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ORIGINAL PAPER

Transformation Through Attachment: The Power of Relationship in Clinical Social Work

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Abstract This case study illustrates the power of the therapeutic relationship that developed between the author and a woman who experienced early relational trauma and childhood sexual trauma, and who suffered from depression, alcohol dependence and bulimia. Examining three and a half years of individual psychotherapy through the lens of attachment theory, the client's relationship to the author appeared to mimic an early attachment relationship and this psychotherapeutic attachment appeared to have contributed to the repair of the client's own insecure attachment to her mother. Through the course of the therapy the client was also able to develop her ability to regulate her emotional responses and create a coherent narrative of her life. She creatively worked through her fear of God as well as apparently circumvent the intergenerational transmission of insecure attachment to her adopted daughter. This case study proposes new treatment considerations for individuals with both trauma histories and substance use disorders.

Keywords Attachment theory · Alcoholism · Relational trauma · Affect regulation · Spirituality

Humans are relational beings. Nurtured in the womb of our birth mother we come into this world wired to be in relationship with other human beings. Our brains are designed to develop in response to human interactions, beginning with our primary caregivers. All we learn and experience in these early relationships sets up a lifetime pattern of relating to other people in familial, romantic, parental, vocational, and social interactions. This pattern becomes deeply embedded into the circuitry of the brain. Neglect and abuse at a young age disrupts this critical developmental process that lays the foundation for healthy emotional regulation, leaving many individuals unable to tolerate, modulate, and communicate painful emotions. The resulting emotional turmoil is often unmanageable and they sometimes seek relief through the use of substances such as drugs or alcohol that conveniently numbs the pain. They find a solution to the inner emotional chaos, making it easier to cope with the emotions that arise in both intimate and casual relationships. Eventually, the substance use begins to interfere with an individual's ability to maintain significant relationships. Often people with substance use disorders are prompted to seek treatment for their addiction by a loved one. Discontinuing the substance use is only the first step in treatment. Learning how to internally transform oneself back into an effective relational human being is the next crucial step. This process often starts in the relationship formed with a therapist. The potential for change exists when a therapist is closely attuned to their client, creating a space and a connection where healing takes place.

Looking through the lens of attachment theory, there is a solid framework that supports the healing nature of the human connection inherent in the therapeutic relationship. The founder of classic attachment theory, John Bowlby (1988), studied the biological attachment process between infant and caregiver that creates an instinctual bond designed to ensure the physical survival of the infant. He theorized that attachment to a primary caregiver contributes to the creation of intimate emotional bonds necessary for effective personality functioning and mental health (p. 120–121). Clinical psychologist Allan Schore

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(2000) strengthened the connection between attachment and emotion, viewing attachment theory as fundamentally a regulation theory in that it is "the interactive regulation of synchrony between psychobiologically attuned organisms. This attachment dynamic, which operates at levels beneath awareness, underlies the dyadic regulation of emotion" (p. 34). Evolving from its beginnings as a biologically driven survival tactic, classic attachment expanded into what Schore and Schore (2008) call modern regulation theory, which considers attachment as "the essential matrix for creating a right brain self that can regulate its own internal states and external relationships" (p. 17). It is a vital process for the development of right brain emotional regulation skills, and a critical component in the creation of emotionally healthy relationships throughout the life span, including the relationship formed with a therapist. Bowlby (1988) acknowledges the role of the therapist as a secure base for the client to explore the past and present with support. Schore (2000) also saw the therapeutic relationship as a context in which affect regulation deficits can be repaired. Offering clients a new relationship that encourages healthy attachment patterns quite possibly can repair the damage done in early parent–child interactions by modeling effective emotional regulation techniques and setting in motion a fresh way of relating to others. It is within this relationship that adult clients can experience implicit emotional regulation from an attuned attachment figure that they did not experience during their early childhood years and internalize these new experiences to navigate adult relationships.

The aim of this case study is to demonstrate how attachment to a therapist imitates an early attachment relationship and contributes to the repair of attachment trauma. Within the boundary of our therapeutic relationship my client was able to process her history of trauma while maintaining her recovery from an addiction and an eating disorder. She was able to set stronger boundaries with her mother and form a secure attachment to her newly adopted daughter. An unintentional outcome of the work she did in therapy was her spiritual insights that developed naturally out of our relationship. This is the story of one woman's transformational journey of recovery from trauma, addiction, and bulimia that occurred through the attachment bond that developed between us over the course of three and a half years of psychotherapy.

Lisa

I remember clearly the day that Lisa first walked into my office. She was a petite woman, with kinky brown hair pulled back into a tight pony tail. Her clothes were loose, hanging on her thin body. Her gaze was intense, and she had a determined expression on her face. We both settled into our respective chairs and she began to tell me her story. She identified herself as being in recovery from an alcohol addiction and bulimia nervosa. After many years of binging, purging, and excessive drinking, she had admitted herself into an inpatient rehabilitation program that forced her to face both of these deadly disorders through intensive individual and group therapy. She completed this two month residential program and was able to sustain her sobriety for almost two years by becoming active in Alcoholics Anonymous (AA). She managed her eating disorder by maintaining strict adherence to a food plan. But she was plagued by disturbing symptoms, often on a daily basis, that would not resolve: depression, suicidal thoughts, violent nightmares, panic attacks, and dissociative episodes. She was plagued with persistent feelings of anger, anxiety, fear, and self-loathing. She had once learned to control her symptoms with her alcohol use and her eating disorder. But now that she was in recovery from these maladaptive coping strategies, her symptoms were back. Lisa had long ago stopped trusting her ability to make healthy decisions, instead relying on the wisdom of a small network of recovering women in AA to tell her what she needed to do to stay in recovery. Knowing her history, and concerned about the depth and intensity of her anger that erupted with little provocation, they insisted that she find a therapist who could help her. Despite knowing that she would have to face painful memories, she gathered up her courage and scheduled her first appointment.

Right Brain to Right Brain Attunement

I found Lisa to be engaging, insightful, and highly attuned to my non-verbal behaviors. As we neared the end of our initial assessment session, she stated astutely, "You seem very anxious." I was taken aback by her perceptivity, for I had been noticing a low level of anxiety within me but thought I had kept it well hidden. I hesitated for a brief moment, deciding whether to choose professional denial or honest disclosure. Sensing that she would appreciate honesty, I admitted, "You are right, I am feeling a bit anxious."

