

The effects of Trauma on Attachment

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Secure and stable relationships are the foundation for healthy emotional development and subsequent secure and stable relationships. Trauma-related experiences (particularly in childhood), undermine attachments, thereby creating a cycle of further trauma, intra psychic distress and alienation from sources of support.

But first we need to outline our Foundational Concepts.

Attachment

Attachment is the emotional bond that is formed between objects in order to establish a sense of security and safety.

The prototype of attachment is the mother-infant emotional bond. Attachment relationships provide:

- A safe haven that promotes a feeling of security even in times of distress.
- A secure base that fosters confidence in one's ability to actively explore the wider world.
- A structured schema that promotes the ability to make sense of mental states such as desires, feelings, and beliefs in oneself and others.

Although attachment begins in infancy, the need for "attachment relationships" continues throughout all life.

Attachment theory began to take shape in the 50's with the work of English psychiatrist, John Bowlby, and American psychologist, Mary Ainsworth. Attachment theory is based on the belief that the mother-child (or caretaker) bond is the primary force in infant development.

Bowlby's premise was that the relationship between infant and the primary caretaker is responsible for:

- shaping all future relationships
- shaping our ability to focus,
- an awareness of our feelings
- an ability to calm ourselves and
- the ability to rebound from misfortune

Bowlby distinguished four patterns of attachment:

Secure attachment

Secure attachment, like Erikson's basic trust, entails a sense of confidence that an attachment object will be responsive when needed in times of distress. The form of attachment will establish the template with which a child will construct: his future relationships with others; her sense of security about exploring the world; his resilience to stress; her ability to balance her emotions, make sense of her life, and create meaningful

interpersonal relationships. A secure attachment will provide the best foundation for these developments.

Avoidant attachment

Avoidant attachment describes that form of relationship where the child decides it is fruitless to rely upon others to meet his attachment needs and attempts to meet them himself. If the parent is unavailable or rejecting, the child can get lost in her own inner world and avoid emotional connection. As an adult she may appear physically and emotionally distant in relationships. She is used to, and more comfortable with, distance and separateness and may therefore appear self-centered and unresponsive to other people's needs.

Ambivalent attachment

The ambivalent attachment pattern involves an erratic emotional clinging accompanied by frustration and resentment. When the child experiences the parent as inconsistent or intrusive, she will often become anxious and fearful, never knowing what to expect. Subsequently as an adult she may be available one moment and rejecting the next. She may love to argue, but rarely reach a resolution and her deep insecurity may fan her need to over attach.

Disorganized attachment

The disorganized attachment pattern is characterized by the fear of relationships and an inability to develop a workable strategy for interacting with those objects to whom he is attracted.

When his need for emotional closeness remains unseen or ignored and the parent's behaviour is erratic and unpredictable, he often becomes disoriented, disorganized and aggressive. He will often have difficulty in regulating emotions, in reading social cues, in academic reasoning, and severe emotional problems. As an adult he may not give love and affection easily and may be unresponsive and insensitive to his partner's needs. He may also become enraged and abusive when he senses their inconsistency or emotional withdrawal.

Although there is a basic life-long need for secure attachments, these attachment relationships undergo many changes in both object and intensity over the course of their development. Attachment relationships may also develop with others such as siblings, extended family, teachers, friends, co-workers, lovers, and pets.

Developmental Timeline

Attachment-Differentiation/Separation-Individuation-Cohesion- Integration

Attachment is the first developmental task that the child consciously undertakes. The form of that attachment lays down the template for the other tasks of Differentiation, Separation, Individuation and the internal structure of Evocative Object Constancy from which our sense of self emerges. Any disturbance in the completion of those tasks can leave the child with relational and self deficits

Attachment therefore plays a key role in trauma for two reasons:

- (1) Attachment relationships in the most critical time of the child's development can be a source of significant trauma.
- (2) An attachment relationship can restore the feeling of safety when there has been a potentially traumatic event.

Trauma

Trauma refers to the condition whereby an individual experiences a cluster of severe negative effects as a result of extremely stressful events. These negative effects may include relational and behaviour problems and psychological disorders such as depression, anxiety, dissociation and posttraumatic stress.

Potentially traumatic events include an objective experience such as witnessing a life threatening event, and a subjective experience such as feeling helpless and terrified that you're about to be killed. Whether or not exposure to potentially traumatic events results in persistent negative effects often depends on whether the "victim" has sufficient emotional structure (Object Constancy) to accommodate the event into her schemata and the support and comfort to restore a sense of safety amid the helpless and loneliness of personal trauma.

