



Facilitating the Shift from Disorganized Attachment to Secure Attachment, Utilizing the Therapeutic Relationship as a Base with Eating Disordered Clients

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Eating Disorder Patients' Experience of Recovery

- Realistic appraisal of medical dangers
- Improvement in care of self (e.g. eating habits, use of leisure time)
- New ways to self-soothe, self-regulate
- Ability to access social support from family, friends, and fellow patients
- Enhanced problem solving skills
- Improved capacity to invest in and work on interpersonal relationships
- Gradual relinquishment of ED identity and eating disorder thoughts (e.g. “this food will make me fat,” “I’ll feel better after I eat this package of cookies, etc.)

Eating Disorder Patients' Experience of Recovery, cont.

- Ability to take responsibility for self and eschew victim mentality
- Establishment of a sense of “true self,” “real me,” or “knowing who I am.”
- Capacity to formulate goals, tolerate setbacks, yet maintain positive motivation to get better.
- Reclamation of sense of one's personal power.
- Decreased emphasis on perfectionism.
- Firmer interpersonal boundaries; enhanced capacities to set appropriate boundaries.
- Cultivation of sense of purpose, meaning of life.

How is Recovery Measured?

Recovery is not just the absence of symptoms...it is the presence of a full life as evidenced by the ability to be human. A truly recovered life will reflect spontaneity, freedom, the ability to breathe, to have wants, needs and desires, knowing that the quest for perfection is an unattainable illusion. Having the ability to embrace the feminine, having close intimate relationships, and it is being aware of the tears in your eyes (whether out of intense or subtle sadness – or out of the joy – or from a flicker of utter gratefulness) and then to allow your tears to flow freely. It is a life in which decisions and choices are made more from self and less from a shame and fear based prison. It is a life where you fully experience pleasure, joy and passion and believe and know it is good to desire and enjoy sex...

Rupture in Attachment Impingement

(Greenburg & Mitchell)

The child's psychological survival must not depend upon meeting the mother's needs. The major consequence of prolonged impingement is fragmentation of the infant's experience. Out of necessity, he/she becomes and requests of others. The child's "true self," – the source of spontaneous needs, images and gestures – goes into hiding, becomes detached and atrophied. The "false self" provides an illusion of personal existence whose content is fashioned out of maternal expectation. The child becomes the mother's image of him.