"Why are you anxious? You don't think you can work with me?" she asked, as a look of concern crossed her face.

"I'm not quite sure why," I answered, and hearing the fear of rejection in her voice I continued, "but perhaps it is your chronic suicidality. I have worked with many suicidal clients but always in the context of a program where there was a team of people and easy access to a psychiatric inpatient program. This is new for me, working individually with someone who can become suicidal quite quickly."

"Don't worry," she assured me, "my suicidality scares me too. I promise I will put myself in the hospital if it gets bad." She appeared satisfied with my response although this exchange left me feeling a bit uneasy at the realization that she had so easily picked up on my emotional state.

From an attachment perspective, Lisa's hyper-vigilance to my internal state of arousal indicated that her attachment processes were activated. Mindful of my own anxiety, I was consciously trying not to let it show. Despite my efforts, Lisa perceived my internal state of anxiety from my apparent non-verbal communications of tone of voice, body posture, and subtle eye and facial movements that I was unaware of. According to Schore and Schore (2008) "these implicit nonconscious right brain/mind/body nonverbal communications are bidirectional and thereby intersubjective" (p. 14). Lisa and I were communicating without words in ways that were beyond either of our conscious attention. In the same way she perceived my anxious state, I intuitively recognized that she needed me to be open with her about my anxiety. I also detected in her the fear that I would reject her. I was clearly attuned to her affective state which would prove to be a critical aspect of the attachment relationship that was already developing between us.

Early Attachment Experiences

As we settled into our weekly therapy sessions, I began to get a better sense of what life was like for Lisa. The most difficult relationship she had was with her mother. "I really don't want to start hating my mother again," she declared, "right now I have a pretty good relationship with her."

Immediately wondering what this relationship was like in the past, I asked, "So it has not always been this good?"

A pained looked crossed her face, "No," she admitted and dropped her gaze. "When I was little she told me she did not know how to be a mother to a girl," she looked up with a wry smile, "and that was obvious!"

"How so?" I prompted.

"She never paid any attention to me unless I was doing something she didn't like." Lisa pulled out a small photo to show me. "I keep this picture of myself when I was seven in my wallet as a way to remember to have compassion for myself." The child in the picture was smiling and Lisa went on, "This doesn't even seem like me. I don't ever remember being happy as a child, and yet my mother insists that I was. When I was in rehab she sent me a poster full of pictures of me smiling just to prove to my counselor that I was happy. She had no idea how sad I was."

"And what happened when you did something she didn't like?" I asked.

"You mean when I messed up her idea of a perfect family?" Lisa grimaced. "I clearly remember her dragging me to a therapist when she discovered my eating disorder and demanding that the therapist 'fix me'."

"And she was different with your brothers?" I wondered aloud. Lisa was quiet for a moment, trying to remember. "When I was little, my younger brother would have these violent rages that scared me so much I would hide in the closet under the stairs. My mother would go to extremes to deny his behaviors. She would get angry with me for being so scared of him." Apparently this brother, who eventually was diagnosed with bipolar disorder, terrorized her frequently. A picture was being created in my mind of an emotionally sensitive child in a frightening family.

"Sometimes I would get so upset that I would cry," she said, "My dad and my brothers would tease me and call me a baby. That would make me cry even harder. My mom never made them stop." She sighed and looked at me, her eyes showing the hurt that she still felt. "I was not like them, I didn't fit in. I always believed something was wrong with me. I still do."

Lisa recalled desperately wanting to be connected to her mother, but constantly felt the pain of her emotional absence. According to attachment theory, an inability to attach to your child often reflects insecure attachment to one's own parent. "What kind of a relationship did your mother have with her mother?" I asked her.

"My grandmother was schizophrenic and had severe OCD. I think she was often in the hospital," Lisa explained. "My mom rarely talked about her childhood. She shared one memory of being given a bath when she was little and being scrubbed by her mother until her skin was literally raw and bleeding."

I cringed internally at the image this brought to my mind. "And what was your relationship like with your grandmother?" I asked her.

Lisa smiled "I was very close to my grandmother. I have good memories of spending time with her. I knew that she loved me, and I loved her." I nodded and smiled back. "She gave you what your mother couldn't give you, love and attention."

Lisa paused for a moment and said thoughtfully, "I think my mother was jealous of our relationship."

The relationship with her mother did not improve as Lisa got older. During her junior year in college Lisa was diagnosed with Hodgkin's Lymphoma, a potentially fatal cancer. She left college, returning home for heavy chemotherapy treatment and her mother's care. Lisa remembers how much she needed and hated her mother during her serious illness and difficult treatment.

"She was angry that she had to care for me," Lisa declared. "One day I had to go to the doctor and even though my hair was falling out, I wanted it washed. So I asked her

to do it. I could tell she was angry because she was very rough, it hurt!" I detected tears in Lisa's eyes and felt my eyes moisten. "My cancer was very inconvenient for her," she concluded.

Intergenerational Transmission of Attachment

It was becoming clear to me that Lisa's mother had difficulty tolerating negative emotions in her daughter and could not respond with empathy when Lisa was in pain. In turn Lisa had begun to hide her vulnerable emotional states, first with her eating disorder and then with alcohol. Bowlby (1988) recognizes that "when a mother responds favourably [*sic*] only to certain of her child's emotional communications and turns a blind eye or actively discourages others, a pattern is set for the child to identify with the favoured [*sic*] responses and to disown the others" (p.132). This interfered with the development of a secure attachment between Lisa and her mother. Mary Main, one of the early attachment researchers who worked closely with Bowlby, developed the adult attachment interview as a way to explore the potential for the intergenerational transmission of attachment patterns. Through her research, she found evidence to suggest that parents with insecure attachment could pass this on to their children (Hesse and Main 1999; Main 2000). I suspected that this was the case with Lisa. Her grandmother was incapable of creating a secure attachment to Lisa's mother, due to her mental illness. In turn, Lisa's mother did not have the capacity to provide Lisa with a secure attachment relationship due to her insecure attachment style that was complicated by her own mental health issues. In order to avoid perpetuating this generational transmission of insecure attachment, Lisa would need to experience a secure attachment relationship not only to reap the emotional benefits but also so that she could provide it to her future child.

