

Childhood trauma and adult attachment

Chris Purnell explores the interplay between childhood trauma and attachment strategies and their relevance in clinical work

The evidence supporting the importance of attachment theory¹ in our understanding of human relationships has grown immensely in recent years, and for most clinicians it has become increasingly relevant when thinking about psychotherapeutic interventions.

Attachment-type relationships form during the early months of life, and become increasingly more complex and sophisticated during the process of development towards adult maturity. These relationships develop around a child's needs for protection from danger and for comfort when they are feeling distressed. They also depend on the response that the expression of these needs elicits in the child's caregivers.

Appropriately responsive caregiving to attachment needs is likely to provide what Bowlby referred to as a 'secure base', namely a point of contact with someone who will provide the reassurance, comfort and safety that will make an individual feel sufficiently secure to interact with and explore the outside world. Bowlby also regarded the provision of a secure base as the first task to be addressed in psychotherapeutic work with adult clients.

Developmental psychologist Mary Ainsworth² built on Bowlby's original theory by identifying three categories of attachment. The first of these, secure, also referred to as 'type B', enables an individual to process information about danger and safety in an accurate way. When there is a threat, the person has a true understanding of the danger through their own feelings of discomfort and through expectations of how others are likely to respond in a protective manner. In other words, they learn through affective and cognitive information processing how best to respond to possible dangers, and how others are likely to react to that response in a caregiving way.

Anxious attachment relationships are likely to develop when a caregiver's responses to safety/comfort-seeking have been inadequate. This can happen in a number of ways. If caregivers have been unresponsive or rejecting of safety or comfort-seeking approaches that would normally involve expressing distress, then an individual will find other ways of maintaining safe proximity to an attachment figure who is likely to reject them if they get too close. Expressing distress is likely to be counter-productive in this situation, and so the person may learn to suppress outward expressions of fear or anxiety and so develop what is referred to as an 'avoidant attachment strategy', also known as 'type A'.

Avoidant, type A strategies rely upon the suppression of negative affect, i.e. anger, anxiety and fear, and a greater reliance on cognition in strategies for dealing with danger. As children, people who use type A strategies will have developed ways of maintaining proximity to their caregivers that don't involve expressing forbidden negative affect, but will elicit approval towards them as a well-behaved child. Elicited approval can develop into compulsive caregiving of others or overly compliant behaviour that avoids disapproval and therefore rejection. As part of this process

there is a distortion in cognition, with the caregiver being idealised and the self taking responsibility or blame for any acknowledged failures in the attachment relationship.

People who have experienced unpredictable caregiving during childhood are likely to develop what is referred to as an ambivalent or pre-occupied attachment strategy, also known as type C. The inconsistency of caregiving they have experienced as children makes it difficult for them as adults to predict the likely response of others to their needs for comfort and safety. Individuals who use type C strategies cannot rely on cognition to predict danger, because the caregiving responses they experienced as children were too unpredictable for them to anticipate. Instead they learned to depend primarily on their own state of affective arousal to inform them of safety or danger. As children they would have been difficult to settle and pacify when distressed, and this would also be true in adulthood when their attachment system is aroused.

An additional classification of anxious attachment, referred to as 'disorganised', was subsequently added to Ainsworth's original three by Main and Hesse³. Disorganised attachments are thought to represent the collapse of any attachment strategy towards caregivers who are either frightening to the child or themselves frightened. Either way, such behaviour on the part of caregivers leaves a child with the impossible dilemma how to safely approach or avoid the person they are attached to. Disorganised attachment is thought to be associated with a history of more extreme trauma or neglect, and tends to combine features of the avoidant and ambivalent strategies even though it is said to represent a collapse of strategy.

The dynamic maturational model of attachment

In the dynamic maturational model (DMM), Crittenden⁴ proposes that attachment responses are always strategic, and that rather than becoming disorganised in response to danger and failures in caregiving, attachment strategies rely increasingly on distortions of cognition and affect, and may employ a combination of type A and type C strategies.

Crittenden describes her model as a dynamic maturational model because of the ability of people to reorganise their attachment strategies according to new experiences of attachment-type relationships, and also because the range of possible strategies increases with maturity throughout childhood and into adulthood, in accordance with brain development and maturity.

The model is illustrated in Figure 1 below. This shows that type B secure attachment strategies can be comfortably balanced in terms of processing accurate information about danger and safety through thoughts and feelings, but can also be slightly reserved in terms of affective expression and more reliant upon cognitive information, or they can be more emotionally reactive.

