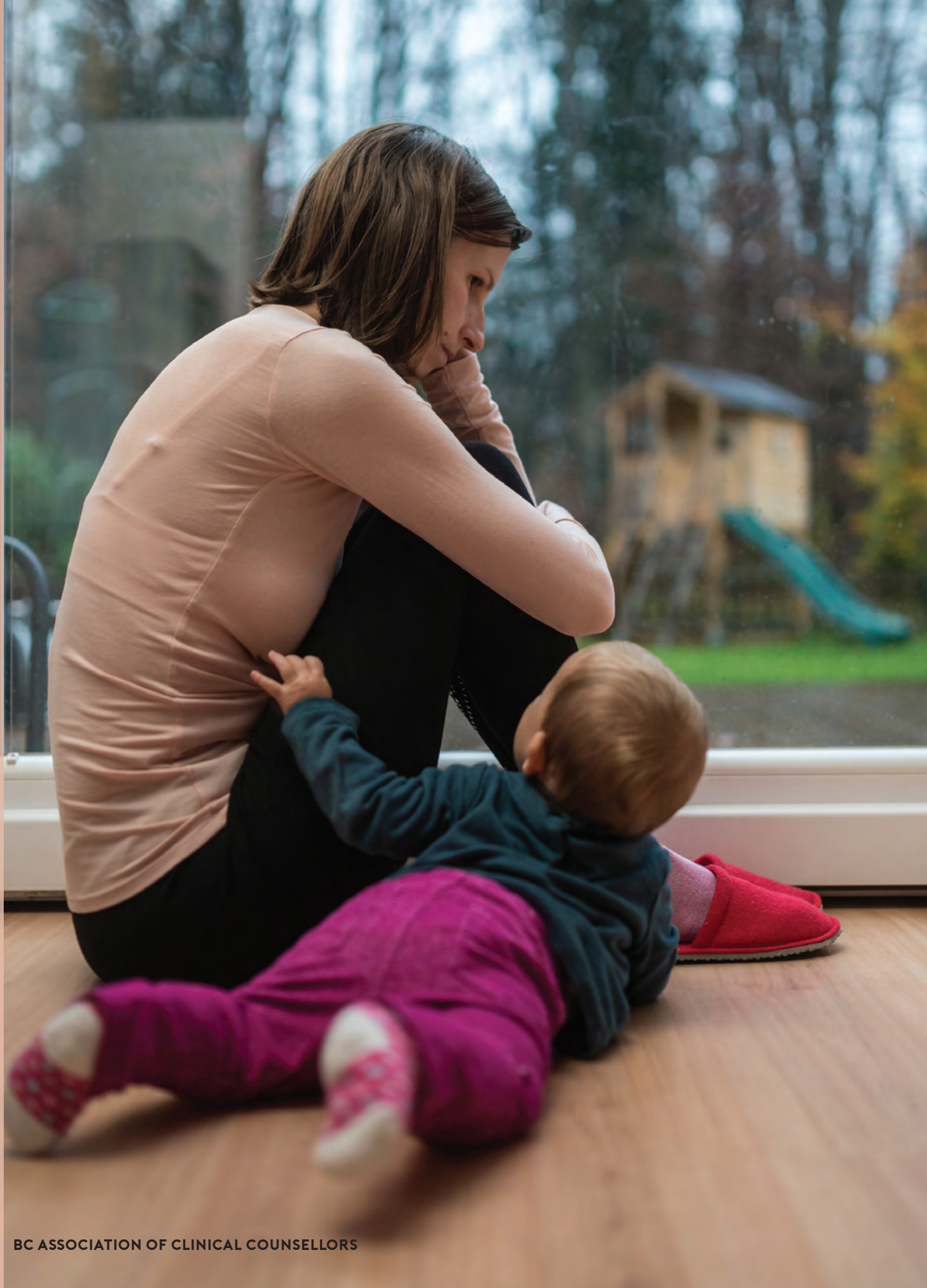

THREE PILLARS OF SOMATIC ATTACHMENT PSYCHOTHERAPY

BY LISA MORTIMORE, PHD, RCC

ATTACHMENT, THE BODY, AND RELATIONAL REPAIR

The legacy of relational trauma, often our earliest experiences of love, wires the right brain (RB) and forges a template in the infant's neurophysiological body and psyche that endures across the lifespan and over generations. These longstanding patterns and functioning, often the undercarriage of the issues that undermine people's fulfillment or success in life and relationships, bring many to therapy.[1]

Often this foundational wound is overlooked or there is difficulty identifying underlying vulnerability, attachment injury/relational trauma, as it is generally less visible than other traumatic experiences to the untrained ear; further, the enduring relational operational system, deeply embedded in daily functioning, can be difficult to discern. Somatic attachment psychotherapy opens the neurophysiological and psychological terrain to understand the intricate relational and regulatory map of one's system and guides therapeutic process.