Lisa and I often spoke about attachment theory as it related to her and her husband's process of preparing for an international adoption. "The adoption agency gave us a book about attachment. They say it is really important to understand how to develop a healthy attachment with an adopted child especially since we will most likely adopt a toddler," Lisa explained to me one day in our session. "But you know what I really worry about?"

"What?" I asked, sensing deep concern in her voice.

"I am afraid that I won't be a good mother because I didn't learn how to be a mom from my mother," she answered.

In the book she was reading, *Adoption Parenting*, she was learning that due to the intergenerational transmission of attachment style, her own child was at risk of developing the same insecure attachment style as she. One contributor to the book, Reilly (2006), referenced Mary Main's notion of *earned secure attachment.* She stated "she [Mary Main] discovered that adults who started with less than secure attachment styles, could, with work, reach secure attachment status" (p. 131). This concept of earned secure attachment was developed out of the research with the Adult Attachment Interview when it was discovered that some individuals whose scores reflected a secure attachment described unfavorable attachment related experiences as children (Hesse 1999, p. 401). At some point in their life these individuals must have developed a relationship with another attachment figure leading them to move from insecure to secure. I reassured Lisa that through the process of working through her negative childhood experiences she would be able to achieve positive attachment relationships with others, including with her child (McCarthy and Maughan 2010). I had no idea how instrumental her attachment to me would become in this process, helping her to earn this secure attachment.

Childhood Sexual Trauma

In addition to the relational trauma that characterized Lisa's early years, she also had fragmented memories of being sexually molested by a female pediatrician as a child. Poor recollection of trauma memories is common, due to the way that the original memory is stored in the brain. Citing the work of Pierre Janet in the late nineteenth century, Herman (1997) states "Janet demonstrated that the traumatic memories were preserved in an abnormal state, set apart from ordinary consciousness. He believed that the severing of the normal connections of memory, knowledge, and emotion resulted from intense emotional reactions to traumatic events" (p. 34–35). Typically, traumatic memories return in the form of intrusive images, sensations, and feelings (van der Kolk 1998). Having worked with many women whose trauma memories were inaccessible, Lisa's lack of memory did not concern me. But it led Lisa to consistently doubt her experience.

Lisa was born with the genetic condition neurofibromatosis, a disorder characterized by the growth of usually benign tumors on the nerves, and visits to her pediatrician were frequent. In addition to her vague memories of being inappropriately touched, she remembers feelings of fear and helplessness connected to the uncomfortable and humiliating examinations the doctor performed on her, often without a parent present. These examinations, according to her own research, went well beyond anything that her condition required. And her mother did not protect her. She could recall one particular visit when, as she was being led to the examination room, she looked desperately back over her shoulder and caught her mother's eye, pleading for her

to intervene. Her mother responded with a look of helplessness and turned away. Despite the fact that Lisa's mother maintains her denial that anything abusive occurred in that doctor's office, Lisa holds firm to her belief that her mother knew that something was not right. Lisa has tried to gather information from her brothers, who also were treated by this same doctor, but while they admit that the doctor was "weird", they dismiss their sister's claims that the pediatrician acted inappropriately. Because of her own vague memories and the lack of validation from her family, Lisa constantly vacillated between believing that this really happened to her and thinking that she must have imagined everything. This was a common theme in many of our sessions and I often had to provide validation that, based on the severity of her symptoms, something traumatic had happened to her.

Telling Her Story

In the beginning, Lisa had difficulty putting her story into words. Bessel van der Kolk, a renowned trauma researcher, discovered that when someone is experiencing a traumatic event, a section of the brain, "the Broca's area, the part of the left hemisphere responsible for translating personal experiences into communicable language, 'turned off'" (van der Kolk 1998, p. 104). It is common for trauma survivors to have difficulty verbalizing a coherent narrative of their experiences as there are no words to describe the horrific events. Often, utilizing creative modalities can help them to recount their story. *The PTSD Workbook* (Williams and Poijula 2002) suggests the use of collages to assist in the telling of trauma narratives and Lisa welcomed the creative collage assignments I gave her. She would complete them at home and bring them into our sessions. One of her assignments was to illustrate her life story.

"So tell me about your collage," I began as we viewed the long, narrow piece of artwork she laid at my feet. The collage was chaotic, filled with images and words cut from magazines, and crumpled papers glued to a background which was inundated with a staccato of handwritten words and phrases.

"This part is my childhood," she began, pointing to the first segment of her collage. My attention was drawn to a cluster of harsh red strips of paper covered by crumpled paper balls glued overtop. The words 'ignorance,' 'stupid,' 'stop clinging,' 'mother,' and 'afraid' surrounded this section of her collage. "What happened here?" I asked.

Silence hung in the air. "That's the doctor," was all she said. I waited. Her body collapsed into her chair and her chin dropped to her chest. "Lately I have been obsessed about it. I can't stop searching the internet for the doctor's name, worried that she is still practicing, hurting other children." She paused, looking up at me, "Sometimes I get worried that I made it all up, that nothing really happened. Could I have made it up? Am I crazy?" Her eyes searched mine, beseeching my response.

"Lisa, the symptoms you are experiencing now are 'normal' for someone who has experienced trauma as a child. I believe something happened. You are not crazy, you are traumatized." My reassurance brought some relief to her eyes, and her body appeared to visibly relax.

Dissociation

One of Lisa's common symptoms was to dissociate. Dissociation is understood as a psychological defense against trauma and "sometimes described as 'spacing out,' 'losing time,' or 'going blank,' it refers to detachment from the current reality that protects against overwhelming trauma related feeling or memories" (Najavits and Walsh 2012, p. 116). Often when Lisa would dissociate it would be more of an internal 'spacing out', barely noticeable by those around her. Other occurrences would be very obvious and embarrassing. One night she was at a meeting and a fight broke out in the group. It seemed like everyone was screaming at each other. She panicked and the next thing she knew she was hiding behind the refrigerator in the kitchen, shaking uncontrollably. She had no idea how she got there or how long she was there before becoming aware of her surroundings. Occasionally Lisa would dissociate in our sessions.

"I had to go to the doctor today, for my yearly checkup. I hate going to the doctor. I feel like I am going to pass out. I think I almost did!" Lisa wrapped her sweater close to her body.

"It makes sense that doctor visits make you uncomfortable," I offered, "it probably brings back bad memories or feelings of when your mother brought you…" I stopped talking, noticing a shift in her body. Her eyes did not appear focused and her body was unusually still.

