Early Trauma: Revisited and Revised through EMDR ,the Narrative Story and the Implementation of Attachment Theory Concept

Bar-Sade Ester

"Secure attachment bonds serve as a primary defense against trauma induced psychopathology… the quality of the parent bond is probably the single most important determinant of long-term damage" (van der Kolk,1966,p.185)

If we regard adult psychotherapy as the basis for a kind of attachment relationship in which the client seeks proximity by having a physical and emotional closeness with the therapist through which the client tries to create a"safe haven" soothing him or her when upset while providing a sense of security, child therapists often regard child-psychotherapy as a means to develop an attachment relationship between child and caregiver, whenever possible. It is a common assumption, that in child-psychotherapy, especially while dealing with trauma, the therapist must stress the importance of empowering the parental figure as an attachment figure and as a "secure base".

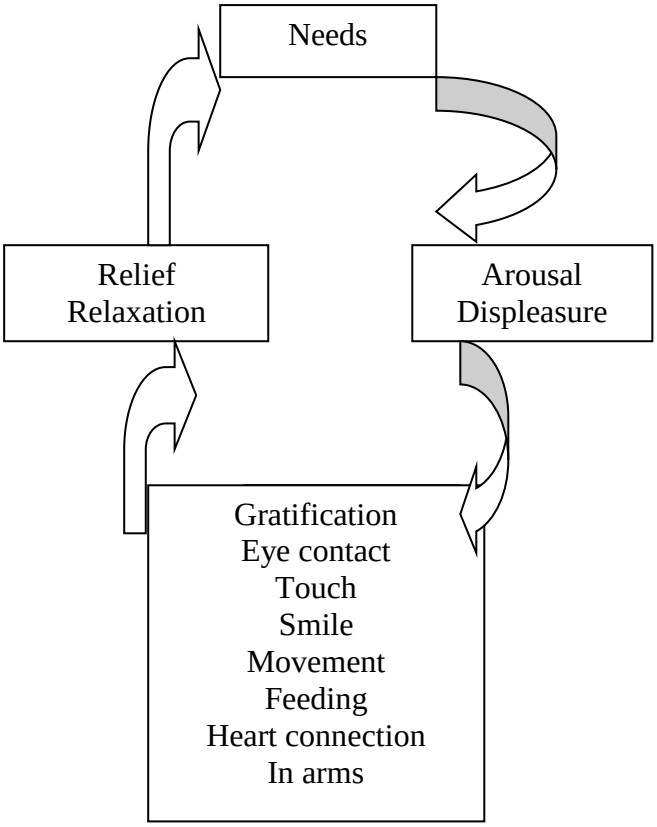
As a method, EMDR contains very specific elements that may be essential for children to resolve their traumas. However, the most effective communication patterns creating an internal security model (called" secure base") are derived from the communication patterns between child and caregiver. I aim to examine, analyze and employ these communication patterns when using EMDR with children.

Attachment is defined as a deep connection between child and caregiver, which is established during the first 3 years of life. It is a learned ability, resulting from ongoing reciprocal interactions characterized by protection, need fulfillment, limits, love, and trust (Bowlby 1969; Levy&Orlans, 1998).

What are these interactions, between caregiver and child that help the child to develop a secure sense of him/herself, helping to regulate his or her emotions while developing a sense of basic trust?

In "Attachment" (1969), Bowlby investigates the mechanism through which the infant develops a secure emotional attachment bond with the mother, as well as the way in which this early socio-emotional experience is subsequently internalized resulting in the ability to regulate and hence generate and maintain a status of emotional security.

"The mother's attachment relationship is accompanied by the strongest feelings and emotions, happy or reserved, (pp.242), **- that this interaction occurs within a context of facial expression, posture, tone of voice, physiological changes, tempo of movement, and incipient action,"(pp.120) and that the** [infant's] **capacity to cope with stress is correlated with certain maternal behaviors (pp.344).**



Interdisciplinary research and clinical data affirm the concept that in infancy and beyond the effect regulation is a central organizing principle in human development and motivation. Schore, (1994;), has proposed, in a series of contributions, that the maturation of these adaptive right brain regulatory capacities is experience dependent, and that this experience is embedded in the attachment relationship between infant and primary caregiver.

Schore postulates specifically that in such attachment transactions the secure mother, at an intuitive, non-coconscious level, continuously regulates the baby's changing arousal levels and consequently his or her emotional status.
Sroufe defines attachment as **"the dyadic regulation of emotion"** (Sroufe, 1966). As a result of being exposed to the primary caregiver's regulatory capacities, the infant's expanding adaptive ability to evaluate stressful changes in the external environment, on a moment –to-moment basis, especially in the social environment, allows him or her to begin to form a coherent response to cope with stressors. Thus, the ability to adaptively cope with stress is directly and significantly influenced by the infant's early interaction with the primary caregiver (Schore1994).