10/7/99
Relationship
with my
mother



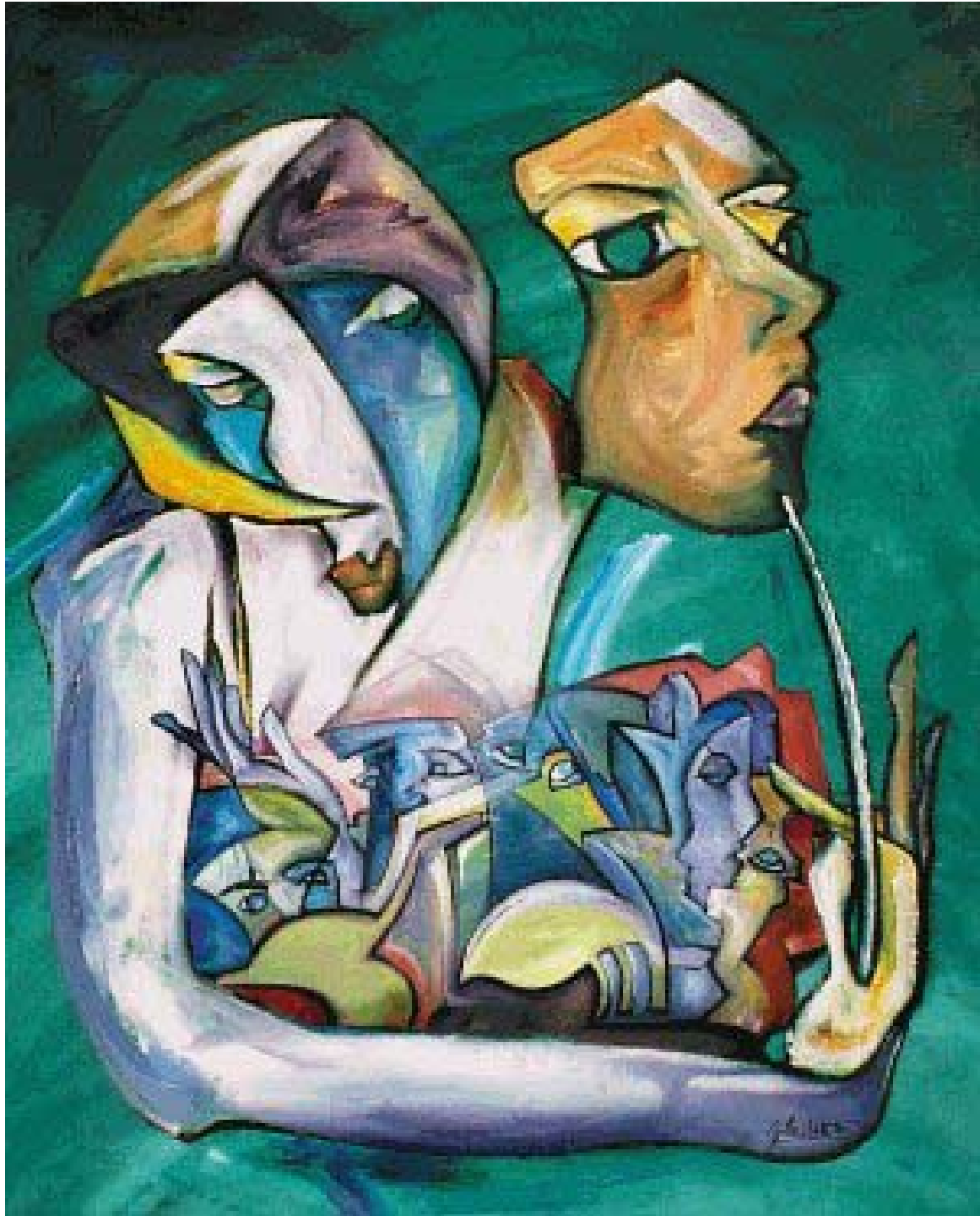
THOU
MUST
ADORE
ME



False Self: Etiology

As a result, the infant learns that an exercise of autonomy is met by a withdrawal of love, and this is sufficient to skew formation of the self away from the independent goal. Instead, a false self is defensively constructed to accommodate the mother's emotional requirements, and so to secure enough positive response (or lack of negative response) to permit psychic survival. Forms of defensive false self take their characterological coloration from particular conditions imposed by the particular mother-child dyad.

From Masterson, J. & Klein, R.(1995). Disorders of the Self, New York: Brunner Mazel, Inc.