Potentially traumatic events range from a single incident (a car accident) to repeated stress (refugee trauma). It is possible to distinguish among three levels of involvement in potentially traumatic events: impersonal (e.g., a tornado), interpersonal (e.g., an assault), and attachment trauma (i.e., trauma in attachment relationships).

Attachment trauma includes physical, sexual and psychological abuse; and emotional and physical neglect related to relationships.

Attachment trauma in childhood may be especially problematic because of its influence on the course of psychological, social, emotional and physiological development over one's entire lifetime.

The attachment bonds formed between an infant and her primary caretaker profoundly influence both the structure and function of her developing brain. Failed attachment, whether caused by caretaker abuse, neglect or emotional unavailability can negatively impact brain structure and function, causing developmental or relational trauma.

Early-life trauma affects future self-esteem, social awareness, ability to learn and physical health. When the attachment bond goes well, neurological integration develops normally, and relationship brings the expectation of safety, appreciation, joy and pleasure. If the attachment bond was unsuccessful and traumatic, neurological impairment and memories of a failed relationship become the basis for adult expectations

A person with a history of childhood attachment trauma may function very well for long periods into later life. Yet relational stresses within adulthood will often expose the use-by-date of his childhood coping mechanisms and trigger a traumatic stress disorder.

Neurological impairment, brought about by disabling experiences in the womb and at birth, is also traumatizing and interferes with the attachment bond. Similar to the healing that can occur in adult victims when they find secure attachments, a good attachment can help bring about neurological regulation in a moderately dysregulated baby.

Persons who have been traumatized in attachment relationships rarely give up on attachments. Despite trauma, most persons are able to establish and maintain some relatively secure attachments.

The Neurology of Attachment Trauma

Trauma is an experience that can transform a child's world into a terror-filled, confusing miasma that dramatically alters his trajectory into and throughout adult life. Ultimately, it is the brain that processes and internalises traumatic experiences including attachment trauma.

It is the brain that mediates all emotional, cognitive, behavioral, social and physiological functioning. Understanding the organization, function and development of the human brain, and its responses to threat help us understand the traumatized child.

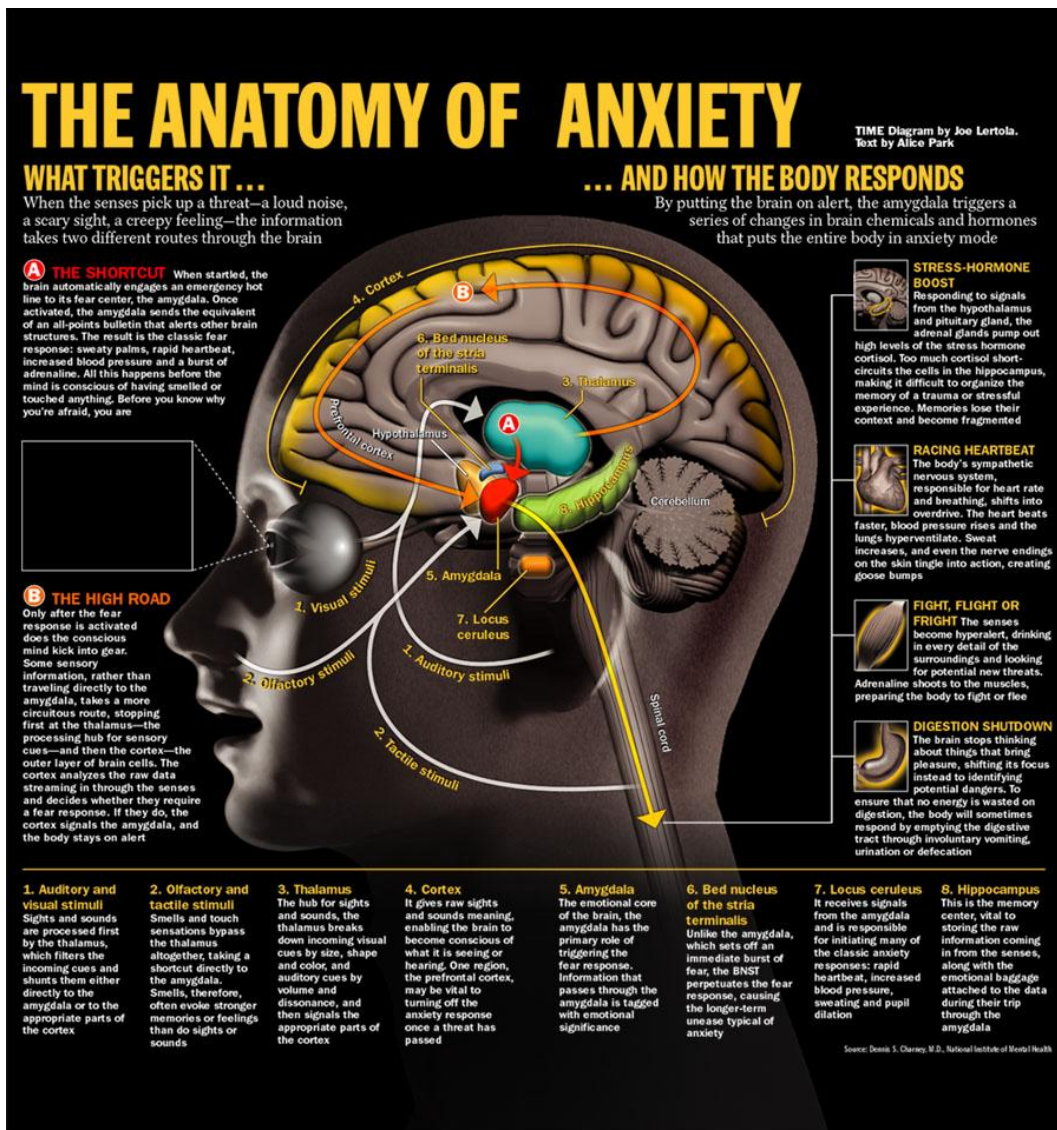
The human brain is an amazingly complex organ comprised of over 100 billion neurons, all organized into networks that are interconnected into systems designed to sense, process, store, perceive, and respond to information from the external senses and the internal environment.