A few moments passed; then her body startled suddenly and she shook her head sharply. "I'm sorry," she apologized, "what were you saying? My mind went somewhere else."

I agreed. "Yes, it did seem like you had left the room. I think you dissociated for a moment."

Lisa put her hand to her forehead, bowing her head slightly. "I hate when that happens. I don't know how to control it," she said. I was not alarmed and my calm response appeared to help Lisa to regain her composure. I could sense that these dissociative moments were frightening to Lisa and we decided to work together to help her gain control over them.

My treatment interventions focused on establishing safety around Lisa's tendency to dissociate when emotionally overwhelmed. Providing her with education on what was happening in her brain when she dissociated was helpful, and she was motivated to learn techniques that would help her stay in the present moment. I explained to her the concept of the triune brain: the reptilian (instinctual brain), the limbic system (emotional brain), and the prefrontal cortex (cognitive brain) (MacLean 1993). She responded positively to the idea that when she is overwhelmed, her emotional brain 'hijacks' her cognitive brain (Goleman 1995), shutting down her capacity to think clearly and leading to an instinctual fight-or-flight reaction. She practiced how to ground herself, or bring herself back into her cognitive brain, by using her five senses (Najavits 2001). She discovered that by focusing on her sense of touch, she could stay present longer. In our sessions, she practiced touching rough surfaces, such as her clothing fabric, as a way to ground. Lisa was empowered by the experience of being able to exert some control over her dissociative tendencies. I also convinced her of the importance of self soothing as another affect regulation technique. She used a favorite old sweater to curl up in when her emotions felt overwhelming and she often wore this sweater to our sessions. She was soothed by the feeling of clean bed sheets and would put them on her bed when feeling emotionally triggered. I noticed less and less dissociation when we discussed emotionally laden topics as she became adept at staying present. At the end of a difficult session I would ask her to identify what she was going to do to take care of herself that night as a way to self sooth. She was usually able to choose something from her list and follow through with doing it. Lisa was slowly learning how to modulate her overwhelming emotions and to self sooth after experiencing emotional overload.

Family Dynamics

Interactions with any one of her family members had the potential to threaten the progress she would make in therapy, shattering her precarious self confidence with one passive-aggressive comment. Lisa's preferred mode of communication with her parents and brothers was email, which seemed less emotionally triggering to her but left her making assumptions about the meaning behind their written words. Lisa began to avoid family gatherings because these face-to-face interactions would trigger memories of the emotional abuse she experienced in the family as a child, often reigniting her suicidal thoughts and cravings. Her absence at family events led to accusations she was being selfish. Lisa attempted to initiate email conversations with her family about why she felt the need to distance herself from them.

> I am sending this to everybody because I think this needs to be said. In the past three years I have been working very hard on myself. This has been contingent upon avoiding conversations and situations in which my recovery is threatened. I have had conversations with you, dad, and my brothers in which my alcoholism, my eating disorder and my personal memories of past traumatic experiences have been brought into question. This is more dangerous for me than I can say since there is nothing more that I would like to do than to get drunk and not feel what I have been feeling these past few years.
> There is nothing more that I would like than to have a healthy relationship with this family. If you don't think I am hurt by all of this, you are mistaken. I understand that this is going to take a lot of work from all of us, but please understand my sobriety and my personal wellbeing will always have to be my priority. I really do love this family. Any actions I have taken that may have offended you, were not meant out of anger, resentment, etc. They were taken out of loyalty to myself, to being well and to creating a home that will meet the needs of our future child.

Her plea for understanding was rejected. It appeared that her mother held the power in the family and was clearly invested in protecting an image of a happy and healthy family. Her brothers and father stood staunchly behind their mother's version, leaving Lisa mired in agonizing rejection as she exposed an alternate truth about her childhood. Their email responses were hurtful, harshly accusing her of being self-absorbed, callous and even abusive. Her youngest brother went so far as to tell her he did not want any further contact with her. Lisa's resolve crumbled.

It took weeks for me to repair the damage that these emails inflicted upon Lisa. Self-doubt and self-loathing returned with a vengeance along with suicidal ideations, nightmares and cravings for alcohol. It was difficult for me to see Lisa in such distress and I found myself becoming angry at her family for the pain they inflicted upon her. I needed to modulate my own anger so that I could respond to her in a manner similar to what a mother does for her infant child "to bear within herself, to process, and to represent to the baby in a tolerable form what was previously the baby's intolerable emotional experience" (Wallin 2007, p. 48). I reflected internally on the intent behind their motives. Perhaps they were all responding from their own pain, equally affected by the same events Lisa was revealing, but unable to acknowledge this reality. Out of self protection they needed to convince her she was the one

who was causing the pain. Through my own inner reflective functioning I felt my anger being replaced with empathy. In response to my ability to process and shift my emotional reaction, I believe Lisa was able to slowly regulate her heightened emotional response to the emails and ground herself. Her symptoms receded.

The Relationship with Mom

Our therapeutic relationship was beginning to resemble a secure attachment. This proved to be invaluable in a phone session I facilitated between Lisa and her mother about a month later. Knowing that her daughter was working with a therapist, Lisa's mother asked to be part of a family session via telephone as she lived quite a distance away. Lisa and I discussed the pros and cons of having this phone conversation. I voiced my hesitation at being able to successfully manage a family session via telephone. Lisa expressed her reluctance to give into her mother's demand, seeing this as another way her mother was taking control. But she also wanted me to experience what it was like to talk with her mother. We wrestled with this decision for a few sessions and finally Lisa made the decision to schedule a phone session with her mother. Lisa and I discussed her goals for the conversation and I naively thought we were prepared for what was to come. I dialed the phone and her mother picked up quickly.

"Thank you for being willing to participate in a phone session," I began, "I am hoping that you are aware that over the past two years Lisa has been working hard and that things have been difficult for her."

Her mother responded, "Yes, and I feel very unloved, unappreciated, unwanted, and I am in great pain!" The volume of her voice began to rise. "I feel that Lisa is afraid of being with me and talking to me. I feel that my needs are unable to be met, and I am powerless since our relationship depends on Lisa's desire and ability to engage. I just want her to come to visit us, is that too much to ask?"

Lisa spoke next, "You know I want to come but I can't right now, I have told you that!"

Her mother interrupted. "It's always all about you and what you want, isn't it, Lisa! You do not want to be a part of this family!" Lisa began to protest but her mother cut her off again.