Middle Adolescence

“What am I as a person? You’re probably not going to understand. I’m complicated! With my really *close* friends, I am very tolerant. I mean I’m pretty understanding and caring. With a *group* of friends, I’m rowdier. I’m also usually friendly and cheerful but I can get pretty obnoxious and intolerant if I don’t like how they are acting. I’d *like* to be cheerful and tolerant all of the time, that’s the kind of person I *want* to be, and I’m disappointed in myself when I’m not. At school, I’m serious, even studious every now and then, but on the other hand, I’m a goof-off too, because if you are too studious, you won’t be popular. So I go back and forth, which means I don’t do well in terms of my grades. But that causes problems at home, where I’m pretty anxious around my parents. They expect me to get all A’s and get pretty annoyed with me when report cards come out. I care what they think about me, and so then I get down on myself, but it’s not fair! I mean I worry about how I *should* get better grades, but I’d be mortified in the eyes of my friends if I did too well. So I’m usually pretty stressed out at home, and can even get very sarcastic, especially when my parents get on my case. But I really don’t understand how I can switch so fast from being cheerful with my friends, then coming home and feeling anxious, and then getting frustrated and sarcastic with my parents. Which one is the *real* me? I have the same question when I am around boys. Sometimes I feel phony. Say I think some guy might be interested in asking me out. I try to act different, like Madonna. I’ll be a real extrovert, fun-loving and even flirtatious, and I think I am really good-looking. And then everybody and I mean *everybody* else is looking at me like they think I am totally weird! They don’t act like they think that I’m attractive so I end up thinking that I look terrible. I just hate myself when that happens! Because it gets worse! Then I get self conscious and embarrassed and become radically introverted, and I don’t know who I really am. Am I just acting like an extrovert, am I just trying to impress them, when I am really an introvert? But I don’t really care what they think, anyway. I mean, I don’t want to *care*, that is. I just want to know what my close friends think. I can be my true self with my close friends. I can’t be my real self with my parents. They don’t understand me. What do *they* know what its like to be a teenager? They treat me like I’m still a kid. At least at school, people treat you more like you’re an adult. That gets confusing, though. I mean, which am I? When you are 15, are you still a kid or an adult? I have a part-time job and the people there treat me like an adult. I want them to approve of me, so I’m very responsible at work, which makes me feel good about myself there. But then I go out with my friends and I get pretty crazy and irresponsible. So which am I, responsible or irresponsible? How can the same person be both? If my parents knew how immature I act sometimes, they would ground me forever, particularly my father. I’m real distant with him. I’m pretty close to my mother though. But it’s being distant with one parent and close to the other, especially if we are together, like talking at dinner. Even though I’m close to my mother, I’m still pretty secretive about some things, particularly the things about myself that confuse me. So I think a lot about who is the real me, and sometimes I try to figure out when I write in my diary, but I can’t resolve it. There are days when I wish I could just become immune to myself!

The Construction of Self

DISSOCIATION AND SELF-DEVELOPMENT

Sexual and physical abuse at the hands of family members cause the child to split off experiences, relegating them to an inaccessible part of self.

Dissociation of one's experiences sets the stage for loss of one's true self. The true self becomes corroded with inner badness and is concealed at all costs. Persistent attempts to be good, thus leading to a socially acceptable self, are experienced as non-authentic. The adolescent is compelled with the demand to create multiple selves in different contexts.