Different systems in the brain mediate different functions:

- Systems in the **frontal cortex** are involved in abstract thought
- Systems in the **brainstem** are responsible for regulating heart rate, blood pressure and arousal states
- Systems in the **limbic areas** are responsible for attachment, affect regulation and aspects of emotion; and
- Systems in the **cortex** are responsible for abstract cognition and complex language.

Each of these systems varies somewhat with regard to function, neurotransmitter networks, synaptic structure, and regional localization. They all do however, obey similar molecular rules mediating development, changes in response to chemical signals, and storage of information.

The single most significant distinguishing feature of all neurons is that they are designed to change in response to external signals. Those molecular changes permit the storage of information by neurons and neural systems. It is this capacity which allows the brain respond to the external and internal environment, and to allow the organism to differentiate, separate, individuate and integrate self and data.



One important neurological principle is that all our experiences are filtered by our senses of sound, sight, taste, touch and smell that, in turn, initiate a cascade of neurochemistry and ultimately a change in brain structure and function. One function created by this process is the formation of our internal representations of the external world. The more frequently a certain pattern of neural activation occurs, the more indelible the internal representation becomes.

Another important neurological principle to consider is that the brain develops in a sequential and hierarchical fashion i.e., from less complex (brainstem) to most complex (limbic and cortical areas). These different areas develop, interact with other systems and become fully functional at different times during childhood.

At birth, the brainstem areas responsible for regulating cardiovascular and respiratory function must be intact for the infant to survive, and any malfunction is immediately observable. In contrast, the cortical areas responsible for abstract cognition have years before they will be fully functional. This means that there are different times during which different areas of the Central Nervous System are most sensitive to systemic experiences and the cues related to them.

While experience may alter the behavior of an adult an experience literally provides the structural framework for an infant and child.

Disruptions of links between neurochemical cues during a particular period may lead to major abnormalities or deficits in the brain's development. Disruption of critical cues can result from:

- A lack of sensory experience during critical periods (neglect).
- Atypical or abnormal patterns of neuronal activation due to extremes of experience (e.g., child abuse).

The child who experiences severe emotional neglect or abuse early in life will experience profound attachment problems later in life.

While deprivations and lack of specific sensory experiences are common in the neglected child, the traumatised child experiences developmental insults related to patterns of over-activation of neurochemical cues. Rather than a deprivation of sensory stimuli, the traumatized child experiences over-activation of important neural systems during these sensitive periods of development.

The mind responses to perceived threat

The human body and human mind have sets of very primitive, deeply ingrained physical and mental responses to perceived threat. The most familiar set of responses to threat has been labeled the *fight, flight or freeze* reaction.

