Treating Trauma Master Series

The Neurobiology of Attachment

a Next Week in Your Practice Session with
Ruth Buczynski, PhD; Joan Borysenko, PhD; and Bill O’Hanlon, LMFT

National Institute for the Clinical Application of Behavioral Medicine

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Dr. Buczynski: Hello everyone – we’re back. This is the part where we’re going to focus on clinical application: how you can use the ideas from the program in your work with your patients.

So, I’m joined by my two good buddies; they’re world-renowned experts and they’re going to join me to talk about clinical application and about applying the ideas: Dr. Joan Borysenko and Bill O’Hanlon.

The ACE Studies and Possible Long-Term Effects of Childhood Trauma

Dr. Buczynski: So, let’s jump right in, guys. Let’s start, both of you, with what stood out to you this week – but we’ll start with you, Joan, and then we’ll go to you, Bill.

Dr. Borysenko: Ruth, what stood out to me is that the whole discussion of attachment and trauma here flushes in a group of studies that were done I think starting about 15 years ago, called the ACE studies. ACE stands for Adverse Childhood Experience.

I always teach these studies to psychologists and other mental health providers who come to seminars that I give and discuss them at conferences, and I’ve been amazed that it’s always a minority of people who have read the ACE studies.

They were very, very compelling – both from a psychological and biological point of view. The fact that people who were traumatized as children have a variety of psychological problems – a lot more anxiety, depression, trauma-related behaviors; but they have a variety of illnesses that range from smoking-related illnesses because there is so much smoking in that population – it’s a way of getting comfort, of numbing out; there are so many eating disorders and obesity in that population – again for the same reasons. And lifespan is greatly foreshortened.

“People who were traumatized as children have a variety of psychological problems, and lifespan is greatly foreshortened.”

And what we also see is that people who have had a lot of adverse childhood experiences – and there are
actually six types of those, from abuse and neglect to violence against the mother, to, oh, things like contact-sexual abuse, physical abuse – the kinds of things that you would think about; or an incarcerated parent – what happens is that the lifespan is tremendously foreshortened.

All these data were gathered by a physician, Vincent Felitti and his colleagues actually at an HMO setting. And really, they are a wonderful set of studies – so if you go to ACEstudies.org, people can get a lot of great statistics in context for the kinds of things that we’re looking at this week.

Dr. Buczynski: Thank you.

How about you, Bill – what stood out to you this week?

Mr. O’Hanlon: What came clear to me was this whole idea – and, I mean, we talked about it but almost everybody mentioned it in one way or another this week – and that was this disconnection, this disintegration, this disjunction internally and externally, where people separate from other people, push other people away, or they pull away from other people. So those external relationships get messed up by trauma.

But the inner relationships – you know, Dan Siegel always talks about this “lack of integration,” and it’s really these aspects of ourselves that aren’t working together –

they’re not connected; they’re not integrated in some ways.

So I think that’s what stood out for me this week – noticing that and then also all the things one can do to create integration, connection and healing in that.

Dr. Buczynski: Thank you.

How Maternal Stress and Cortisol Can Affect a Developing Fetus

Dr. Buczynski: Joan; Allan Schore talked about when cortisol passes through the placenta that it can have a negative impact on the development of the fetus. Can you talk about the long-term effects that this could have on someone?

Dr. Borysenko: You know, this is a very interesting question because cortisol has a lot of functions in the
body that people don’t realize.

For example, about 20% of the variance in the weight of the baby is due to cortisol; if there’s too much cortisol – and, by the way, normally the maternal cortisol is two to four times the normal level – but when it gets higher than that, if there’s a lot of cortisol around early in the pregnancy, you get a low-birth-weight baby and a bigger risk of premature birth. So, it was about 20% of the variance in birth weight is due to cortisol variation, and about I think 9 or 10% of the variations in the length of the baby.

But cortisol is necessary for the development of all the systems in the body. It’s one of the prime metabolic hormones, and we tend to forget about how many functions cortisol has.

