when someone had a weak connection with their caregiver growing up? Or perhaps not even any connection at all? How can we help to restore their capacity for secure attachment?

Well, let’s begin with the most severe cases. In these, the patient may never have felt safe with another person. They may have been hurt by so many people that it’s nearly impossible for them to feel safe with anyone.

**Dr. Lanius:** This is where you can use interventions where you can use imagery – for example, with an animal. Imagery as well as having an animal can be extremely helpful.

For example, I have a client who's severely traumatized with no healthy safe attachment figure at all in her background. She never experienced love. She has a complete inability to experience any positive emotion – but she has a cat.

So, we work with the cat and her being close to the cat – touching the cat, feeling the fur of the cat, feeling a sense of connection to the cat.

This is the first time in her life when she was able to start experiencing some warm feelings in her chest, some positive feelings. She doesn't know what love is because she's never experienced love.

So she began to think, *this is what experiencing love must be like.*

So, for a person like that, working with an animal is helpful. Because thinking about a relationship with

another human being would be too dangerous. But working with an animal can be very helpful.

**Dr. Buczynski:** So for people who don't feel safe with other people, animals can play a key role in healing. This idea was reinforced in a study that Ruth conducted.

**Dr. Lanius:** Something that we noticed actually when we did a brain imaging study years ago – we asked traumatized clients to come up with a scenario that causes sadness for them. The traumatized clients invariably came up with the death of their animal.

Whereas, the non-traumatized clients usually came up with the death of a relative.

So, I think that relates to the fact that our traumatized clients often never had a safe human attachment figure.

**Dr. Buczynski:** But what if the client doesn't have an animal? Can this approach still work?

**Dr. Lanius:** I think working with an image of an animal can also be very important and can really foster some of those positive emotions.

So, bringing up an image of an animal that they feel safe with – for example, a horse or a dog or a cat. Then, while they bring up this image, really getting them to think about what the fur would feel like, what the animal would feel like being held close to their body. Getting them to feel a sense of connection to the animal can be a real resource for the person.

**Dr. Buczynski:** So just using the mental image of an animal can be helpful.

Now, let's talk about what to do once the client is comfortable with the animal image – or if we're starting with a less severely traumatized client. How do we approach someone who has experienced what it's like to feel safe with another person?

“Thinking about a relationship with another human being would be too dangerous. But working with an animal can be very helpful.”

“It can be extremely effective in helping bring online positive feelings and self-compassion to feel a connection between the adult self and the child self.”

**Dr. Lanius:** I think what you can do is work with the adult self and the child self. Really encourage people to get the adult self to nurture the child self and really be there for the child self; to protect the child self; to feel that connection between the adult self and the child self.

I've seen that this can be extremely effective in helping bring online positive feelings and self-compassion, which then helps people to engage in less abusive relationships and really helps to foster more secure attachments in their life.

**Dr. Buczynski:** These practices can help clients to feel safe. But more than that, it can help them develop healthier relationships. That's because secure, healthy attachment relationships beget more healthy relationships.

## How to Use Choice to Create a Sense of Safety During Sessions

**Dr. Buczynski:** Let's get back to safety. So how else can we nurture secure attachment after trauma in order to help clients feel safe?

Take a minute to think of your own work. Is creating safety an area of strength, or do you need some more strategies for helping clients feel safe after trauma?

Well, you'll remember the big misconception Bessel van der Kolk thinks many practitioners have about safety. Our kindness and warmth could actually be a trigger for some patients. We'll go deeper into that problem in the TalkBack session.

In fact, there's another way in which our empathy can become problematic when working with trauma. But right now, let's talk about one of the practical solutions – because Dr. Pat Ogden has an approach that sidesteps the issue.

**Dr. Ogden:** When I have a new client who's had trauma, the first thing that I think of is choice, because in trauma, choice is lost. A client doesn't have any choice; it happens to them. Something from the outside injures them, violates them in some way. They have lost their control.

So reinstating choice at the very beginning is essential. Even in little ways, like when a client comes into my office, I might say, "Where do you want to sit?" – rather than have me dictate where they sit.

Those little things are establishing, re-establishing, the control.

**Dr. Buczynski:** But beyond creating safety, why else can choice be so powerful for clients?

**Dr. Ogden:** When they experience, with you as the therapist, that choice is being offered them and that they're in charge, that starts to stimulate an inner security and what we would call **organicity**.

That's a term from Gregory Bateson about inner wisdom.

So, in these little moments when you're demonstrating trust in the client's own intelligence and own healing power, that starts to establish a certain kind of relationship that they can begin to rest in

that you know that answer, that intelligence, is inside them. And they start to find that in relationship with you.

