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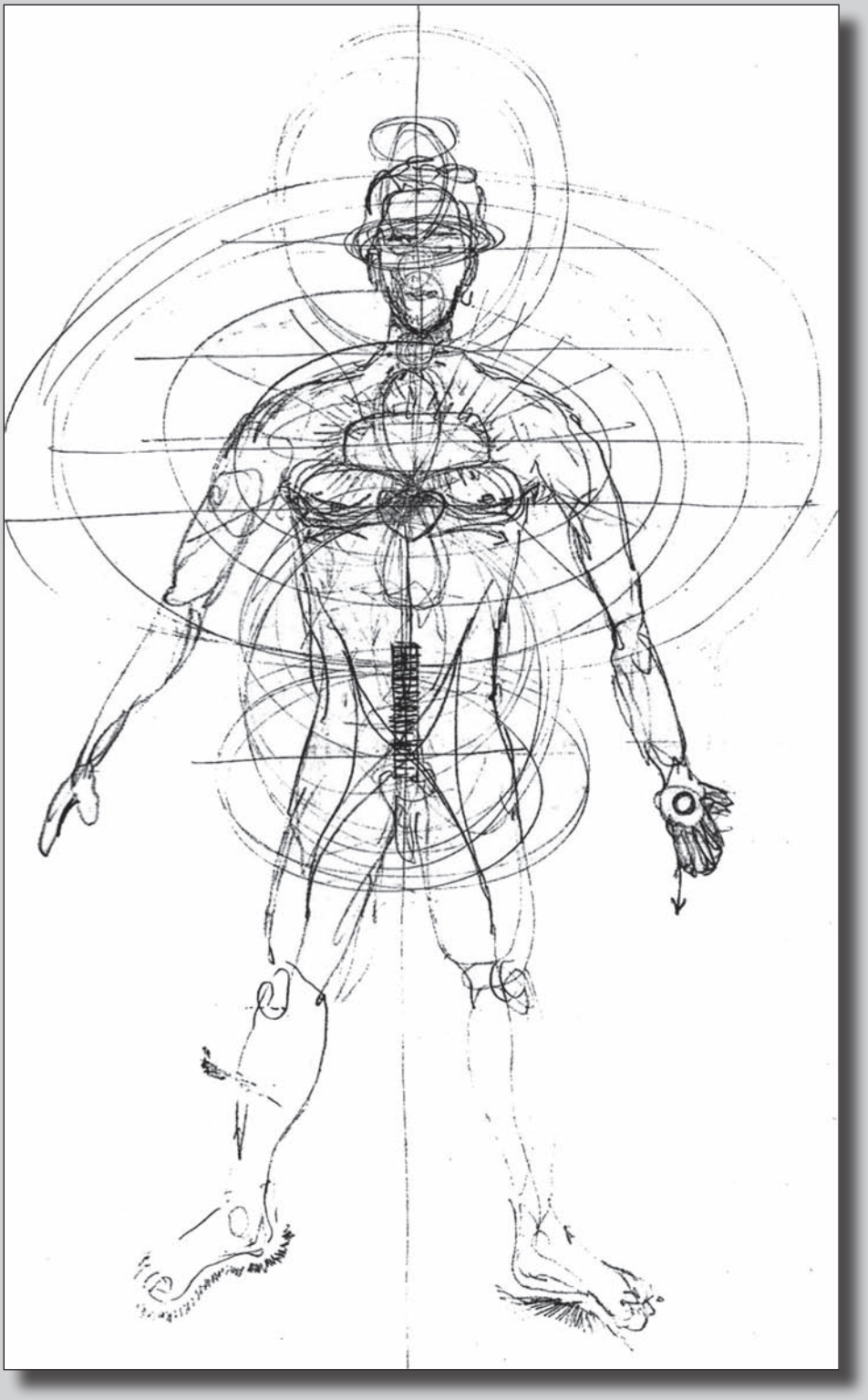

Attachment Theory and the Therapeutic Relationship

By Heather L. Corwin, PhD, MFA, Certified Rolfer™

"Safety and security don't just happen, they are the result of collective consensus and public investment. We owe our children, the most vulnerable citizens in our society, a life free of violence and fear."