The classifications shown in the model would normally be determined by conducting an adult attachment interview, Main and Goldwyn⁵, Crittenden⁶. However, it is often possible to recognise many of the attachment strategies contained in the model during the course of client work without resort to conducting and classifying an interview.

The DMM view of attachment as a dynamic as well as a maturational process is similar in concept to Bowlby's developmental pathways⁷. For example, as illustrated in figure 1, avoidant type A attachment strategies can become increasingly reliant on distortions of cognition, which result in idealisation of caregivers who may not have

been ideal, compulsive caregiving, and compulsive self-reliance among other things. The dynamic nature of the model also means that with increasing distortions of cognition, there is also an inhibition of negative affect – particularly anger and fear, and an emphasis on false positive affect. For example, a client talking about some traumatic event in therapy may laugh, even though the event has been distressing.

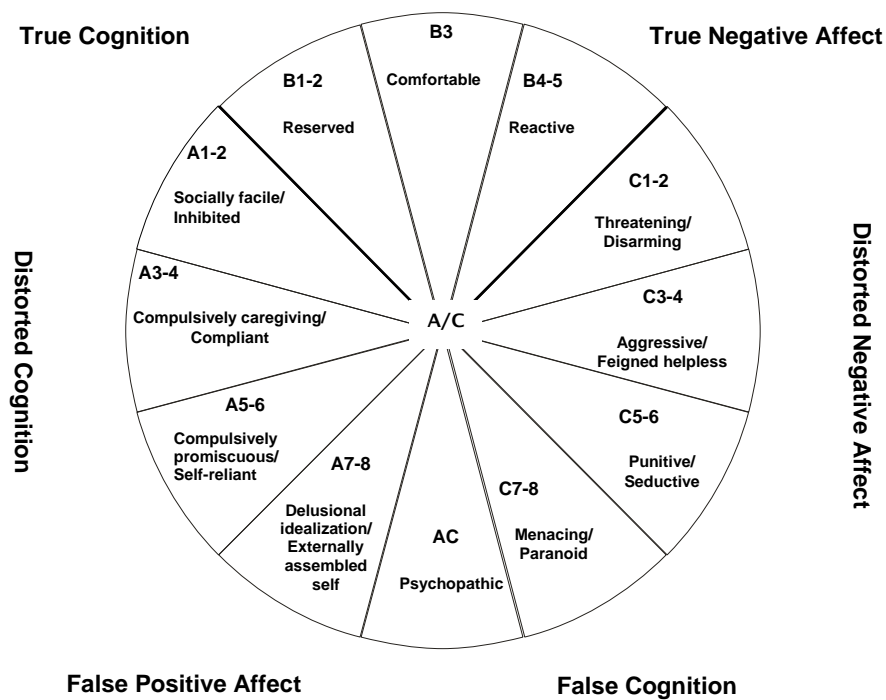


Figure 1. Dynamic maturational model of attachment

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Type C attachment strategies are the opposite of type A in that they tend to be overly influenced by negative affect. Arousal of the attachment system triggers fearful or angry responses towards caregivers, but rather than suppress these feelings, type C responses tend to exaggerate them and employ coercive strategies towards others. These can be mildly threatening or angry or can be disguised by disarming responses that are subtly coercive in their intent to control attachment relationships. People who use type C strategies can distort their negative affect to become increasingly coercive or aggressive, either employing openly threatening or angry responses or more subtly feigned helpless or seductive strategies which disguise their coercive intent. Again, these strategies can often be experienced with clients in the therapist’s consulting room as the attachment system is activated as part of the therapeutic relationship.

Employing more extreme type C strategies also involves increasing the use of false cognition such as false blame of others or false claims of innocence of the self, when in fact the person may have been complicit in the events they are complaining about.

As the diagram illustrates, it is possible to combine type A and type C strategies as well as to have increasing degrees of intensity in the use of distortions of cognition (type A spectrum) and affect (type C spectrum). At the extreme, there is a balance of distortion of false cognition and affect, which in the model is the polar opposite of a comfortably secure type B attachment. This would represent the strategy of a true psychopath, who presents false cognition and affect in a wholly convincing way to the external world.

The influence of trauma

The DMM describes the range of adaptations that is possible in response to adequate or inadequate caregiving. Generally speaking, the more exposure to danger there has been through neglectful or abusive caregiving, the more distortion there will be in the attachment response. Trauma in itself does not inevitably lead to anxious attachment. It is possible for children to experience trauma and other hardships, but because their caregivers are adequately protective in response to the dangers, they will have secure or relatively secure attachment strategies.