Everybody has this set of principles, whether they're conscious or unconscious, that they embody when they're doing therapy. For me, one of those principles is organicity, that the intelligence is *within* the client. The answers are *within* them.

The therapist starts to *elicit* that intelligence – and I think that really starts to build confidence and security in relationship.

**Dr. Buczynski:** So choice can elicit the client's innate intelligence, as Pat put it. It can build confidence and security in relationships. So how does she draw out this organic intelligence from within her clients?

“When you're demonstrating trust in the client's own intelligence and own healing power, that really starts to build confidence and security in relationships.”

## How to Draw Out a Client's Innate Intelligence for Healing

**Dr. Ogden:** Offering choice, as we just talked about, rather than making these top-down decisions. If a client asked me a question, like, "What do you think I should do?" – in the old days, in the '70s when I was learning

“The better way to elicit that intelligence is to say, *I'm not sure. Let's talk about that. What do you think?*”

to be a therapist, I was supposed to tell them what to do. "Well, this is what you should do."

But the *better* way to elicit that intelligence is to say, "I'm not sure. Let's talk about that. What do you think?" and explore it together rather than just taking charge.

**Mindfulness** is a very important element in evoking that intelligence because mindfulness gets us out of the content into the present moment organization of experience. And within that present-moment experience,

then that organicity starts to emerge.

**Dr. Buczynski:** Now, when Pat talks about mindfulness, she isn't talking about a sitting practice. When she uses mindfulness in her work, it is often more about attention, and noticing the body. Here's an example –

**Dr. Ogden:** For example, if you say to a client — and this is a mindfulness question — "What do you notice right now in your body, your emotions, your thoughts, when you remember that rape. What do you notice right now?"

And the client might say, "My whole body is tightening up. My hands are starting to come into fists."

So right there is the intelligence of the impulse to fight back and protect herself. So that intelligence is elicited through mindfulness.

We could have talked about the rape and this and that, and the client probably never would have said, "Well, my body really wanted to protect myself. I had this wisdom inside that was ready to defend myself."

"If you use mindfulness, it elicits a whole other wide, vast intelligence from within the client."

The body never would have said that if you're just talking – but if you use mindfulness, it elicits a whole other wide, vast intelligence from within the client.

**Dr. Buczynski:** So the client says, "My whole body starts to tighten and my hands move into a fist," so what do you do after that?

**Dr. Ogden:** This is how you do it. You say, "That's great. Let's follow your body. Let's trust your body." And you're giving the impression there is intelligence there. And if you say, "Just stay with the tension, if that's okay with you" — you give them the *choice* — "and let's find out what your body wants to do. Maybe there are words that come with this tension. Maybe your body is talking to us."

And they might say something like, "Yeah, my body is saying, '*Get away from me.*'"

So right there is that wisdom again. Okay, so your body knows that. So what action does your body want to make? And often, it's a pushing away, striking out, some kind of protective measure.

## How to Work with the Body to Reverse Feelings of Victimhood

**Dr. Ogden:** Most traumatized clients, when they come to me, they often don't even realize they have this inside them because they feel like a victim. And they go into that helplessness and that collapse rather than being able to discover those instinctive, defensive responses that are alive inside of them.

**Dr. Buczynski:** Let's pause a moment here because that's an important point. Feeling like a victim often goes hand-in-hand with trauma. That's especially true when the person wasn't able to run away or fight back. When they couldn't take action to escape and protect themselves.

So how do you work to reverse that feeling of victimhood? Let's go back to Pat.

“With some clients who are dissociative, there's one part of you that feels like a victim. There might be another part of you that wanted to fight back. We start to help those parts integrate.”

**Dr. Ogden:** With some clients who are dissociative, we'd start to work with parts of the self. There's one part of you that feels like a victim. There might be another part of you that wanted to fight back, for example. So we start to help those parts integrate.

One client, for example, felt two sides of her body. One side felt like a victim, and the other side wanted to fight. So as she started to realize that she wasn't just a victim, she also had this other part that had not been able to fight back during the trauma.

Then those two parts could start to communicate, and there could be an internal integration.

**Dr. Buczynski:** When Pat talks about helping the two parts to communicate, she's not talking about an empty chair type of interaction. For her, it's more deeply rooted in the body.

So, how'd she do it?

**Dr. Ogden:** Like for her, with her left side felt like a victim and the right side felt so empowered . . . Now this came from her body. This was not a suggestion of mine.