Dissociation

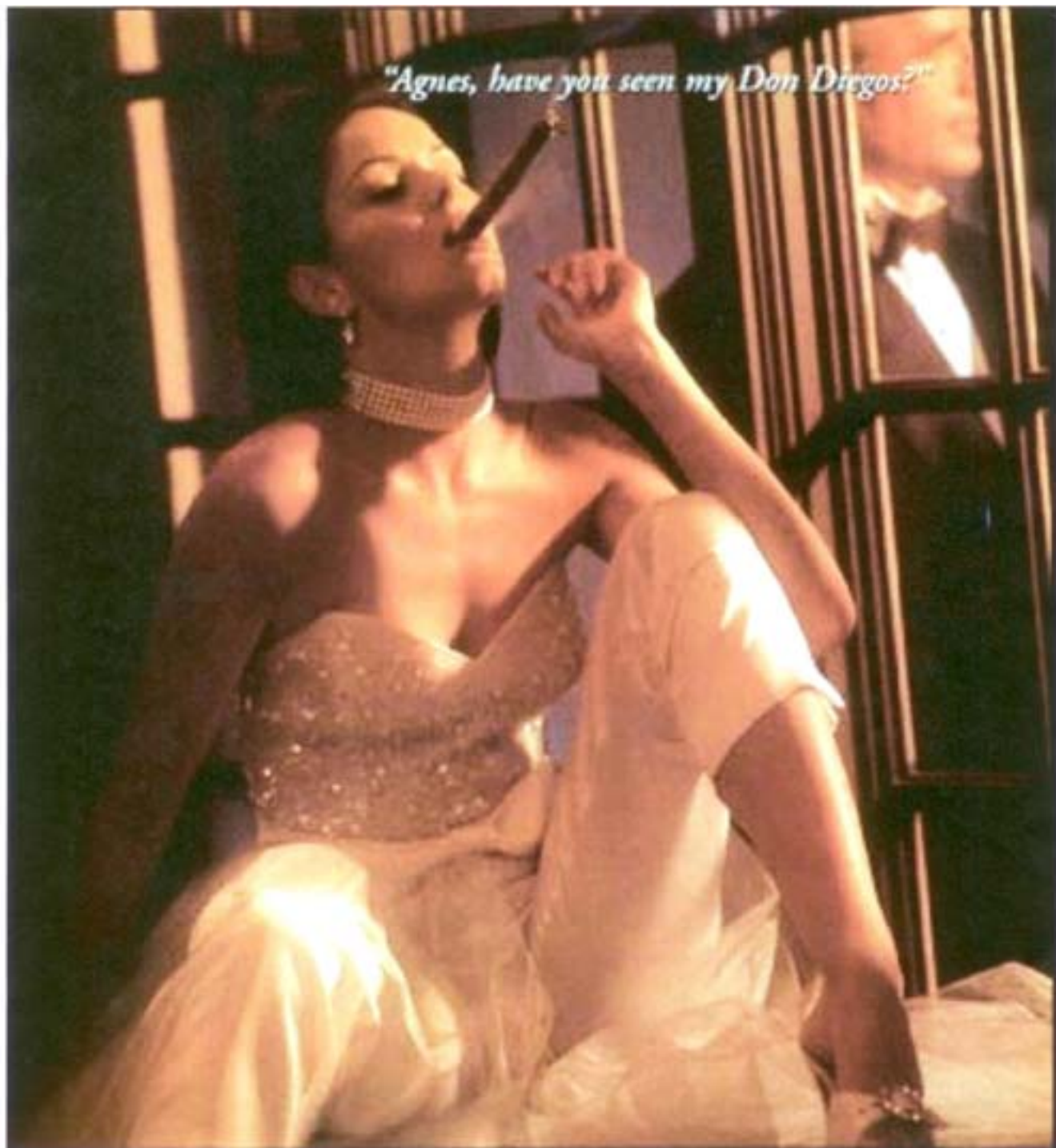
- Early dyadic processes lead to a “primary breakdown” or lack of integration of a coherent sense of self, i.e. Unintegrated internal working models.
- Disorganized attachment is the initial step in the development trajectory that leaves an individual vulnerable to developing dissociation in response to trauma.

Liotta, 2000

Self Differentiation

1. Absence of true sense of self
2. Hyper-sensitivity and hyper-reactivity to others, especially in reaction to rejection or abandonment.
3. Gullibility and suggestibility in relation to authority.
4. Complaints of isolation and neediness, without self-support
5. Boundary problems, inability to conceive of self without reference to others.

"Agnes, have you seen my Don Diegos?"



Qualities of Self

Calmness

Joy

Curiosity

Gratitude

Clarity

Humor

Compassion

Equanimity

Confidence

Perspective

Courage

Peace

Connectedness

Kindness



Seeding Development of Self





Relationship with Self

Therapy involves helping the client reclaim parts of self that were sacrificed to gain safety.

In therapy, we create a context and relationship where pain, anger and difficulty can be safely acknowledged while maintaining a connection.

SELF-INJURY

(David Calof, 1991)

- Self-injury is the container for unmetabolized traumatic stress and underlying unresolved trans-generational trauma and loss.
- Self-injurious/destructive behavior is functional and is always an attempt to protect the client (system).
- Expresses (communicates) underlying dynamics and need and is “trance logical” (“hurting releases pain”).
- Because behavior dissociated from sensation, affect and knowledge, linkages to specific meaning, function or intent, will typically be unclear.