"You don't even know what is going on with Sara," she said accusingly. A look of shock passed over Lisa's face; Sara was her youngest niece.

"Mom, what's going on with Sara?"

Her mom's voice took on a shaming tone, "See, now you want to know." There was a long silence on the other end of the phone as if she were debating to share the information or not. Finally she relented.

"Well just for your information she is going to a specialist for precancerous and basal cell skin conditions. If you would stay in touch you would know that." I watched Lisa crumble before my eyes, clearly stunned by the fact that her family had kept this information from her. I began to question whether my agreeing to facilitate this phone session had been wise, considering the impact it was having on Lisa.

As the phone call continued, her mother dominated the conversation and was critical and insensitive, accusing Lisa of being selfish and making up things about her family. It was apparent that she saw this as her opportunity to let me know the 'real' truth about Lisa, sharing with me how difficult she was as a child. "I did everything I could do to help her," she insisted, "but she would not cooperate."

Lisa's mother painted a picture of herself as the sacrificial mother to a daughter who refused her mother's help. Lisa attempted to respond to her mother's diatribe with little success. I tried valiantly to turn the conversation to a more positive direction to no avail. The call lasted an interminable forty minutes before I was able to bring the phone session to an end. Lisa's mother ended with this question for me.

"What can I do to get Lisa back in my life? I just want her to visit!"

"I suggest you give Lisa the time she needs and wait for her to decide when she is ready to come for a visit," I responded.

"You are asking me for too much. I cannot do that," she replied.

The call ended and Lisa's eyes met mine for a moment; an understanding silently passed between us. No one, except her husband, had borne witness to the helplessness that Lisa had always experienced with her mother, even as a child. I worried about the potential damage this intervention may have caused for Lisa, exposing her to more emotional abuse from her mother. Unable to protect her during the phone call, I could only feel helpless alongside her. Apparently this was enough. According to Schore and Schore (2008) "the intersubjective work of psychotherapy is not defined by what the therapist does for the patient…rather the key mechanism is how to be with the patient, especially during affectively stressful moments" (p. 17). This moment of psychobiological attunement appeared to strengthen our attachment and renew Lisa's trust in her version of reality. Despite this outcome, I made the decision to not facilitate any more family sessions by phone; a decision that Lisa gratefully agreed to.

With Lisa feeling more secure in our relationship, our work together took on a new energy. Lisa began to accept that her mother was not going to change and her ability to control her emotional reactions to her improved. The guilt-inducing emails continued and with my support, she was

able to not respond out of anger or spite. When challenged on her version of events, Lisa steadfastly held to her convictions that her perception of her childhood was valid. She continued to keep strong physical boundaries, refusing to attend family gatherings where she knew that the combination of family dynamics, alcohol, and food could trigger a dangerous relapse. She was better able to withstand the demands from her family to attend these events. Her cravings decreased and her suicidal ideations became quieter and less frequent. This provided us with some relief from our hyper-vigilant focus on these distressing thoughts and created an opening for her to attend to a part of herself that she had been neglecting: her spiritual self.

Trauma and Spirituality

Lisa, like many trauma survivors, lived with an uneasy sense of God which she brought into therapy with her. Herman (1997) writes that traumatic events "undermine the belief systems that give meaning to human experience. They violate the victim's faith in a natural or divine order and cast the victim into a state of existential crisis" (p. 51). I was curious about the role spirituality played in Lisa's life because she often spoke about her belief in guardian angels, which are considered by many as belonging to the supernatural world. And she was strongly committed to the principles of AA, which are based on a belief in a higher power. Early on in our work together I had broached the topic by asking "Do you consider yourself to be religious or spiritual?" Immediately I noticed a subtle reaction as she shifted her eyes away.

She straightened in her seat. "Not really. I guess I would say 'avoidance' is a good way to describe me when it comes to those things."

"Mmmhmm, did you grow up in any religious tradition?" I probed.

Lisa looked back at me and grimaced. "My mom was Jewish, my dad Catholic. They did not talk about it much, didn't really push me in any direction."

"Do you believe in God?" I asked. Again, she looked away.

"There might be a God. I don't really understand what there is. My mom thinks believing in God is a weakness." She paused and then asked sharply, "I don't like to talk about this, it makes me anxious." I complied but my instincts told me that this was a topic that would arise again.

The subject did periodically come up in our sessions. I discovered that anxious was a mild descriptor of the feelings that were evoked when she talked about God. For most of her adult life she had been resisting a belief in a God whom she feared would only allow more bad things to happen if she were to acknowledge his existence. She was convinced that to do so she would expose herself as an easy target. This both terrified and angered her. Her anger was often triggered in AA meetings.

"I used to go to meetings with my hat pulled down over my eyes, and a scowl on my face, just daring someone to talk to me. Any time someone would start talking about how recovery depends on God I would get angry. Sometimes I would impulsively say something in the meeting and it came out pretty bad." The look on her face showed regret at how her anger had defined her. "They called me 'Angry Lisa' and many people were afraid of me."

"And now?" I asked.

"I still get very angry and frustrated at meetings and I try to avoid the more religious ones. But I can't stop going, meetings saved my life; it is how I keep sober. Now I think I am better at how I express my anger, I don't always say something. But the people who make God the most important part of recovery still infuriate me."

The concept of God promoted by the AA philosophy does not work for everyone and many people in recovery cannot get past the obvious religious aspect of the program. I wondered if Lisa would be able to let go of her fear and anger, and reconcile herself to a kinder, gentler God of her own understanding. Interestingly, as her work on her past trauma and relational issues progressed, she was less fearful when exploring her spiritual beliefs. She shared about her past exploration of Buddhism that included learning yoga and engaging in Buddhist practices to connect with the spiritual realm. But these activities apparently did not give her the answers she sought. She wrestled with the concept of God and whether or not she could believe in such a supernatural being.

From a psychoanalytic point of view, our psychological representation of a god-figure is directly connected to the type of relationship we have with our parents (Freud 1961; Rizzuto 1979). In her book *The Birth of the Living God,* Rizzuto (1979) applies an object-relations theory to the development of a child's image of God. She theorizes that "every human child will have some precarious God representation made out of his parental representations" (Rizzuto 1979, p. 52). If a child's internalized representation of his or her parents influences how they come to represent God, this would explain the difficulty Lisa was having in viewing God as a benevolent being. Neither her mother nor her father provided a positive introject from which she could develop a positive god-representation. In their empirical investigation of religion from a psychoanalytic object relations perspective, Hall et al. (1998) found that "individuals who tend to experience others as critical and to emotionally withdraw to protect themselves are more likely to experience God as critical and to emotionally withdraw from God when this experience occurs"

(p. 310). Lisa related to God in the same way she related to her parents; she kept her distance.