The ways in which a recent or current trauma is handled by a client seeking help through talking therapies will be influenced by their attachment strategy, as well as past traumas they have experienced and the manner in which they have been able to process these experiences. People with relatively secure attachments (type B) may need a supportive, caregiving response to their fear, uncertainty or anger, which are part of the normal process of adjusting to the losses and/or changes associated with trauma. Secure attachment promotes the capacity to be reflective about thoughts and feelings regarding danger, thus enhancing the ability manage trauma more effectively.

Historically neglectful, unpredictable or dangerous behaviour by caregivers is inherently traumatising, and leaves a child less able to deal with its longer-term traumatising effect and with no adequately secure base to turn to for safety when danger threatens. Thus in addition to developing a strategic response to failures in caregiving, it is also necessary to find ways of dealing with traumatic experiences that remain unresolved because of these failures.

It is not uncommon in therapy to encounter clients with long-past traumas that they have been unable to resolve. The DMM identifies two general forms of unresolved trauma: preoccupying and dismissed. Both have a number of variations⁸, which represent an individual's strategic response to the trauma itself. It is important to understand these responses as an individual's effort to protect themselves psychologically from past dangerous events in which no adequately protective caregiving was available. The amount of trauma remaining unresolved is likely to correlate with the higher, more distorted attachment classifications described in the DMM, with a greater likelihood of complexity of both forms as one moves towards the lower segments of the circle in the model.

Dismissing a trauma serves a self-protective function of splitting off the truth about a historically dangerous event from conscious awareness, so that the person describing the trauma does not acknowledge any bad feelings that are associated with it. For clients who have developed a type A attachment strategy, dismissing past trauma will serve to avoid the arousal of negative affect that they have learned not to express.

Preoccupying trauma represents a different response to historical danger with an equally self-protective purpose. By excluding the anticipation of future safety and

comfort, the client is able to remain vigilant to danger. Unlike dismissed trauma, preoccupying trauma tends to be associated with affective alertness and arousal and distorted cognitive anticipation of danger, which is often seen in clients who have developed type C attachment strategies through learning to deal with dangerously unpredictable caregivers.

Both the dismissed and preoccupying forms of trauma remain unresolved in the sense that individuals find it difficult to review their perspectives of what has happened to them and to find more effective or appropriate ways of integrating this into their responses to and understanding of danger in the present. Thus understanding the nature of unresolved trauma is important when considering a client's psychotherapeutic needs.

Dismissed trauma

It is sometimes possible to hear various forms of dismissed traumas when listening to a client's discourse in the therapy room. The trauma may be simply dismissed as unimportant, or normalised. It can also be distanced from the self and displaced onto others, e.g. *'Father used to regularly beat us with a cane; my brother was beaten really badly'*. The trauma may be presented as repaired when, in listening to the client's story, they offer no evidence to confirm that this is the case, e.g. *'I was terrified when my father beat me with a cane when I was a child, but it was a long time ago so I am over that now'*. Traumas may also be dismissed by blocking them from conscious memory. There are particular difficulties associated with working psychotherapeutically with blocked trauma because of the danger of encouraging false memory, and also because blocked trauma may indicate dissociation, which would require a different therapeutic response.

The tendency of dismissed trauma to be more associated with type A attachment strategies usually indicates that there will be a reliance on compulsive control of negative feelings through false positive thinking or by directing negativity towards the self rather than others. In situations where suppressed anger or fear becomes overwhelming, their intrusion leaves the individual momentarily without a strategy and consequently no sense of control. The more traumatised clients we see in therapy can therefore experience intense outbursts of anger during which they lose control and subsequently feel remorseful or guilty.

Therapeutic work may involve self-affirmation and gently supporting the expression of previously suppressed negative feelings, or it may involve helping clients to deal with intrusions of anger or fear that they are unable to control.

Cognitive-based approaches to treatment need to be applied carefully with some traumatised clients who use type A strategies, because of the risk of simply reinforcing their tendency to think about their need for self control rather than feel forbidden feelings that are the root cause of their problem. It can sometimes be more productive in the first instance to focus on the process of affective arousal of the attachment system through which a perceived threat or danger would normally lead to an anxious care-seeking response for protection. Increased anxiety can escalate to self-protective anger and fear, which ultimately explodes. Rather than teaching clients simply to control anger, it can often be more effective to help those who are type A to recognise, understand and deal with the forbidden feelings and thoughts that are associated with the build up to an explosion.