When cortisol rises very late in the pregnancy, or it’s given prophylactically if they’re expecting an early birth and the lungs might not be mature, cortisol can be given to help lung maturation. And you get different effects as to whether the cortisol is early or late in the pregnancy.

But some of the interesting research on this – very interesting in terms of our work as therapists – comes from the University of Denver. Dr. Elysia Davis and her colleagues looked at what happens when a fetus is stressed, and what they found was that if the stress starts early enough in the pregnancy, you will get a baby who is less able to comfort themselves, who is more anxious, who grows into a more anxious toddler who has more trouble establishing autonomy.

And in addition to that, these babies actually have larger amygdalas; the actual formation of the fear and anger center in the brain is changed, so there’s a tremendous effect of cortisol. And I wanted to stress the fact that some of it really has to do with the physical effects of the drug, of their hormone, which then last through the life of the individual.

**Dr. Buczynski:** Thank you.

Bill, just to say one thing about that: you know, we used to think of the cortisol only as a measure of stress, not seeing that it has value. You know, we wouldn’t get out of bed in the morning if we didn’t have some cortisol running . . .
Dr. Borysenko: That’s right!

Dr. Buczynski: . . . and it really has – it’s more of what we would have said *curvilinear* – too much/too little kind of thing, that it’s more complicated.

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**How to Draw Out a Client’s Strengths and Coping Skills**

Dr. Buczynski: Bill, we discussed the important role of the therapist in downregulating negative emotions and upregulating positive emotions. Can you talk about how you can actually do this with a client? Let’s have the “rubber meet the road” here.

Mr. O’Hanlon: All right. Good. I mean, this is what I’ve specialized in a lot.

I got influenced by Milton Erickson, and he really focused on where were the resources? Where did people have strengths and abilities? Even in their symptoms – how could that be an asset *and* a liability?

So, I created a kind of an approach from this that asks about these things.

To me, therapy is like the old saying, “What you focus on expands.”

So, in therapy, I’m often asking about – sort of interspersing with the “problem talk” – *what’s going wrong and how are your challenges? How have you coped with that?*

That’s my first question for people who are traumatized: “Wow. How did you cope with that? How did you get yourself to actually come to a therapist and ask for help? Not everybody will do that.”

I start to focus on that – kind of not like they’ve solved the problem *but* their positive coping mechanisms and their positive coping actions and attitudes, and “How were you able to admit that you had a problem? Some people just deny it and they get defensive.”

I start with that, kind of lifting the person up and building the person up, and getting them to recognize they don’t think about that but that *is* a strength; that’s a positive thing, to be able to ask for help, admit you need help – that kind of stuff – and be able to cope better than your worst moments.
So they say, “Well, I’m not very good at it most of the time,” and I go, “Okay – most of the time. Occasionally you cope better. How is that? Tell me about those moments.”

I try and focus on the moments.

The other thing is: “Usually you cut yourself,” or “Usually you lay in bed and can’t get out of bed because you’re so depressed – but today you got out of bed,” or, “The other day you got out of bed.”

I’m looking for exceptions to the problem. So that’s the second way I sort of downregulate those negative emotions and upregulate positive emotions.

The third thing is just notice what’s working. I’ll sometimes have a client come in – maybe it’s the second or third session – and they’ll say, “Oh, right after I left here I was doing so well. I really loved what we did last time and it really helped me, and then a couple of days later I just crashed.”

And instead of saying, “Okay, well, how did you crash?” I’ll say, “Wait – so you did a little better for a couple of days. Tell me what was going on during those couple of days. What did you do? How were you thinking? How were you coping?”

And I don’t go too fast, because I want to go back to those moments, and then we’ll get to how did things crash, and what went wrong. But if you give them that basis for a little praise, if you will – how they did well – and a reminder that they do have strengths and abilities and resources – I think someone used the phrase resourcing – you’re resourcing them, so when the tough stuff comes and when you do talk about the problems, they have a better floor. They don’t drop down so much.