In other words, the same interactive regulatory transactions that co-create a secure attachment bond also influence the development and expansion of the infant's regulatory system while playing a central role in helping the child to develop his or her own internal mechanism to cope with stress.

Trevarthen describes"emotional communication" as a traffic of visual, prosodic auditory, and gesture signals that induce instant emotional effects (Trevarhten, 1990). This process is mediated by eye-to-eye orientations, vocalizations, hand gestures and movements of the arm and head".
Sander (1977) asserts that the parent expresses a behavior that is particularly fitted to catalyze a shift in the infant's inner state. Effect attunement works in a manner that the mother's regulatory functions occur at levels beneath awareness. The mother monitors the baby and her own internal signs at the same time.

However, the caregiver is not always attuned. It is well known that now and again the regulation of the caregiver effect as well as the child's may be a demanding task. Often, in periods of great pressure and stress, for example, when a child has to undergo a surgical procedure or when the child has been severely injured, or when the caregiver is emotionally unavailable to fulfill the task of arousal-regulating transactions, there may be a disturbance in the interactive synchronicity that may intensify the effect of traumatic events in the infant's life.
Van der Kolk wrote: "from birth, interpersonal processes provide the meaning and context of sensations and emotions. Newborns are continuously exposed to internal and external stimuli that they do not understand or know how to change. Babies depend on their caregivers to change the way they feel and are programmed to cry out to attract attention. They leave it to their caregivers to figure out how to relieve their distress, which they do by acting (feeding, changing diapers) and by making sounds (prosody), and through movement (rocking)", (van der Kolk,2002,pp.63).
.
As mentioned above, Bowlbey, Schore and Trevarthen have identified the most effective patterns of communication that create secure attachments. These are patterns that involve reciprocal, contingent collaborative communication. This type of communication involves an exchange of signals between the two interacting members of the pair.

It is my purpose to learn how these communication types can be introduced in the EMDR procedure when working with children.

If we can assume that the core of an effective child trauma therapy is rooted in the manner by which the child and the parent are able to engage in a form of attachment communication, while the child revisits the unresolved trauma, it is then essential to address the issue of the therapeutic role of the parent, and how he or she can help and be helped? While the traumatic experience is revived and revisited, the parent has the opportunity to be there for the child, once again, this time not as a frightened overwhelmed parental figure, but as a "secure base", enabling the child to enter terrifying situations, while processing information that previously may have led to excessively restrictive or chaotic patterns. This interpersonal communicative experience may help to resolve the unresolved trauma. The parent's presence provides the child with a sense of security, allowing the traumatic experiences to be re-lived and, if possible, communicated and altered into more adaptive coping patterns.
In addition, I would like to stipulate that not only the traumatic event itself affects the child's ability to overcome the trauma. Also the way the caregiver handled and perceived the experience, as well as his or her ability to cope with the stressful situation and the way the event was conveyed when interacting with the child, play an important role. When the caregiver and child experience a traumatic event involving

intense emotions, the child depends on the parent (primary caregiver) as the interpreter of his or her inner world and as a mediator enabling the enhancement of a comforting regulatory positive effect.

In the case of early trauma it is very clear that the child's capacity to process adaptively the traumatic event depends greatly upon the parent's ability to serve as an affect-regulator. The child responds to the parent's internal state of arousal that is conveyed through the attachment behaviors.
With regard to the above, Schore further postulates that effect regulation is not only the reduction of affective intensity, it also involves the intensification of positive emotions, a condition necessary for more complex self-organization (Schore, 1994). This phrase may have an important implication in the work we do when treating children using EMDR.
When we look at this entire body of evidence as well as the theoretical data regarding the break-down of regulatory functions after a traumatic event, it becomes very clear that the caregiver plays a major role, both in fostering the disturbance of the regulatory affect functions and through his failure to deal with his or her own anxieties. This may result in the child's inability to process the trauma and enhance the development of PTSD
In many cases we may find that caregivers are unable to empathize with the child since they are overwhelmed by feelings of distress themselves. As a result, the caregiver may not be able to provide the child with the necessary soothing and comforting support, which consequently may inhibit the child's development of positive affect and positive sense of security.
Regulation of emotions during development is associated with modulation, modification, direction and control of intense arousal distress and developing modes of coping with stress. Ample care and containing is required to facilitate this process. Adequate care-giving as well as the parental capacity to empathize with the infant's overwhelming distress, fussing and crying, enable the growing infant and young child to internalize a supportive parental figure and take control of the overwhelming distress.