Some attachment theorists consider religious faith as a form of attachment. Granqvist and Kirkpatrick (2008) "argue that some core aspects of religious belief and behavior represent real manifestations of attachment processes similar to those seen in infant-caregiver relationships" (p. 906). One could surmise that if a child was insecurely attached to his or her primary caregiver this would lead to the development of a negative god-representation. Lisa's insecure attachment to her mother was feasibly connected to her fear of, and anger toward, God. It was interesting to notice that as Lisa worked through her attachment issues and gained more control over her emotional responses, her god-representation began to shift. This could also be attributed to her internalization of our relationship as a positive introject that transformed and reshaped her representation of God. Discussions about God and faith began to occur more frequently in our sessions as Lisa began to feel less anxiety while exploring these topics. She appeared to tune into the fact that I had a strong spiritual foundation. I attribute this to the implicit communication of my own religious values that naturally occurs when one is psychobiologically attuned with a client. It also reflects my relational style of working with clients. Without revealing my own religious beliefs I am always attentive to any spiritual leanings that my clients bring into our sessions and if they are willing, dig deeper. Inadvertently, information I chose not to disclose was discovered.

Self Disclosure

One day Lisa came into our session looking like she had a secret to share. "I have something I want to tell you. I have known this for a few weeks but wasn't sure if I should tell you," she began.

"What is it, tell me!" I played along.

"Well, two weeks ago I took my sponsee to a meeting in that church across the street, and I saw the name of the pastor on his office door." I immediately felt my body stiffen slightly. I knew what was coming next. "His name is the same as your name, which is not very common. I was wondering if you know him," she said. I gave into the resignation that swept through my body and unable to deny it, I acknowledged this to be true. "Yes, that's my husband."

"And that is your church?" she inquired. I nodded. Worried that this information would change her view of me, I asked, "Does it make a difference to you now that you know my husband is a minister?"

Lisa pondered my question for a moment, "No, not now. But if I had known that when I first met you I would never have come back. But now, I am kind of glad about it." I was relieved to hear that this new information was positive for Lisa. I was amazed at how Lisa embraced her new knowledge about me, her curiosity prompting her to initiate deeper discussions about faith. But I also found it disconcerting to soften my boundaries and share my beliefs in response to her inquiries. From the beginning, my relationship with Lisa was characterized by honesty on my part. I discovered that I needed to work at maintaining a balance between candor and restraint in order to maintain my professional role around a topic that has significant personal meaning for me. It was not always easy. For months she engaged with me around these spiritual issues, both repelled by and attracted to the idea that there might be a representation of God different from the one she came to know in her childhood. My therapeutic responses were carefully crafted to be as authentic and unbiased as possible so they would not be construed as an attempt to convert her to my beliefs. This was a difficult stance for me to sustain considering how strongly we were attuned to each other. Eventually it was her own creativity that helped her to have a breakthrough.

A Coherent Narrative

Long after I had stopped assigning creative collages as homework Lisa began to create her own visual journals, intuitively constructing a coherent narrative. In these journals she used a variety of collage techniques and mediums: magazine images, paint, stickers, letters, pins, ticket stubs, glitter pens, string, and an assortment of other unusual items. These journals became a place where she illustrated her life experiences, her self-image, her relationship with others, and ultimately, her relationship with God, through image, color, and shape. She would bring in her work to show me and I was impressed by how emotionally revealing these pages were, reflecting things about her that she had no words for. They often prompted new insights about herself that seemed to give her more and more hope about her future. Strewn throughout the journals were little notes she would write and cleverly tuck inside hidden pockets. She would bring her journal into sessions with her to show me her recent pages. I was astounded at the images that jumped from the pages.

"These are amazing, so creative! They seem to be helping you process some things," I commented as I turned the pages of one of her journals.

"I want your thoughts on something; here, let me show you," Lisa said as she took the journal from my hands. She turned to a page that had a small pocket attached to it. Undoing the string that held the pocket closed she pulled out a note and read it to me: "Dear Lisa, No matter what happens, you will survive this. You will be a mom and you

will live a long happy life. Love, me". She sat quietly for a long moment and then looked up and asked, clearly confused, "Who is 'me'?"

I waited in silence for a moment, measuring my response. "Hmmm, I'm wondering if it is a part of you writing a note to yourself."

"That's what I first thought, but now I don't think so," said Lisa decidedly.

"No? Who do you think it is?" I asked her.

"I don't know, it freaks me out to think about it!" she said quickly and, returning the note to its pocket, she turned to another page. The identity of the author of the notes in her journal remained unanswered that day.

Attachment to God

Lisa began experimenting with a new technique as part of her visual journaling: using two colored pens, she would record a dialogue between herself and someone other than herself. She did not share this with me when she initially started to do it, but did remark on occasion that her journals were becoming more spiritual. One day she presented to me her most recent completed journal. I started to open it, as was our routine, to view it while she waited for my response. She stopped me. She mentioned that there were some pages that were fastened shut and that I had her permission to open them after our session. Later that evening, alone in my home office, I opened her journal. As usual, I was awed by her imagery, and the raw emotions they expressed. I carefully undid one of heart-shaped brass fasteners that she used to seal two pages. It opened to a two-page spread of dialogue, alternating in black and red ink:

> I need to talk to you. **OK.** But I feel like an idiot. This whole process makes me feel almost schizophrenic or something. **Why do you say that?** Because! You are not really here! **Then who are you writing to?** I don't know?!? Myself? A second personality? I feel like I'm going crazy! **Is this what crazy would feel like?** guess not. **Are you uncomfortable?** No, I'm too comfortable. **And it scares you?** Yeah, I'm afraid that if I start to let you in, you are going to take over. You're going to allow stuff to happen to me without my consent. **Like what?** Cancer. Addiction. Bulimia. **Do you think I did that to you?** I don't know. I'm not one of those 'angry at god' people. I just don't want to give up the ability to protect myself from you.