Preoccupying trauma

Clients with preoccupying trauma will be identifiable in therapy by their absorption with the trauma rather than their dismissal of it. Rather than distancing themselves from the traumatic event they tend to become enmeshed in it, because danger is often perceived as all-pervading. Thus in talking about an historical trauma, clients will frequently refer back to it and have great difficulty in moving on. It is also possible that detail will appear confusing, with some aspects of the trauma being described in ways that cannot be fully or clearly understood by either the client or the therapist. If an adult attachment interview were to be conducted, it would likely reveal unresolved trauma that was vicarious, imagined, delusional or disorganised in nature. This is not to say that the trauma is unreal, but rather that the manner or extent to which it has been possible to integrate it is reflected in the client's presentation.

Clients who use type C attachment strategies tend to not be troubled by their loss of control of negative affect, and are therefore less likely to have dismissed unresolved trauma. Rather they tend to overemphasise their feelings, and to give less attention to accurately describing the detail of the event.

When such clients experience pre-occupying trauma, they are more likely to show an affectively aroused response in relationship to their therapist and, in particular, are more likely to bring their historical trauma into the present in the form of fearful or angry anticipation of rejection or hurt. This may be openly confrontational, or it may involve employing more subtly coercive or feigned helpless strategies, as previously described, in which cognitive information is falsified in terms of blame and innocence. The temptation may be simply to label these clients as deceptive or manipulative, rather than to understand their behaviour as a self-protective response to the expectation of unpredictable availability of safety and comfort. Therapeutically, they may require an approach which challenges their falsified cognition in a manner that is not too confrontational, and which encourages a capacity to be reflective.

Attachment, trauma and psychotherapeutic interventions

Individuals with the higher type A and type C attachment strategies and associated unresolved traumas are more likely to present with mental health difficulties. In considering treatment approaches from an attachment perspective, it may be helpful to review the following points:

- 1) Thinking about Bowlby's proposal in regard to primary therapeutic tasks, how can you begin to offer your client a secure base? In order to offer this, it is necessary to have at least a sense of what attachment strategy your client uses. This does not necessarily require an adult attachment interview. What is your client's perception of safety and danger, and how is this likely to influence their response to your attempts at intervention? Being aware of their attachment strategy, how are you then going to respond to them?
- 2) Given that different attachment strategies can involve varying distortions of cognition and affect, what is the most appropriate modality of therapy? Clients who use type A strategies may feel very comfortable with cognitive-based treatments, but in terms of unresolved trauma they may need a treatment approach that can help them to deal safely with unexpressed forbidden negative affect. Conversely, those who use type C strategies may not be helped by exploratory therapies that intensify their affect and fail to address their need to develop more of a capacity for cognitive reflection. Some clients with combined A/C strategies may require a different kind of creative responsiveness in their therapist, and a more integrative approach in the

treatment they are offered. A range of modalities of therapy are able to embrace the principles of attachment theory. Consider the ones that most appropriately match the client's needs and their attachment strategy.

- 3) What is the nature of your client's unresolved trauma? Do they need help to re-connect emotionally with trauma that has been dismissed in order to process it, or do they need help in disconnecting from preoccupying trauma that overwhelms them and prevents them from moving on? Sometimes unresolved losses are also associated with the trauma, and these may need to be mourned before it is possible to move on.

Even in adulthood, attachment strategies are open to revision and change. Thus in providing a secure base and helping your client to work through unresolved traumas, you are also attempting to facilitate a shift towards a more secure attachment strategy that will improve their ability to handle close relationships in future.

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¹ Bowlby J. Attachment and loss. Vol. 1: Attachment. Penguin Books: London; 1978.

² Ainsworth MDS, Blehar M, Waters E, Wall S. Patterns of attachment: A psychological study of the strange situation. Hillsdale, NJ: Erlbaum; 1978.

³ Main M, Hesse E. Parents' unresolved traumatic experiences are related to infant disorganised attachment status: is frightening behaviour the linking mechanism? In: Attachment in the preschool years. Greenberg MT, Cicchetti D, Cummings E (eds). 1978

⁴ Crittenden PM. A dynamic-maturational approach to continuity and change in pattern of attachment. In: Crittenden PM, Claussen AH (eds). The organisation of attachment relationships: maturation, culture and context . Cambridge University Press: Cambridge; 2000.

⁵ Main M, Goldwyn R. Adult attachment rating and classification system: Manual in draft. Unpublished manuscript. University of California at Berkeley; 1990.

⁶ Crittenden, P. M. & Landini, A. The Adult Attachment Interview: Assessing psychological and interpersonal strategies. New York: Norton (in press).

⁷ Bowlby J. A Secure Base. Tavistock/Routledge: London; 1988.

⁸ Crittenden PM. Raising parents: attachment, parenting and child safety. Uffculme, UK: Willan Publishing; 2008.