So those are the methods that I use: just spending some time asking about that, not letting it go by so quickly – when they say one thing I’ll go, “Oh, okay. Great” and then we move on – no. “Tell me a little more about that.” I just ask a little more detail and we spend a little more time with that.

Dr. Buczynski: Thanks.
How to Mindfully Help Clients Manage Physical and Emotional Pain

Dr. Buczynski: Joan; Pat Ogden talked about paying attention to the body in a mindful way. Can you share a story about how you’ve done that with someone in your work and tell us how it turned out?

Dr. Borysenko: Well, you know, when I ran a mind-body clinic at Beth Israel Hospital in Boston (that later became the Beth Israel Deaconess Medical Center), that program was for people with stress-related disorders. And we did a lot of mindfulness experiments together that were really, really interesting.

One always gave rise to fascinating conversation in the groups, and it was something that people tended to internalize. We would just scan through the body and I’d ask two questions.

First of all – “Find a place where it’s tight, tense or painful.” Then we would just stay with that in a mindful way, noticing what we could notice, without any attempt to make the pain or tension go away.

And I think, as most of you know, if you do that, the pain and tension will go away, and people pretty immediately get the idea, “Oh – nothing lasts! Everything changes. Even this pain, which I thought was there forever, actually changes when I really notice it.”

So we would do that.

And then we would contrast it with looking in the body for a place of pleasure, because usually the brain is constructed that we’re going to go first to the pain and we’re going to ignore the place of pleasure, because pain represents a threat to survival so we’re wired to pay attention to it.

But it’s very, very interesting to begin to notice, “Well, what does pleasure feel like? What can I notice about that in a mindful way?” and then to fool around with, “Well, what happens if I try to take that sensation of pleasure and simply allow that to blossom in the place where there was pain?”

And this just approach to experimenting with the body in that way – almost what you’re saying, Bill – they have a resource they weren’t paying attention to. Actually, so many parts of the body they were very happy and it was pleasant in there, and it’s nice to call the attention to that. And then to recognize that the body is a living system: there’s pleasure, there’s pain; it changes.

“Recognize that the body is a living system: there’s pleasure, there’s pain; it changes.”
But asking them – “What is it that contributes to the feeling of pleasure, and can you move that into, somehow or other, the place where there’s pain?” – gave rise to a great deal of insight that was very helpful to people both in pain management physically but also emotionally, because emotionally there’s that sense of, “Oh, my God, my heart is doing this and my back is doing that and my stomach is upset.”

And it was a very useful technique.

Dr. Buczynski: Thank you.

**Two Questions That Can Reignite Hope for the Future**

Dr. Buczynski: Bill, in the session we talked about how curiosity can be so easily lost when someone has experienced trauma. What are some ways to help rebuild a client’s ability to explore and to be curious?

Mr. O’Hanlon: You know, I think – and what I’ve noticed with people who’ve been traumatized or people who are depressed – is sometimes there’s a collapse of the future because the past is sort of living in the present again and again, so it’s discouraging. It’s like, oh, I’m just going to feel the same thing and be the same way over and over again. I can’t imagine being any other way.

“Sometimes there’s a collapse of the future because the past is sort of living in the present again and again, so it’s discouraging.”

So one of the things I try to do is rehabilitate the future, like, “What’s going to happen up there, out there sometime in the future?” And of course I skew it towards a positive future.

One of the people who had a great influence on me was Viktor Frankl; I read *Man’s Search for Meaning* in high school. And I had a chance to meet him and hear him speak later in my life.

Dr. Borysenko: Wow.

Mr. O’Hanlon: It was in 1990 at the Evolution of Psychotherapy Conference. And he told this story about when he was in his fourth concentration camp – he’d been moved to different ones – and a lot of the prisoners thought, *We’re not going to survive* – there was not enough food, they were starving, they’ve been mistreated of course terribly, they’d seen a bunch of their people that were prisoners with them killed – and so pretty unlikely they were going to survive.
And all of a sudden, things started to change a little, and Viktor Frankl said that the Nazi soldiers started treating them just a little nicer and they didn’t know why because they had no radio or newspapers. But they started to get the sense, because they saw allied bombers coming over, that the Germans were losing the war, so they got a little hope back.