She filled six solid pages with similar dialogue and from the content of her words I could surmise that she believed she was having a conversation with God. Lisa's relationship with God had always been marked by fear and this fear was dissipating, as her god-representation slowly shifted.

When I returned the journal to Lisa the next week, we talked about the conversations she believed she was having with God. She admitted that she had worried for a moment that I would finally, after all this time, announce that she was crazy. But because I had shared my beliefs, and due to the strength of our therapeutic relationship, she was able to extinguish her fear and openly explore her growing relationship with God.

One day she came into her session with a look on her face that told me something was different. She was hesitant and yet buoyant. I anticipated some good news about her family. "Something happened to me yesterday that was really powerful." Lisa had difficulty looking me in the eye.

"What was it?" I coaxed.

"I had another god-moment," she confessed, using a term she had coined to describe when she felt a spiritual presence. I sensed that this moment was different than others she had shared with me. She found the courage to meet my gaze. "Yesterday I had a really hard day emotionally and almost couldn't stand it." She stopped. "You are going to think I am really crazy when you hear this one!"

Her eyes had an intensity I had not seen before and I was the one who found it hard to keep eye contact. "I was in the shower and the pain was so great that I fell to my knees," she paused and took a breath, "and I liked the view."

In her gaze I saw relief and trepidation, her eyes seeking mine for affirmation. "Kinda like a prayer?" I asked her tentatively. She nodded. "And you are worried, as usual, that I might think you are crazy." She nodded, continuing to maintain steady eye contact.

My response matched the intensity of her gaze, "You're not crazy!" She smiled sheepishly.

It took me a moment to understand the significance of Lisa's confession. For over two years she had fought to resist a strong spiritual pull, toward something or someone whom she feared. That morning in the shower she gave up her fight and succumbed to its presence by assuming a posture of prayer. Lisa's transformational moment in the shower was the culmination of the excruciating process of redefining her family relationships, the painstaking creation of a coherent narrative in her visual journal and her honest conversations with God. And all of this was grounded in my ability to provide for her a secure base to return to for emotional regulation in our weekly ritual of psychotherapy.

The day that she shared with me her experience in the shower was the same day she decided that she was ready to start coming less frequently. Throughout our lengthy termination stage, things began to change in her relationship with her mother. Lisa's developing capacity to set firm emotional boundaries coupled with the impending adoption

of a child appeared to bring about a subtle transformation in her mother. The emails became less accusatory and more supportive. This in turn prompted Lisa to tentatively initiate phone contact with her mother and she finally agreed to a long overdue visit to her parents' home. The changes in the mother-daughter relationship were connected to her own transformational experiences: her decision to seek therapy, the security of her attachment to me, the phone session with her mother, her dialogue with God, and finally, the prayer-like moment in the shower. And yet the final test was yet to come with the long awaited adoption of their daughter.

Attachment to Her Daughter

Finally, after enduring an extensive two year adoption process that Lisa described as "having every corner of my life scrutinized by strangers", they received news that their dossier was accepted by all the necessary parties involved. Lisa and her husband Eric immediately embarked on their trip overseas to meet their daughter Angie and bring her back to her new home and family. They returned five weeks later with their daughter and, no longer anxiety-ridden about her ability to be a mother, Lisa embraced her new role with confidence. Our sessions resumed but were scheduled less frequently as Lisa was able to maintain her emotional stability while transitioning into full-time motherhood. As her life settled into its new routine, our sessions focused on the developing attachment with her daughter and Lisa's tendency to be an overprotective mother. Eric, on the other hand, possessed a more easy-going style of parenting that made Lisa uncomfortable.

Throughout our work, Lisa and Eric occasionally came in together for a joint session, offering me an ongoing opportunity to assess the marital relationship. I did not find any evidence that Lisa's attachment issues were being played out in her relationship with her husband and these sessions primarily focused on educating him about what Lisa was experiencing so he could be supportive of the process. This time, Lisa requested a joint session with Eric to address problems she was having with his family's interactions with their daughter. She asked if it was okay to bring her daughter Angie with them. She really wanted me to meet her. I agreed, as I too wanted to meet this little girl who had been the topic of our sessions for the last year or so. She was beautiful. Her eyes were bright and she smiled shyly at me from her father's arms, hiding her face in his neck when I greeted her. We entered the office and sat down. Angie perched in her father's lap, curious but cautious. Lisa began to speak about her concerns.

"Eric's family is so excited when we visit and they are all over Angie. It is too much for her! And they want to babysit Angie all the time. But her cousins are older and very rough with her. Angie gets very overwhelmed when we visit with them. No one seems to be bothered by this but me." She looked pointedly at her husband. Eric shrugged and she continued. "Angie is now hitting and biting. I don't think we should let her go there. We need to set strong boundaries!"

Her emotions were heightened, and she looked to me for validation. This was a typical response for Lisa when she felt overwhelmed and out of control. Her instinctive response to overwhelming situations was to take flight, and now her protective instincts toward her daughter were being activated. But based on the amount of work we had done on emotional regulating and trusting our on-going right brain to right brain attunement that had been continuous throughout our relationship, I was confident in her ability to regulate her emotions. As our eyes connected she appeared to relax into her chair. I turned to Eric and asked for his opinion on what was going on.

By this time Angie had gathered up the courage to slip off of her father's lap. I found myself paying attention to her movements while the conversation continued. She toddled over to her mother and touched her knee, looking up to her face. Lisa made eye contact and gave her an encouraging smile. Angie appeared to interpret this as permission to explore as she toddled a few feet over to my bookshelf. She looked back over her shoulder and both parents paused their conversation to speak to her playfully. She smiled and then toddled quickly back to her father's knee. She buried her face in his lap and then looked up at his face. She then returned to her tentative exploration of my office always checking back in with her parents for approval and reassurance. Upon occasion she would toddle back to where they were sitting, touch one of them and then roam away for a few moments. Occasionally she would wander close to my chair, stop a safe distance away and look at me. When I caught her eye she would smile shyly but turn quickly to return to her mother's arms. I was completely amazed to be witnessing such basic attachment behaviors so soon after the adoption. After seven months, Angie was clearly attaching to her primary caregivers. And both Lisa and Eric were responding naturally, providing a secure base for their daughter to explore this new space, even with a stranger in the room.