RE-FRAMING THE MEANING OF SYMPTOMS

- Start with the assumption that every symptom is a valuable piece of data!
- Use psychoeducational material to make educated guesses about the meaning of symptoms, as a symptom-memory or a valiant attempt to cope
- Ask her, “How would this _____ have helped you to survive in an unsafe world?” “Helped you feel less overwhelmed? Less helpless? More hopeful?”
- Look for what the symptom is still trying to accomplish: i.e., chronic suicidal feelings might offer comfort or a “bail-out plan;” cutting might help modulate arousal; social avoidance could be an attempt to avoid “danger”
- Once it is clear what the symptom is trying to accomplish, then therapist and patient can look for other ways to accomplish the same goal in a context that describes the patient as an ingenious and resourceful survivor, rather than as a damaged victim

Fisher 2001

Failed Protectors

Where part got the idea that it had to coerce and shame her into dieting, working, being nice – usually a parent monitoring and scolding – part like a single parent – these are inner censors and tyrants that control us, keep our noses to the grindstone and do not risk any behavior that brings us the slightest embarrassment.

Diagnostic Dilemmas

- Several investigations with bulimic (Ame-Finkel et al., 1992) or mixed (Gartner et al., 1989; Kennedy et al., 1990) samples have noted a tendency for Axis II diagnoses to erode when treated samples are reassessed; for example, in one study the classification of subjects as borderline fell from 80% at intake to 32% by discharge (Kennedy et al., 1990). An opposite pattern may hold for restricting anorexics, at least in the immediate aftermath of treatment. In one study, this subgroup tended to disclose more personality pathology after 12 weeks of inpatient treatment (Gartner et al., 1989), perhaps as a function of decreased denial or reactivity to rapid and typically unwelcome weight gain

(Vitousek & Manke, 1994)

Table 1. Impulsive Behaviors in the Four Diagnostic Subgroups of Eating Disorder Subjects

	Whole sample (n=554)	Restricting AN (n=183)	Binge eating/ Purging AN (n=65)	Purging BN (n=244)	Nonpurging BN (n=62)
Suicide attempts*	55 (10%)	6 (3%)	9 (14%)	35 (14%)	5 (8%)
Skin cutting	87 (16%)	21 (12%)	10 (15%)	48 (20%)	8 (13%)
Skin burning	18 (3%)	5 (3%)	1 (2%)	10 (4%)	2 (3%)
Other self-damaging behaviors	96 (17%)	20 (11%)	14 (22%)	50 (20%)	12 (19%)
Seeking out dangerous situations*	77 (14%)	10 (6%)	13 (20%)	47 (19%)	7 (11%)
Aggressive towards others	71 (13%)	18 (10%)	8 (12%)	39 (16%)	6 (10%)
Running away*	101 (18%)	20 (11%)	15 (23%)	59 (24%)	7 (11%)
Stealing*	137 (25%)	26 (14%)	16 (25%)	81 (33%)	14 (23%)
Substance/ alcohol abuse*	110 (20%)	16 (9%)	17 (26%)	68 (28%)	9 (15%)

* The difference among the four groups is significant at $p \leq 0.001$.

Compassionate Witnessing

This occurs when the Self of the client is able to witness the stories of parts from a compassionate position. Ask the client to identify an activated part (usually associated with extreme behaviors, thoughts or feelings). Ask the client where in the body the part (position of Self) indicates that another part is blended with the Self. Ask the blended part to please step aside and let the Self work with the activated part. (This may include asking more than one part to step aside).

CHANGING ATTACHMENT RULES

Rules of Attachment

The rules of attachment are quite literally rules to live by – given that they emerge out of interactions between biologically channeled, survival-based attachment systems. The behavioral/communicative strategy eventually generates repressed internal/attachment strategies.

Avoidants could neither be aware of, or express, attachment-related feelings – they inhibit or minimize internal experiences.

Preoccupieds amplify or maximize awareness and expression of attachment-related feelings and needs, to ensure continuing care.

Disorganized have their attachment figure unsafe so the person that comforts is dangerous. Such interactions create deeply entrenched templates for relating that result in distorted beliefs about self and others causing enactments and do not learn to separate and develop self-agency or a core sense of self, they are overinvolved in watching and caring for their inconsistent mom, they inhibit the attachment system and distract attention away from unmet needs.