Nelson Mandela

Attachment Theory

Attachment theory was pioneered by John Bowlby (1958, 1982) who looked at the child's ability to regulate emotions in relationship to the proximity of a primary caregiver (usually the mother) to whom the child can run if he feels he is in danger. The more secure the attachment, the more the child is able to investigate his or her world feeling safe. Similar to attachment theory is an effective therapeutic relationship, though this relationship most often occurs between adults. A therapeutic relationship has many components, but the foundation is trust combined with the interest of the 'caregiver' (e.g., therapist or practitioner) in supporting and facilitating the client's health, which is similar to secure attachment. What the therapeutic relationship adds beyond trust and health is both the caregiver and client actively participate in addressing the client's barriers to wellness. What this article will discuss is how the elements of secure attachment combine with the therapeutic relationship to foster wellness in the minds and bodies of our clients.

Going through your day, do you ever think about the elements that make you feel safe or comfortable (assuming you do experience those feelings)? In children, secure attachment is most evident through a child's ability to easily seek out and accept comfort from their parents. Securely attached children probably have parents who are sensitive and responsive to the child's needs (Ainsworth et al, 1978). Secure attachment is "when a child thrives in her environment as a direct result of her caregiver's efforts" (Corwin 2012, 39). Part of our ability to be able to take in information has to do with how we have been taught to do so, consciously or unconsciously, by our caregivers. Ideally, we are supported through our developmental stages in learning how to manage the vast amount of information around us, which helps us develop the necessary management tools to not just survive, but thrive. An example of this would be in the process of emotional regulation. Infants are not capable of regulating emotions and learn to do so by connecting with the caregiver's ability to regulate emotions (Schore 2001; Seigel and Hartzell 2003). Specifically, the part of the parent's brain that regulates emotions links with the child's in such a way that the parent's ability is then transferred to the child (Schore and Schore 2008). As bodyworkers, this is important to know because how we relate to our clients can mimic a supportive parental relationship. We are caregivers.

Why Security Matters in the Therapeutic Relationship

Security is mostly a superstition. It does not exist in nature, nor do the children of men as a whole experience it. Avoiding danger is no safer in the long run than outright exposure. Life is either a daring adventure, or nothing.

Helen Keller

It is possible for a person who has not had the experience of feeling supported and nurtured to have that opportunity through the therapeutic relationship – whether through therapy or through the Rolfing® Structural Integration (SI) process – to discover what a safe, trustful, and secure relationship feels like. However, a person who has not had much success in interpersonal relationships often has challenges in the arena of trust, and will push a caregiver through acting out. This is also known as testing boundaries. Acting out occurs consciously and unconsciously, and may seem like sabotage to some. However, please note that people who grow up learning that their needs are not important will not easily be able to recognize or believe otherwise, even if they understand this dynamic logically exists. Some examples of people who may have trouble with secure relationships include, but are not limited to, a wide variety of abuse survivors, adults who lost a parent at a young age (which may manifest as abandonment), children of alcoholics, children of divorced parents, and more. Ways in which insecure relationships can manifest include eating disorders, anxiety, dissociation, depression, and more. Blame is not helpful in addressing secure attachment, but understanding the history of your client is important to identify the challenges you will both face in relationship with each other. Secure relationships create the space to redefine how a person can be in relationship with another person in a way that's supportive, nurturing, and fulfilling.