It is very common for children's therapists to find that, due to the overwhelming nature of the experience, the parents themselves have failed to create a secure and trusting environment ("safe haven") for the child. Sometimes their own anxiety inhibits their ability in helping the child to regulate and control his or her fears and anxiety. It is also common for children who have experienced a traumatic event to regresses to earlier forms of developmental behavior. However, this often perplexes and confuses the parents since they want to distance themselves and their child from the experience as soon as possible. This is often achieved by denial, silencing the event and sometimes forgetting it. All this aims to avoid the painful feelings that accompany recollection of the event. In such cases, the parent does not recognize the fact that the child needs the parent as the modulator and regulator of his own anxieties. Often we may find that in cases where the parents, through repression and denial, ignored the child's need for their comforting and anxiety-free behavior, PTSD symptoms may develop.

In EMDR we help the child go through the traumatic experience in a" secure environment" we have created. By providing the client with a sense of being grounded, at some distance from the experience and by using devices that aid in

regulating the anxiety when it becomes overwhelming. When working with children that have undergone trauma we are facing a bigger challenge: we have to be aware that we meet them in the midst of a developmental process in which they are still forming their regulatory functions and therefore are still dependent on their parents as regulation and stress management or mediators. The dyadic process, in which parent and child are both engaged in a mutual dance where they react and interact with each other, in face of the distress while coping with it, is the setting in which multiple resources may be found to strengthen and empower them while processing the traumatic event..

I will present tow cases in which I will examine various parental attachment behaviors: soothing, tonal expression, rocking, proximity, hugging, lullaby singing, and foremost being present with the child while he or she revisits and revives the trauma. I will also demonstrate how these attachment behaviors, which occur during the processing stage of the traumatic event, may help the child to desensitize and work through the overwhelming experience.

The case study of Boris:

Boris is the eldest of two brothers born to Russian immigrant family. At the time of the referral he was seven years old. He was referred by his teacher since she suspected he suffered from ADHD. He was very restless, chatty and had trouble concentrating. While the mother came to my office he had already been seen by a child neurologist who subscribed Ritalin.
Boris and his baby brother were both born with a Cleft Pallet. By the time Boris was a year and a half old he had undergone three operations. The parents never talked to him about his or his brother's condition. When I saw him for the first time his baby brother was supposed to undergo a surgical procedure for the first time. It was never discussed openly with Boris. No pictures were taken of Boris as a baby except one in which he is almost completely covered. The mother reported she suffered from post-natal depression after his birth. When I saw him he had no knowledge of his past and the surgical procedures. The only way the family explained his scar was by telling him he fell down and his lip had to be stitched.
The mother was willing to participate in building a narrative for Boris in which he could process the traumatic events with her full participation. I first worked with Boris at what he presented as recollection of falling down and going to the hospital after which I processed the mother's narrative with her full participation.
As I watched the tape I noticed elements that are typical of the dyadic communication between mothers and infant: voice attunement, smiling, and her choice of words (you were as sweet as a bunny) and singing a lullaby. These elements were not consciously implanted in the narrative we have composed but emerged spontaneously as we performed the processing.

The case study of Shahaf

Shahaf was five years old. The girl and her parents were only 500 meters away when a bomb exploded in a Gas Station and 50 people were killed. It was the first day of a holiday and Shahaf and her family were having a good time in a Mall after they had been to the Children's Theatre Festival where she watched a play about a dying old bear. When they were in the Mall they heard the explosion and people started running

and shouting hysterically. In the Mall TV reports were shown on big screens. The girl came to my office three weeks after the bombing occurred. She could not sleep. had bold spots in her head from pulling her hair, had difficulties separating from her parents and if they were late she would cry fearfully and hysterically.
We stared working by creating a safe place, offering a connection to comfort resources and by overcoming other obstacles (like the time they moved to a new house where at first she could not sleep alone in her new room), and then we continued to work on her separation anxiety. However, as soon as we tried to trigger the day of the bombing or any related nightmares she would run away from the room, close her ears. She was unable to bear the anxiety, as she felt flooded by it just by mentioning the event. When talking with the mother I realized that she too was still feeling a great fear and distress and that both mother and child were feeding each other with anxiety. I asked the mother to process the events of that day while the child was in the room. In the next meeting the mother told the narrative of the day they went to see the play about the dying day. As we watch the video you may notice the spontaneous occurrence of soothing behavior: the child is clinging, the mother is rocking her and finally tapping her on the back. All of these are elements of attachment behavior.
Child and mother revisit the realms of horror but the parent is able to contain both her own and her daughter's anxiety. At last the child was able to regulate her effect through the mother supportive holding and comforting.
Francine Shapiro wrote: "The assimilation of the event into the associative memory network and the accommodation of the client' previous identity to encompass it can be considered the basis of personality development. Clinicians using EMDR as a distinct approach should consider personality not as an immovable mountain but rather as an accumulation of characteristics internal patterns and responses. Each of these characteristics is believed to be an interaction between genetic predisposition and experiences. If the responses are appropriate, they are considered to be engendered by adequately processed childhood experiences that have laid the ground for adaptive behaviors. If the responses are dysfunctional, they are considered to be engendered by inadequately processed experiences that are activated by current conditions…"(Shapiro, 2002,pp.10)
For the child therapist the encounter with an evolving personality in the midst of its developmental process is an opening of opportunities. The therapist can help parent and child not only by working with dysfunctional memories and experiences, but also by facilitating positive effects in their bonding and communication. Thus filling the gap and deficits caused by developmental needs and lack of parental support with regard to the traumatic event. It is my suggestion that in addition to processing dysfunctional memories, EMDR with children has to incorporate positive affect and experiences that are offered by the attachment cues that are part of the dyadic communication between parent and child. Integration of the attachment cues into the process allows the child to build inner resources that make it possible to convert the initial negative imagery effects, beliefs and sensations into weaker and less valid feelings.