A framework oriented to the reparation and regulation of the neurophysiological body and wounded psyche calls clinicians to work with an embodied, affectively oriented, relationally focused approach, heeding Kalsched's assertion "what has been broken relationally must be repaired relationally."[2] Executing this can be stymied by the scope of what is being called for and often therapists are left with the questions: how do we translate attachment theory into embodied clinical practice? And how do we regulate and facilitate reparation of attachment injury? This article speaks to this in broad strokes.

THE FOUNDATION

The work of regulation and reparation centres on facilitating shifts in affect management strategies, attachment patterning, and re-organization of the body and psyche to support the maturation and development of complex RB functioning rather than merely working with symptom reduction. Inhabiting the body as a living site of knowledge for both therapist and client is of utmost importance.[3] The somatic attachment therapist uses the body as the central perceptual instrument through explicit understanding and use of the RB in terms of relational practice and attunement to the neurophysiological information and fluctuations in the body (client and self). This guides the use of right hemispheric processing (sensation, gestures, emotions, images/imaginal, symbolic/archetypal) towards regulating, metabolizing, and integrating implicit and explicit traumatic material.

The heart of the work reaches beyond regulation of the autonomic nervous system (ANS) as interruption of the narrative, the internal working models[4] (IWMs – which organizes one's self-perception, world, and identity), and the neurophysiological undercarriage are required to make

shifts to the foundational framework of the self. Back and forth dialogue is commonplace; however, a strong bias towards the body as an epistemological site and engaging the right hemisphere (RH) to work towards congruence of the explicit (narrative) and implicit (body) systems is forefront.

In this way, this work departs from traditional talk therapy and relational practice as there is a consistent return to RH processing and attending to a "discreet confluence of both"[5] body and mind.

EARLY ATTACHMENT EXPERIENCE BUILDS THE PSYCHE AND BODY

The neurophysiological body begins developing at conception and continues to be shaped in the womb in response to the mother's physiology which is impacted by her context — the environment and her history — culminating in her regulatory capacity and relational strategies. During this time, the hypothalamus, pituitary, adrenal (HPA) axis, the neuroendocrine system which governs the stress response and impacts several other major functions in the body (digestion, immune system, emotional regulation, etc.), is forming.

From the last trimester of pregnancy through the second year of life, a brain growth spurt develops the fundamental terrain for the functioning of the RB.[6] Experiences of love in the primary relationship(s) are "affectively burnt in"[7] and imprint, encode, or wire the self with specific affect management and attachment strategies that shape the RB, a process which is integral to emotional processing in the limbic system and the ANS.[8] These strategies, developed in direct response to the attuned or misattuned primary caregiver(s), underpin the developing regulatory capacities of the self and create pathways through

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which relational behavioural strategies are correlated. The psychobiological interaction of the caregiver and infant, the "facial-visual, auditory-prosodic, and tactile-gestural"[9] communication of attachment, is the construction zone in which these neurophysiological and psychological structures develop.

This is not to say that those with insecure attachment were and are not loved; rather, the expression of love by the caregiver(s) was interrupted in its execution, likely due, at least in part, to the caregiver's own attachment injuries that unconsciously shape their relational behaviour and regulation capacity. The interactive relationship between infant/child and caregiver(s) creates patterns of relating which are neurophysiologically wired and anchor beliefs about oneself and how the world and relationships work; they are scaffolded onto physiological structures of the body and establish the IWMs. The earliest experiences of love establish the ground for the neurophysiological and psychological self to develop.

THE LEGACY OF INSECURE ATTACHMENT

Disruption in the attachment relationship interferes with optimal development of the growing infant self who is reliant on their primary caregiver(s) to attend, attune, regulate, and respond to the infant's needs, both bodily and psychologically. If the caregiver(s) is unable to meet the needs of the child or consistently do so, the developing infant's system and sense of self (IWMs) are distorted by the inconsistent regulation of their ANS and interrupted attachment bids. Attachment strategies are formed (in general) by nine months of age[10] and remain constant across the lifespan unless there is significant rewiring through relational contact, including psychotherapy.

To put this into a whole body/psyche context, the neuroaffective and physiological states of early life endure and shape our capacity to regulate our ANS and affective state; interpret incoming relational information; respond under stress, particularly relational stress; and, understand ourselves, relationships, and the world. This groundwork has long-term health implications as the chronic stress of dysregulation and bias of high/hyper or low/hypo arousal impact the functioning of our physical body. Moreover, the legacy of insecure attachment wreaks havoc, interrupting the execution and perception in intimate and familial relationships. Suffering of this persuasion can be chronic, cyclical, and confusing.