And one day he was being marched out in a field with a bunch of other prisoners to repair a bridge that the allies had bombed that was part of the German supply line, and Frankl was ill – he had pneumonia or something. It was a freezing day in the winter of 1944, being marched in this field, and he collapsed to his knees coughing and he couldn’t go on. And the guard started beating him – it was so frustrating because it was so cold out there that he said, “You’re slowing everybody down. Get up.”

Frankl couldn’t. And he thought, Okay, this is the day I die. I just can’t get up.

And all of a sudden, without his conscious will, he had a vision of himself in post-war Vienna giving a talk on the psychology of death camps and the psychology of meaning, and he was giving this amazing lecture that was filled with exactly the words he wanted to say, that would move the audience and describe this experience – but also how they kept hope and meaning alive.

And he imagined giving it to an enrapt audience of about 200 people, all the while that he’s ill and on the ground in Poland in this snowy field.

And, “during this imaginary lecture,” he says, “there was a moment when I thought I was going to die.” And he describes this moment in the field which he’s experiencing right now – but now he’s not there; he’s dissociated, he’s gone to the future. And he says, “I was sure I couldn’t get up and I was going to die that day, but somehow I found the strength to get up.”

Meanwhile, while he’s describing this in his imagination, he gets up and starts walking. And he survives that day.

And when I heard him talk about that, I was so moved by that, number one; and number two, I thought, that’s what I did when I was depressed, to keep myself going: I imagined a future that was better.

And that’s what he did – and that’s what I’ve been doing with some of my clients and patients.

And so, what I do is, the first thing I say is I ask a funny question when they come to therapy: “How will we know when we’re supposed to stop meeting like this? That is, how will we know when you’re better?”
And immediately that takes them out of the past and out of repeating problems in the past and the present, to a future with hope and possibility.

And sometimes they can’t answer that – but it doesn’t even matter because I’ve planted the seed of curiosity about how would it be if it were better?

Second thing is: How would life be if you weren’t experiencing these traumatic things? If somehow we work together and we were able to make a difference – using all these things that we’re hearing in this series – if we could make a difference in you, what would your life be like where you weren’t just repeating the old trauma in the ways that you’ve been?

And those two questions, even if, again, they can’t initially answer them, they come back and they start to tell me, “You know, you asked me last time and I just couldn’t even imagine that, but I’ve been thinking about it all week . . .”

You’ve engaged their curiosity about the possibilities for the future.

Dr. Buczynski: Thank you.

That’s it for us for this week. Now it’s up to you. All the learning in the world doesn’t matter if you don’t apply it to your work, so be sure to go out and see how you can maybe even take some notes about how you can use these ideas in your work.

Meanwhile, we’ll be back again to talk about how you can use more ideas in your work. So, everyone out there, thanks for being here. Thanks for all that you do.

Thanks to you, Bill, and you, Joan.

Bye-bye.
Joan Borysenko, PhD has been described as a respected scientist, gifted therapist, and unabashed mystic. Trained at Harvard Medical School, she was an instructor in medicine until 1988.

Currently the President of Mind/Body Health Sciences, Inc., she is an internationally known speaker and consultant in women’s health and spirituality, integrative medicine, and the mind/body connection. Joan has also a regular 2 to 3 page column she writes in Prevention every month. She is author of nine books, including New York Times bestsellers.

Bill O’Hanlon, LMFT is a psychotherapist, author, and speaker. He co-developed Solution-Oriented Therapy, a form of Solution focused brief therapy, and has authored or co-authored over 30 books, including Out of the Blue: Six Non-Medication Ways to Relieve Depression.

He is also a musician who plays guitar and writes songs.