Infants and very young children are much less likely to use a classic 'fight or flight' response because it is not a real option and usually "freeze". At different stages of development, and in the face of different stressors, one of two major neuronal response patterns; the hyperarousal continuum and the dissociative continuum, are activated.

In the initial stages of threat, an alarm reaction is initiated. The alarm reaction is characterized by hyperarousal of the sympathetic nervous system, resulting in increased heart rate, blood pressure, respiration, a release of stored sugar, an increase in muscle tone, a sense of hypervigilance, and screening out of all non-critical information.

In this early stage of threat, the young child commonly utilises the hyperarousal response which is designed to bring caretakers to defend them. If the threat continues she tends to utilise the dissociative continuum, initially becoming immobile (freezing) or compliant, and on through to dissociation.

Dissociation is more likely to be used if:

- The child is female
- The child is younger
- The child feels helpless
- When physical injury, pain or torture is involved

If dissociation is imprinted by repeated utilization, it becomes the standard response to perceived threat throughout life. The cues that trigger the response then become generalized and the adult is at risk of escaping any form of conflict or challenge with an attached threat. The damage this can to relationships in general is immense.

Effects of Trauma on Emotions

Emotions are packages, consisting of

- cognitive appraisals (interpretations as to the state of your wellbeing as well as your ability to cope),
- physiological responses (providing energy for coping),
- adaptive actions (running, hiding, resisting)
- expressions (communicative facial and vocal expressions), and
- feelings that provide information about our emotional state.

A child can become conditioned to respond automatically in any one or a combination of these ways to the cues associated with attachment trauma experiences. These cues can continue to trigger the same emotional response into adulthood and beyond.

A normal emotional response package that was designed to assist in righteous living through appropriate responses now comes with an accumulation of associations that can overwhelm an individual and they have a \$100 response to a \$10 situation.

Sometimes the same triggered emotion can be both beneficial and harmful. Anger, for example, provides fuel for assertiveness and fosters self-protection but can also be destructive when it smolders and turns to hostility, hate, and vengeance, or erupts into rage.

Shame and guilt are common emotions associated with trauma. These twin emotions not only create existential pain but also tend to create vulnerabilities that perpetuate the trauma and inhibit close attachment.

- Shame involves pervasively negative feelings about who one is.
- Guilt relates to pervasively negative feelings about what one has done.

Often these feelings have their bases in attachment trauma. A reparative attachment bathed in acceptance is the antidote to shame, while the antidotes to the trauma based guilt feelings are reallocation, and forgiveness.

Memory

Trauma poses two main challenges to memory:

- Intrusive memories of traumatic events, and
- The accuracy of these memories.

It is no different for attachment trauma.

It is important to understand something about the nature of memory when you're struggling with the recollection of traumatic events.

Researchers distinguish between implicit memory (conditioned emotional responses) and explicit memory (conscious remembering). Trauma includes both the conditioned responses and the memories of specific events in our past. We also construct an autobiographical narrative based on what we believe or imagine might have happened, what we have been told, and what we infer happened to us.

By and large, the gist of our autobiographical memory is accurate, although we are liable to mix up many details. Persons with a history of repeated childhood trauma may have an amalgam of abuse memories that vary widely in clarity accuracy and impact.

The goal when treating trauma is for the sufferer to be able to remember rather than relive his trauma. This requires him to keep the trauma in mind rather repressing or suppressing it since a crucial part of trauma treatment is the construction of a meaningful autobiographical narrative. That narrative will enable him to make sense of his history and his current symptoms.

It's also important to cultivate positive memories alongside painful memories. A part of living in reality is to live with some degree of tension as whether the trauma occurred as remembered. The ability to live with this tension is often impaired when attachment trauma occurs during development when object constancy is formed.

Self

We can distinguish two aspects of the self:

- The "I" or self as active agent
- The "me" or how I think and feel about myself.

Importantly, the "me" has a strong impact on the "I". How I feel about myself influences who I become. For example, if I think of myself as vulnerable, having more negative than positive qualities, I may be reinforcing avoidant and timid behavior. If I think of myself as capable, having more positive than negative qualities, I may be more inclined to develop my strengths.

Both the "I" and the "me" can be influenced by attachment trauma.

Many events can be overpowering and render one helpless. Repeated traumas can undermine one's sense of security and influence (the "I") as well as one's sense of worth (the "me").