Active Implementation

The avoidant infant actively restricts attention to mother – as if to distract from the anxiety and distress of wanting mother's comfort.

The preoccupied actively seek and confines self to monitoring mom's whereabouts, ignoring the toys and exploring the environment. Gives up the development of self to survivor.

The disorganized capitulate in external relationships, they also extend internal relational exchanges between parts of the self, leading to chronic inner conflict, internal abandonment of parts of self holding traumatic affect and ruthless self-criticism.

Outpatients actively live by the rules of attachment. Dismissive clients find attention focused on needs of others, denying their own needs. Preoccupieds are consumed with doubts about self and others and yearnings. They store up strategies to justify and maintain pre-existing beliefs.

Secure Attachment I

- Because their caretakers have been routinely available to them, sensitive to their signals, and response with some degree of reliability (though by no means is perfect care required), these infants develop a confidence that supportive care is available to them.
- They expect that when a need arises, help will be available. If they do become threatened or distressed, the caregiver will help them regain equilibrium.
- Such confident expectations are precisely what is meant by attachment security.

L. Alan Stroufe, 2000

Dismissing of Attachment

1. Idealization.
2. Dismissing derogation.
3. Lack of memory.
4. Response appears abstract and remote from memories or feeling.
5. Regard self as strong, independent, normal.
6. Little articulation of hurt, distress or needing.
7. Endorsement of negative aspects of parents behavior.
8. Minimizing or downplaying negative experiences.
9. Positive wrap-up.
10. No negative effects.
11. Made me more independent.

Metacognitive

Metacognition means treatment of one's mental contents as "objects" on which to reflect, or in other words "thinking about one's thinking." Distinct skills contribute to its characterization, such as the ability to reflect on one's mental states, elaborating a theory of the other's mind, decentralizing, and the sense of mastery and personal efficacy.

CRITICAL PART

- Comparing myself to unrealistic/impossible standards.
- I criticize for criticizing myself
- You can't recover!
- I'm dead
- Failure
- You're worthless
- You'll always be rejected
- Be thin again
- My dreams will never come true
- Disgusting
- Stupid
- No success
- Disappointment
- Be perfect
- Therapy is not working
- You'll never be happy
- You're a failure
- I hate myself!
- Insecure
- Why did you give in?
- Comparing
- Bottled up
- I want to kill myself!
- I always quit
- Unworthy
- Don't exist
- No help! No support!
- I can't recover
- Suffer!
- Self is never accessible and never will be!
- You're pathetic
- FAT!
- YOU WILL NEVER RECOVER!
- Hurt
- Nobody cares
- Unappreciative
- I hate myself!
- Depression
- Pesticides

- ✘ Errors
- ✘ You'll never go to college
- ✘ Why?
- ✘ Too judgmental
- ✘ Intoxicated
- ✘ You will never recover!
- ✘ You should of...
- ✘ Will I...
- ✘ Too hard for you to handle!
- ✘ Toxic
- ✘ I'm hopeless
- ✘ You're not capable
- ✘ Why did you trust?
- ✘ You're a piece of shit
- ✘ Mistakes
- ✘ Don't let anybody in
- ✘ Never accept yourself
- ✘ Be miserable.
- ✘ INSANE
- ✘ You'll never travel the world.
- ✘ You'll always have ED
- ✘ TOO HARD!
- ✘ Helpless
- ✘ Fuck me and everyone else!
- ✘ UGLY
- ✘ Exposed
- ✘ No progression
- ✘ Empty
- ✘ How dare you let go of your restrictive side!
- ✘ Incapable
- ✘ Don't motivate
- ✘ Nothing pays off
- ✘ I have to live up to certain standards
- ✘ Mentally ill
- ✘ Get it right!
- ✘ Pointless
- ✘ Additives
- ✘ Pessimistic
- ✘ I don't care