She wanted to push out, but she wanted her right hand to support her left hand. So there was an integration of the part of her that felt like she could fight back with the part that felt like a victim.

**Dr. Buczynski:** Now that was one specific case. But what else do we need to think about to understand the physiology of victimhood. And just as importantly, how to reverse it.

**Dr. Ogden:** This is critical for people who feel like a victim, because when you feel like a victim, you usually keep yourself small, your body collapses. Feeling like a victim is not this empowered way of living in your body where you're taking up space and you're aligned. So, I work a lot with posture.

“When you feel like a victim, you usually keep yourself small, your body collapses. So, I work a lot with posture.”

The thing though is that you don't want to override parts of the self. If somebody is feeling like a victim and you just work with posture to get them all aligned and everything, but you haven't really addressed that part of them that feels like a victim and helped the internal integration happen, then there could be a backlash.

That's why it was so wonderful with that one client – she found in her body a gesture that supported the part of her that felt like a victim, not just overrode it.

**Dr. Buczynski:** When we're working with trauma, we need to keep in mind the different parts of the client. Each part could have different needs, and a different response to our interventions. A successful approach will honor all parts, and help the client to integrate them.

Does this idea about parts make you think of any clients? If so, we'll pause for a moment so you can take a few notes about how this idea could be useful in a session.

## How Proximity-Seeking Actions Can Build Secure Attachment

**Dr. Buczynski:** Now as we heard earlier, trauma can disrupt the social engagement system. And with developmental trauma, a client may struggle to read facial expressions, tone of voice, and other social cues.

One way that Pat has helped her clients learn to safely connect with others is through proximity-seeking actions. They are a key part of secure attachment.

So, what exactly are proximity seeking actions?

**Dr. Ogden:** There are ways that we signal to our attachment figures or relationships, that we need them, that we're in distress.

As a child, there's crying, there's screaming, etc.; there's facial expression; and then there's the actual *seeking* attachment – like making eye contact.

Right now, you and I are making eye contact, even though we're miles away through our computers.

Reaching out to another person, moving towards another person, receiving support from another person.

I had one client with a lot of attachment disturbance. She didn't have physical or sexual abuse, but she was so, so neglected. And she would bring her dog — her dog's name is Spirit — to therapy because that was her attachment figure. And that really helped us.

But I remember one time — and she had never received support as a child — we were sitting on the floor, and I sat behind her, and I placed my hands about this far from the back, and I said, "Let's try that, if you're willing. If you lean back to receive support, what happens?"

At first, she felt nothing. She couldn't even really feel my hands because that experience had been so absent for her.

“Physical experiments start to reset the body, the nervous system, and the psyche to begin to have better relationships.”

In my work, we physicalize it. We don't just talk about it. "Can you feel my support?" - That's a very physical way. *Lean back. Feel that someone is there.*

At first, she couldn't feel it. She *couldn't* feel it. And we accessed a very young part of her that just went numb because she was all alone

all the time. And there were tears and lots of crying. And eventually, she was able to feel my hands. But it took much, much longer before she could actually rest in my support.

So those kinds of physical little experiments start to reset the body, the nervous system, and the psyche to begin to have better relationships.

**Dr. Buczynski:** If there's one thing that most of the experts we've heard from today would agree on, it's that trauma has a profound impact on the body, the nervous system, and the brain. That's why it's so important to think about treatment strategies that address all of these parts of the client.

Thank you for joining us. Remember, all the training in the world doesn't matter if you don't put it into practice.

“Trauma has a profound impact on the body, the nervous system, and the

Be sure to check out the TalkBack and the Next Week in Your Practice segments. You'll get concrete strategies and exercises that are based on the ideas we've just heard. I think you'll find it incredibly useful.



## References

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## About NICABM . . .

**Ruth Buczynski, PhD** has been combining her commitment to mind/body medicine with a savvy



business model since 1989. As the founder and president of the *National Institute for the Clinical Application of Behavioral Medicine*, she's been a leader in bringing innovative training and professional development programs to thousands of health and mental health care practitioners throughout the world.

Ruth has successfully sponsored distance-learning programs, teleseminars, and annual conferences for over 20 years. Now she's expanded into the 'cloud,' where she's developed intelligent and thoughtfully researched webinars that continue to grow exponentially.

**The National Institute for the Clinical Application of Behavioral Medicine** is a pioneer and leader in the field of mind-body-spirit medicine. As a provider of continuing education for health and mental health care professionals for over 20 years, NICABM is at the forefront of developing and delivering programs with "take home" ideas, immediately adaptable for practitioners to use with their patients.