Every person is extremely complex, and every self-concept is potentially based on a complex mixture of good, bad, and indifferent characteristics. As mentioned above, persons without object constancy often focus on the negatives and negate the positives, or vice versa. To a degree, one's self-concept mirrors how one is regarded by others. When primary carers treat a child in contradictory and inexplicable ways, her sense of self can become confused and impair her identity and behaviours throughout her lifetime.

Relationships

Patterns for our adult relationships are developed from the internal working models of our infant relationships. Secure attachment relationships in infancy produce positive working models that in turn promote healthy adult relationships. Insecure and problematic attachment models that stem from trauma produce often contradictory interpersonal dynamics that include isolation, a yearning for closeness and affection, dependency on others, being controlling of others and being aggressive toward others and feelings of fearfulness of, and victimized by others.

It is common for persons with a history of attachment trauma to find themselves reenacting traumatic patterns in later relationships. Such reenactments can contribute significantly to

their general level of stress, trigger reminders of previous trauma and the re-experiencing of symptoms. An example of a pattern of reenactment is the following cycle: feeling isolated, longing for rescue, feeling let down or abused, retreating into isolation, and feeling alone and neglected.

One particularly troubling pattern of relating is traumatic bonding. On the surface, it seems puzzling that a person would cling to a relationship that is frightening and injurious. Attachment theory helps explain this pattern. Fear often prompts a child to seek attachment. The more frightened they feel, the tighter they cling, even if this person is also the source of the fear.

Similarly in adulthood, fear will drive one to cling to the available attachment figure, even at the risk of further conflict. In object relation terms this is an all-and-nothing split to retain the idealized object. It is this conflict between need and fear that leads to the disorganized attachment pattern. Learning self-protection and finding other secure attachments is the pathway out of traumatic bonding.

The vast majority of persons with a history of trauma in attachment relationships in childhood are able to develop some relatively secure attachments in adulthood. A network of supportive relationships is ideal, because different persons can meet different needs and not unduly burden any single relationship.

Physical Illness

Exposure to extreme and prolonged stress can cause persistent maladaptive physiological changes in the brain and the body that can create a wide range of physical illnesses including: headaches, gastrointestinal symptoms, sexual dysfunction, trauma specific pain, hypertension and fatigue. While it's alarming that traumatic stress can lead to brain impairment, recent research also shows that these brain changes can be reversible with treatment that includes reattachment to secure objects.

Psychological Disorders

Depression

Depression is perhaps the most common trauma-related problem and is often the result of internalised emotion over sustained irresolvable stress. Attachment trauma is a common cause of childhood depression. If this is so, the disorder is often carried into adulthood.

A relatively direct link between trauma and depression can be made by the fact that depression is often a response to feelings of being overpowered, intimidated or burdened. Traumatic relationships are likewise oppressive. The natural response to being threatened is to fight, flee or freeze. However, when a child is overpowered, fleeing is not possible and fighting back may result in actual physical pain. The only option is to submit and internalise all its negative emotions.

Posttraumatic Stress Disorder (PTSD)

PTSD is aptly named: it's a disorder that develops after traumatic stress. The hallmark of PTSD is the re-experiencing of the trauma in response to cues. Sufferers often experience flashbacks of the event and nightmares that relate directly to it. PTSD adds insult to injury since the experiencing of extremely stressful events is bad enough in itself; however, it also induces a disorder that renders sufferers vulnerable to reliving those experiences over their lifetime.

Often current relationship conflicts trigger re-enactments of past attachment trauma. It is therefore important to place major emphasis on working through the relationship conflicts that cue the PTSD.

Repeated and severe stress, such as attachment trauma, may not result in PTSD alone, but can also affect identity, relationships, and emotional responsiveness. Persons with a history of such trauma may meet criteria for personality disorders, such as BPD but they may be better thought of as suffering a complex form of PTSD.

Dissociative Disorders

Dissociation can be described as a defensive process or coping mechanism, in which the unity of consciousness is disrupted, normal integrated awareness is disturbed, and mental functions are separated into complexes that operate autonomously.

Dissociation is a form of mental flight and although it mentally removes one from a painful experience, it can undermine regular functioning if it develops into a habitual way of coping with stress.

Some therapists link dissociation and the defense mechanism of repression when there are significant differences between the two. Repression creates a horizontal split whereby the offending material is transferred to the dynamic unconscious, whereas in dissociation a vertical split occurs whereby the material exists in a series of parallel consciousnesses. Dissociation is a common result of trauma, whereas repression is more likely activated by conflictual thoughts and desires. Once mobilised however, dissociation can also be activated by wishes and desires related to the traumatising love object. In most cases of dissociation the disparate self and other representations must be maintained in separate mental compartments as they either conflict with each other or with reality.