A useful tool to gauge where a person might be on the secure attachment spectrum is a health-history intake form. Ron Kurtz, who created and practiced Hakomi therapy, spoke of not needing to take a formal history from his clients. He said that clients' history walked into the room with them. Though I wish I could intuit a person's history like that, I do need intake forms to help me understand the path that led the client to our working together. Before I earned my PhD in clinical psychology, many new clients in my Rolfing practice would not mention any anxiety disorders or past abuse for a variety of reasons. When I would tactfully ask directly about past experiences, ensuring confidentiality, clients would become more forthcoming with pertinent history like abuse or anxiety. I didn't always ask in the first session, because people need to feel trust before revealing events that they may feel are none of my business. However, that type of information is vital for me to mindfully lead our work together.

Shame can be a powerful silencer, but the body never lies. Physical evidence of a client having an insecure attachment style may include an engagement of the sympathetic nervous system (sweating, avoiding eye contact, fight, flight, or freeze) when work begins. To be clear, these sympathetic cues can be signs that the work is moving too fast for the client to integrate, or that there is past trauma that is active in the moment, yet these too can be evidence of an insecure attachment style. Regardless of the reason, when you can tell a person's sympathetic nervous system has been activated, slowing down and asking questions is necessary. The questions can begin with physical observations. For example, "I notice you're perspiring. Can you tell me what you feel

like inside right now?" An observation is made and an open-ended question is asked, avoiding judgment, to discover what the client is thinking and experiencing. This simple observe-and-ask protocol has often helped me build trust with my clients. I believe this is true because not many people are asked about their experience by others with a sincere curiosity. This process introduces to the client ways of regulating his or her nervous system.

Security matters because this therapeutic bond allows a person to learn or relearn ways of being that allow the nervous system to remain on an even keel and avoid overstimulation. When this relearning happens, it allows a person to be present and engaged when forming and participating in relationships through talking and listening, because that's what the client and I practice together in my studio. Consequently, we as Rolfers and as therapists are able to assist clients in having healthy interactions with others.

Dyad Means Two
People Working Together

An interesting part of the therapeutic relationship is that the interest goes in one direction, to the client. Though we as practitioners can and do share some of our own stories, doing so is usually in support of and/or mirroring feelings or experiences for the client – confirming that she is not alone in her experience – and modeling secure-attachment caregiver behavior. For the secure or well-adjusted client, being heard can be enough to heal a fissure of hurt. The insecure client may have to separately and clearly observe/name being witnessed, heard, believed, and supported to have the possibility of *becoming* secure. To be clear, insecure adults *can* become secure. This transition can occur when engaged in loving relationships with secure adults. Specific ways that we can facilitate security in the therapeutic relationship with our clients is to name when changes in the room are happening. For example, I have a client who has a history of childhood sexual abuse. She's been in 'talk therapy' for years and on the outside seems like a well-adjusted, smart, and unhurt person. Much of the time, she is fully functioning. However, when touch is introduced, a chain reaction of dissociation, shame, and an inability to articulate her needs can take over the session. In our time together, I name where I intend to work before starting, ask what she's noticing as body sensations as we work, and give each contact some time to settle after I touch her. All of these choices that I make in our work together clearly allow her the ability to be present with me in our Rolfing sessions. I support her nervous system by acknowledging how her history impacts our work. Through this mindful and deliberate process, she tolerates and begins to believe that she can be present when a person is touching her and that she will not be hurt. This is the foundation necessary to begin to heal an insecure attachment style.

Abuse in a relationship involves violated boundaries and severed trust. Sexual abuse is one of the areas that I help clients address with the use of healthy touch. In the previous paragraph are some tools you can use to support a client's evolution in relation to touch that decrease the charge of negative associations so that touch can be enjoyable. In many cases, clients may have anger or other big emotions that spring up as we work together because the space is a safe one to address the feelings. When this happens, I often slow the session way down (do not touch as much or as often) and make sure we are both in the present moment, allowing observations to occur. While working in the moment, it can sometimes be tempting to dwell on the story. The story is not actually as important as the sensations occurring in the client that are translating into big emotions. If you are able to home in on one location in the body that is drawing the most attention and work with that area, you are highlighting the fact that the abuse occurred in the past and will not be relived in the present.