The following outline is a possible suggestion for the implementation of the "Attachment cues" wherever it is relevant in the eight phases protocol:

“Attachment Cues” as Resources in Children’s EMDR Processing.

Phase One: History

Learn the details of the traumatic event including the child’s knowledge of the incidence, the family myth’s as well as the parent’s reaction to the event. Look for secrets in the past and both the parents’ and the child’s coping strategies.

Phase two: Preparation

You may look for a song or a lullaby the parent often sings to the child at times of distress as a possible “safe place”. You can begin the process by letting the parent sing the song or use it whenever required.

While the child processes the event ask the parent to be seated so that he or she can maintain eye contact, or let the child be seated on the parent’s lap or in his or her arms.

Instruct the parent that he or she can be a full participant in the therapeutic process by filling in details and adding to the child’s story regarding the target.

If necessary, build a narrative with the parent.

Phase three: Assessment

If the child has no implicit memory of the traumatic event, ask the parent to tell the narrative and use it as the target.
If the child refuses to tell the story or recall memories allow the parent tell the narrative.

Phase Four: Desensitization
Carry on the processing according to the protocol whenever possible. As long as the child provides associative channels you may proceed.
When obstacles arise you may do one of the following:

Ask the parent to hold the child, rock him and help him in any comforting manner to go through with the processing. Remember, the parent’s physical holding and containing is a resource that may be used in the desensitization procedure while processing with the child.(Resource Installation).

If the child refuses to go on you may ask the parent to model the reprocessing while the child remains in the room.
You may ask the parent to perform any soothing actions he or she normally uses with the child, or sing a comforting song (RC), the parent may also offer words of comfort and relaxation (“It’s all over now”,” mommy and daddy will protect you”…).

Phase seven: Closure

When finishing always ask the parent and child to hug while continuing to perform the bilateral stimulation.

References:

Bowlby, J .(1969). Attachment and loss: Vol.1.Attachment. New York: Basic Books.

Levy, T.,& Orleans, M.(1995)Intensive short-term therapy with attachment disordered children. In Van de Creek, S. Knappp & T.L. Jackson (Eds), Innovation in clinical practice; A source book (Vol.14, pp.227-252) Sarasota, FL: Professional Press.

Levy, T.,& Orleans, M.(1998). Attachment trauma & healing. Washington, DC: Child Welfare League of America Press.

Sander, L.(1977) Paradox and resolution from the beginning. In J. Noshpitz, S., Greenspan, S. Wieder, & J. Osofosky (Eds), Handbook of child and adolescent psychiatry, Vol.1(pp.153-159).New York: Wiley.

Saroufe,L.A.(1966). Emotional development. New York: Cambridge University Press.

Schore, A.N (1994). Affect regulation and the origin of the self: The neurobiology of emotional development. Hillside, N. J. Erlbaum.

Shapiro, F .(2002).: Introduction :Paradigms,processing and personality development. In Shapiro,F(Ed), EMDR as an integrative psychotherapy approach(pp.17-18), American Psychological Associstion, Washington DC.

Trevarthen, C.(1990)Growth and education of the hemispheres. In C. Trevarthen (Ed), Brain circuits and functions of the mind (pp.334-363). Cambridge, England: Cambridge University Press.

Van der Kolk,BA. (1996). The complexity of adaptation to trauma. In B.van der Kolk, A.C. Macfarlane, & L. Weisaeth (Eds). Traumatic stress (pp. 182- 213). New York: Guilford Press.

Van der Klok,B,A.(2002). Beyond the talking cure: somatic experience and subcortical imprints in the treatment of trauma, In Shapiro,F.(Ed.), EMDR as an Integrative Psychotherapy Approach (pp.57-83). American Psychological Association, Washington DC.