Dissociative identity disorder is the most severe form of dissociation and involves radical changes in one's sense of identity and normal behaviours coupled with amnesia for behaviour in dissociative states. Depersonalisation, trance possession, amnesia, fugue, and many other unusual experiences may occur as symptoms of DID. In this disorder two or more personalities seem to be occupying the same body and mind. Switching occurs under stress, during an emotional crisis, or in responses to certain environmental cues or triggers.

PTSD and dissociation overlap, and some clinicians consider flashbacks to be a form of dissociation since they involve altered consciousness and detachment from current reality. Grounding techniques are helpful in coping with dissociation and PTSD symptoms. These techniques draw the client's attention to current reality by heightening their sensory awareness.

Self-Destructiveness

Many persons struggling with intense, painful feelings stemming from attachment trauma resort to forms of self destructive behaviour including substance abuse, and self-injury to relieve unbearable emotional states. These forms of coping may momentarily relieve tension, but they create further feelings of shame and guilt, which then contribute to a further desire to escape from the pain.

Healing

Emotion Regulation

When a client is vulnerable to painful emotional states, teach them to find a safe place, push the pause button and sit with the painful emotion. There are three steps to this process:

- identifying feelings,
- modulating them through soothing techniques
- resolving of interpersonal conflicts and reenactments that fuel posttraumatic symptoms.

An important component of regulating painful emotions is cultivating positive emotions. Positive emotional states facilitate flexible and creative thinking, and they also undo the physiological arousal from distressing emotions. Positive attachments breed positive emotions.

Treatment Approaches

We face a dilemma in treating any form of trauma because reminders of trauma activate symptoms, and treating trauma evokes traumatic memories. Processing trauma; thinking, feeling, and talking about it must be balanced with grounding, containment, safety, support, self-regulation, and structure. Many attachment trauma sufferers require lengthy periods of containment prior to processing since their anticipation of abandonment can make it difficult for them to form a therapeutic alliance. However, a benefit of their doing so is they learn how to trust, confide, and work on fears and conflicts within a positive attachment that can serve as a bridge to other relationships.

Whatever orientation you choose, the crucial elements are:

- bringing the memories to mind,
- talking about them in a trusting relationship, and
- developing the capacities for containment

This approach promotes restructuring, which, in turn, promotes resilience by enhancing emotion regulation and secure attachments.

Group therapy provides an opportunity not just for helpful feedback and supportive relationships but also for the experience of universality. Family therapy can help with relationship conflicts as well as providing education and support to other family members. Medication can be employed to help with symptoms and emotion regulation. Antidepressants (SSRI) are employed in the treatment of PTSD as well as depression. Anti-anxiety agents, mood stabilizers, antipsychotic medications, and medication to help with sleeping are all options that need to be explored in partnership with a psychiatrist.

Hope

Counsellors are accustomed to thinking of traumatized persons as survivors rather than victims. Even with the best of treatments, it is not possible to be certain of preventing recurrence of illness or suffering so we might think in terms of thriving in the context of illness and suffering, while trying to minimize both.

Both the scriptures and psychological research identify two main ingredients of flourishing: intimacy, and hope.

Intimacy is about positive attachments while hope is about transcendence within the present.

Three factors are crucial for hope:

- finding meaning,
- developing a sense of benevolence in the world, and
- cultivating a feeling of self-worth.

Menninger psychologist Paul Pruyser says that hope is based on the belief that there is some benevolent disposition toward oneself somewhere in the universe. That something for a Christian is God.

Principles relative to attachment and trauma issues

Emotional/psychological trauma stands out as a primary predictor of future mental, emotional, learning and physical problems.

While some degree of stress may be beneficial to the organism, trauma creates an ongoing threat that has profound influence on the developing brain and development in general.

Emotional trauma is often linked to attachment issues.

Emotional trauma is likely to be caused by neglect and abuse.

Principles relative to helping survivors of attachment trauma

Children depend on primary caretakers for brain regulation and development. Therefore, treat the parent in order to treat the child.

Brain change is a process triggered by physical and emotional experience.

Physical and emotional experiences are engaged in children by nonverbal forms of communication, including eye contact, facial expression, tone of voice, posture, touch and proximity.

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