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INTERRUPTING THE INTERNAL FRAME

As clinicians, we want to disrupt both the psychological and neurophysiological scaffolding that underpins the IWMs, affect management strategies, and relational patterning. What I mean by this is that through an embodied detailed inquiry, "the heart of the treatment process,"[11] we bring both bodily based and narrative "inattended material into awareness,"[12] challenging the embedded, distorted (mis) understandings or perceptions of oneself, relationships, and the world; in many ways, our work is to "make the familiar strange."[13]

In working between the left and right hemisphere, we disrupt the narrative (top down) and invite implicit memory held in the body through somatic right hemispheric processing (bottom up), allowing the silenced/disavowed material to emerge into consciousness and re-organize into "more complex and flexible patterns,"[14] brokering new understandings and re-organization.

Over time, this remediation aids in the development of self-cohesion[15] and forges a "continuity of self-experience,"[16] creating more coherence in the implicit and explicit memory systems and regulation in the ANS, and increases one's reflective awareness and capacity in the relational realm. This increases the client's capacity to know what has been unknowable, unbearable, or unformulated and supports the processing, metabolizing, and integrating of aspects that have been too much.

THE BODY

To re-organize a body dysregulated by relational trauma, the therapist meets

body to body, RB to RB,[17] negotiating past the protective LH[18] that works (unsuccessfully but valiantly) to organize the arousal in the system and establish safety through intellectual, logical, and cognitive reasoning. This often severs bodily based experiences from consciousness.

Directing clients' attention inwards to notice their shifting bodily states and body-based information and to track congruence/incongruence between their narrative and felt sense begins the process of re-inhabiting the self disrupted through relational trauma. Theoretical understanding and clinical application of the window of tolerance,[19] the polyvagal theory,[20] and RH processing are the bedrock of bringing the body into practice.

The window of tolerance orients clinicians to the regulation of the ANS, while the polyvagal theory explains how hierarchical behavioural strategies, specific ANS states, and psychological feelings correlate and are incited by trauma; RH processing regulates, metabolizes, and integrates unprocessed material. In using the body as a living site of knowledge, we access unconscious material and process what has yet to be integrated.

EMBODIED RELATIONAL PRACTICE AND REPAIR

The "interpersonal theme of the past embedded in the present"[21] is fundamental to understand unconscious relational ways of being and recapitulation of early relational patterns, often enacted in the therapeutic relationship. As the dyad engages, the therapist notices the client's affect regulation strategies, attachment/relational patterns, and IWMs and begins to build a working theory of what has been interrupted, interfered with, and impaired. Noting this, tracking connectedness, safety, transference, and countertransference is paramount as is attending to the unattended ways in which relationship was not on the client's terms in their developing years and presently.

Bringing explicit attention to the client's needs begins to re-orient the IWMs to a new experience of relationship. As the therapist listens deeply, mirrors, validates, and responds with authenticity to the silenced parts of story and body, the emotional loop of knowing one impacts the other, comes full circle, and begins to mend the developmental injury embedded in insecure attachment. The "therapist's expression of emotion toward the client served to complete the cycle of affective communication that was insufficiently developed in childhood. In expressing emotion at the appropriate times, the therapist provides an emotional re-education and remediates a developmental void."[22] Throughout the work, the dyad attends to the unattended fragments, the disavowed self-states, by supporting the client's adult self to make embodied contact internally through the RH with the dysregulated self in the present moment, working with the distorted/fragmented IWMs of insecure attachment.

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During the course of therapy, it

is inevitable that the transference-countertransference matrix, the "continuous, unconscious, mutual influence"[23] of client and therapist, will create enactments. These "interactions occurring between the patient's relational unconscious and the therapist's relational unconscious"[24] bring into consciousness relational dynamics and recapitulated injuries of the past as "people act out what they cannot remember or what they cannot allow themselves to feel."[25] As the dyad find themselves in dissociated self-states where the RB has disorganized, they are without the "ability to process socioemotional information and without the capacity to understand the complexities of what was happening in each other."[26]

The therapist's embodied witnessing and willingness to regulate, attend, be accountable, and work collaboratively towards repair offer new experiences of relationship: "The power to foster healing lies not only in the therapist's opportunities to be experienced as an authority who differs from previous objects of attachment but also in his or her willingness to tolerate, name, discuss, explore, and express remorse for the inevitable ways in which old patterns get transferred to and repeated in the therapeutic partnership."[27]

In this way, recapitulated injuries are tended to and, over time, with a renegotiation of relational opportunities, processed through the RH, and new neurophysiological pathways and a re-organization of the IWMs can emerge.

FINAL THOUGHTS

Attending to the injuries of early relational trauma calls for clinicians to be embodied and have a strong understanding of the implications of impaired attachment on the body and psyche. Weaving understandings from interpersonal neurobiology, attachment, trauma studies, relational practice, and somatic processing into a cohesive framework allows an in-depth rendering of interdisciplinary knowledge into clinical practice oriented towards the reparation and regulation of the neurophysiological body and wounded psyche. Somatic attachment psychotherapy works to increase the complexity and flexibility of functioning by supporting regulation of the ANS and re-organization of the IWMs and relational and affect management strategies.

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