Despite being distracted by Angie's movements, I was still tuned into the relational dynamics between Lisa and Eric. Lisa's instinct to withdraw and her interpretation of Eric's response as unsupportive reflected the activation of her insecure attachment style. I was able to gently confront her because I trusted the secure attachment relationship that we had developed. I also understood that Lisa's need to withdraw was a protective gesture and not really what she truly wanted. Eric's family offered to her what her family

could not—relationships that could tolerate conflict and an openness to resolve problems that inevitably arise in families. I suspected that this frightened Lisa, who for so long needed to navigate familial relationships where her perspective was not respected. They ended the session agreeing to approach Eric's family as a united front, communicating their concerns and asking for their help to solve the problem.

Termination

As they were leaving, Lisa said she would email me to set up her next appointment. She never followed through with that email and her treatment ended. This did not come as a surprise to me as I sensed intuitively that she was done with therapy. Her experience of a secure attachment with me appeared to repair some of her dysfunctional adult attachment behaviors, moving her from an insecure to an earned secure attachment style. Interactions with her mother no longer had the power to emotionally hijack her, as she was able to practice effective emotional regulation strategies. At the time of her last session she had not had a craving to drink or experienced suicidal thoughts in over ten months. She still followed a strict food plan although since adopting Angie, thoughts of food no longer dominated her day. She had also demonstrated the capacity to develop a healthy bond with her adopted daughter, overcoming her long held fears that she was destined to pass on her insecure attachment style to her child. And miraculously, she had not had any dissociative moments after becoming Angie's mother. One of her biggest fears had been that she would dissociate in the presence of her daughter and put her at risk of harm. Because of the work she had done in therapy, this fear was not realized. And finally, she had developed a spiritual attachment to God, her higher power. Four months after our last session I received this email from Lisa:

> I have been meaning to contact you for some time now. I guess my hesitation had to do with time slipping away from me and a fear of telling you that I believe my time in therapy has come to a close. I am quite sure that I would not have the life I have today if our paths had not crossed. I came to you a broken mess. Today I feel strong and at peace. Angie is thriving. She turned two in February and started school last week. She talks non-stop and charms everyone she meets. I never thought I'd enjoy life so much. I came to you barely able to tolerate myself. I was pushed around by all these monsters. While they still exist and there are symptoms I must manage, my visual journals are brighter than ever and my life is filled with hope and compassion for myself and others. The 'conversations' I've been writing continue to help me a great deal, and my faith is at a place I never thought it would be. Spiritual fitness was never one of our goals, but I think it was the thing I needed most. I don't think any other therapist could have provided me with that. The words "thank you" are insufficient.

Concluding Thoughts

Is the therapeutic relationship as powerful as the research claims it to be? This is the question that lingers for me long after my sessions with Lisa ended. Based on Herman's (1997) hypothesis that relational trauma can only be healed in a relationship, I am convinced that our relationship was a critical factor in the healing that Lisa experienced. And I surmise that it was because the bond that formed between Lisa and I resembled an early attachment relationship mimicking the biological attachment process between infant and caregiver that is thought to be the foundation of emotional survival and development (Bowlby 1988; Schore, 2000). When I look back at this relationship through the lens of attachment theory, it seems to explain so much of what occurred between us.

It is important, however, to acknowledge that although attachment theory appears to be widely accepted as a valid lens through which to view the therapeutic relationship, it has its critics. One of the most vocal is Jerome Kagan, a developmental psychologist and professor emeritus at Harvard. Kagan (2011) challenges one of the basic assumptions of attachment theory, "that the quality of attachment in infancy has a permanent effect on the child, independent of future experiences or the child's social class and culture" (p. 31–32). He claims that there is no research to support the claim that experiences in infanthood and early childhood will impact an individual's ability to form healthy relationships in adulthood. He also criticizes the theory for failing "to recognize the profound influence of social class, gender, ethnicity and culture on personality development" (Kagan 2011, p. 50). He considers the varied responses of children in the famous Strange Situation experiences, upon which attachment theory is built, to reflect temperament, not the strength or weakness of the attachment bond (Kagan 1998). Kagan would consider Lisa's temperament to have greater influence on her ability to regulate her affect and overcome her relational difficulties than the therapeutic relationship that formed between us. Nevertheless, if I place Lisa in the figurative role of infant, and myself as

caregiver, the processes of attachment appeared to be operating in the experience.

First, this was apparent in the affective attunement that occurred allowing us to "feel what the other was feeling and to convey the fact of this shared experience" (Wallin 2007, p. 53). This transpired in our first session when Lisa was attuned to my anxiety as much as I was to hers. This was not the only time I experienced our right brains nonverbally communicating with each other, analogous to what occurs between a child and its mother. If it is true that early attachment experiences contribute to the neurobiological development of the right brain (Schore and Schore 2008) then it is possible that my affective attunement to Lisa's emotional states potentially altered the structure of her right brain so as to create attachment security (Schore 2009). Second, I engaged in a task that is usually facilitated by a primary attachment figure, that of the implicit transmission of affect regulation. "Secure attachment depends upon the mother's sensitive psychobiological attunement to the infant's dynamically shifting internal states of arousal.…The mother appraises the nonverbal expressions of the infant's arousal and affective states, regulates them, and communicates them back to the infant (Schore 2009). Lisa often came into our sessions in a hyper-aroused emotional state and my ability to regulate my emotional state in response to her distress enabled me to become a safe and secure base, assisting her in tolerating and modulating unbearable emotions. I became her emotional regulator while she learned and practiced self-regulation with grounding skills, self-soothing activities, and the use of creative artwork, ultimately allowing herself to feel difficult emotions without the use of substances.

Transformative change occurs within our clients and we are privileged to be a witness and a participant in it. Lisa's transformation into a healthy relational adult was a slow, painful, and ultimately successful journey. It is only in retrospect that I began to see how the process of attachment may have been the intuitive force fueling her efforts toward change. If the potential for attachment is what truly gives the therapeutic relationship such transformational power, imagine how this could change clinical treatment. Indeed, such a paradigm shift is already happening as there is a shift away from cognition toward bodily based emotion in psychotherapy as a result of advances in neuroscience (Schore 2012). Instead of being focused primarily on what clinicians *do* with clients in our evidenced-based practices, more attention would be paid to knowing how to *be* with clients. This is the direction that research is leading us. I wonder how the treatment world, so deeply entrenched in evidenced-based cognitive behavioral interventions, will respond.

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