- Uncontrollable
- Kill yourself!
- Inadequate
- Nothing's working
- End your life
- You're going to become obese
- SHAME
- Criticism
- Don't upset people
- Humiliation
- Vulnerable
- I have no capacity of succeeding in the future!
- I can never change
- Pollution!
- Too difficult
- Fake and unreal
- Ostracized
- No risks
- Poison!
- You'll always be lonely
- Liar!
- Prison
- Lazy
- You'll never have sex
- Graduate? No!
- Why bother?
- Suffer!
- PAIN
- Preservatives!
- Feel worse
- Push away
- Artificial
- Everything and everyone will reject you
- Artificial
- Nothing pays off
- Sink!
- There's no way out
- Isolate
- Anger

Therapists Job with Attachment Trauma

1. Transformation of the self through relationship.
2. Provide a secure base for exploration, development and change.
3. Provide attunement in helping the client tolerate, modulate and communicate difficult feelings.
4. Affect regulating interactions for accessing disavowed or dissociated experiences strengthening narrative competence.
5. Deconstruct the attachment patterns of the past to construct new ones in the present

(see David Wallin, Attachment in Psychotherapy, Guilford Press, 2007)

The Intergenerational Transmission of Insecure Attachment Results in Problems With:

- Affect Regulation
- Self-soothing
- Self-defining gestures
- Affect tolerance
- Self care
- Pacing self (vs. avoidance/immersion)
- Interoceptive awareness

Deconstructing Attachment

Implications of Psychotherapy:

1. Idealization.
2. Dismissing derogation.
3. Lack of memory.
4. Response appears abstract and remote from memories or feeling.
5. Regard self as strong, independent, normal.
6. Little articulation of hurt, distress or needing.
7. Endorsement of negative aspects of parents behavior.
8. Minimizing or downplaying negative experiences.
9. Positive wrap-up.
10. No negative effects.
11. Made me more independent.

FACILITATING “EARNED SECURE ATTACHMENT”

1. Facilitating a coherent cohesive and reflective narrative
2. Neutralizing idealization and loyalties to family system
3. Facilitating metacognition
4. Facilitating self-compassion
5. Utilizing an attuned relationship with therapist as a home base for exploration of developmental change
6. Asking others for self-soothing under stress
7. Re-examine detailed beliefs about self and others
8. Relinquishing defense of dissociation and re-associating affect, sensation, and knowledge
9. Not inhibit or minimize internal experiences and learn to tolerate, express attachment and related emotions
10. Resolution of internal relational exchanges between parts of self
11. Internalize self-parenting, is forgiving of mistakes, listens to disowned parts of self
12. Sets and teaches healthy boundaries
13. Resolution of significant losses in one’s life
14. Deconstruct the attachment patterns of the past and construct new ones
15. Integrate traumatic attachments, losses and re-enactments.
16. Establishing appropriate entitlements related to having needs, expressing needs, and meeting needs

Sense of Coherence

The global orientation that one has a pervasive, enduring, though dynamic, feeling of confidence that one's internal and external environments are predictable and that there is a high probability things will work out as well as can be expected.

Aron Antonovsky

Phase II: Narrative Story Telling: NST

- Repeated narration
 - Organization of trauma memory
 - Fear reduction through habituation
- Meaning analysis/contextualization
 - Revision of beliefs about self and others (trauma schemas are part of past vs. present)
 - Integration of trauma memory into a life history
 - Exploration and resolution of feelings other than fear: shame, guilt, anger and loss

(Marylene Cloitre, 2008)

Repetition

Nevertheless, the need to repeat also has a positive side. Repetition is the language used by a child who has remained dumb, his only means of expressing himself. A dumb child needs a particularly empathic partner if he is to be understood at all. Speech, on the other hand, is often used less to express genuine feelings and thoughts than to hide, veil or deny them and, thus, to express the false self. And so, there often are long periods in our work with our patients during which we are dependent on their compulsion to repeat - for this repetition is then the only manifestation of their true self.

- *Alice Miller*