Another tool I use is to have the client put a hand on an area of her body first. I make clear that what we are doing is giving her the power and choice to touch or not be touched. After that, I ask her to ask that area of her body if there's something that it needs. If she is able to do this, we keep moving forward in this manner until we feel there is a good stopping point. Depending on the time frame and where we are in the session time, we might stop there or move to a place of grounding, like working on the feet, to help the client make connection to the ground in a supportive manner.

All of this may sound like work for a marriage and family therapist, and some of it is, but practitioners in that scope of practice are by law restricted from using touch. This type of work should go hand in hand with your client seeing a psychotherapist. Sometimes, through trust, we can let big emotions, memories, or trauma be present in the room, but additional harm does not occur because the story is not alive in the present moment and in the therapeutic relationship.

If you do not feel comfortable using the ideas above, I would suggest that when emotion or memories arise for your client, you slow the session down and work more on the periphery of the body to help the client ground and be present. Make what you're doing deliberate and slow. You can always ask the client if she needs a break – if you feel like you need a break, she probably does too. This doesn't mean remove your focus from the client, it just means giving the client space to *be* until you both feel like she's ready to receive again. Honor your comfort level with the client as well as your own boundaries. By doing so, you will both have the likelihood of experiencing a profoundly honest and transformative session.

Somatic Psychology

Transformation is not an easy endeavor. However, with the intention to be of service to the client, combined with a gentle curiosity supporting the client's alignment and health, I have witnessed profound events (small and large) in my studio. In support of this is the field within clinical psychology known as somatic psychology. This pioneering field supports the idea that the body can lead the mind in change more easily than the reverse. Secure attachment and the therapeutic relationship are important elements in the somatic psychology approach. In my experience, the body has more 'pure' feedback than the mind, which allows a person to sense, recognize, and address important issues.

An example of body leading the mind is illustrated in a client whom we'll call "Stan." Stan's body is sending him clear messages that he's in pain, but his physical structure is not offering any evidence of compromise. Consequently, the medical diagnosis is that he is somaticizing his pain – a condition where a person's emotional reaction to a trauma perpetuates and magnifies an event to extreme proportions. Stan feels extreme depression because his current pain does not allow him to do activities that he loves such as surfing, basketball, running, and other sports. His mindset is "because I can't do the things I love to do, my life is over." His thoughts do

not match up with the actual experience. His emotional reaction is extreme, and also manifests as sciatic pain, pudendal nerve pain and sensations in his pelvis and groin, as well as an overall tightening of the sleeve muscles. Stan's 'team' includes me for Rolfing SI, a pelvis specialist who is a physical therapist, and a somaticized pain specialist. In our few months of working with him at least once a week, he has experienced tremendous relief. All practitioners have established effective, secure and therapeutic relationships with Stan, and I feel confident that since we are addressing the mind and the body simultaneously, and he is open to a variety of therapies, we have and will continue to aid him on the path to healing. For Stan, an effective therapeutic relationship has been vital for his recovery. I look forward to hearing about him surfing again. Though a client does not have to have an extreme condition to merit his caregiver's employment of secure attachment and therapeutic relationship behavior, when these approaches are used, the groundwork is laid for comprehensive change.

Conclusion

As a Rolfer, forming and maintaining relationships with my clients that include the elements of secure attachment has made my practice profoundly satisfying and prosperous. These elements include the curiosity to discover the ways in which I can support my clients to grow in alignment, support, flexibility, and choice in the body. Furthermore, all of these qualities are consistently reflected in the mind. Though my way may not be the approach you have with your clients, history is an alive thing that enters the room with us – our history and our clients'. Modeling trust, safe touch, safe space, and an ability to recognize and ask for what is wanted (or needed) are all areas of secure attachment that we have and do practice continually with our clients. Helping clients understand how to better exercise and utilize these skills can impact their lives far beyond the studio and far beyond our limited time together. As my grandma always said, relationships are about "quality, not quantity." By modeling secure attachment through a therapeutic relationship you may help others change their histories.

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