



March 2020

WORKING WITH ATTACHMENT & TRAUMA

Dr David Van Nuys Interviews Daniel Brown, PhD.

INTERVIEW

Introduction: My guest today, Daniel P. Brown, PhD., is an Associate Clinical Professor of Psychology at Harvard Medical School and has served on the faculty for over 38 years. Recipient of many awards and author of 24 books, he is co-author of the book, *Attachment Disturbances in Adults: Treatment for Comprehensive Repair*. For more information about Dr. Daniel Brown, please see our show notes at ShrinkRapRadio.com.

Dr. Dave: Dr. Dan Brown, welcome to Shrink Rap Radio.

Dr. Daniel Brown: It's a pleasure to be here.

Dr. Dave: Well, I feel really honored to meet you. I know you have a lot of areas of expertise. Among them is your work on attachment and trauma, and also a program that you've developed to treat attachment disturbances in adults. Those are the main areas I'd like us to focus on in our conversation today. How did you first become interested in attachment and trauma?

Dr. Daniel Brown: Well, I became interested in trauma in 1978 and there was somebody who took a three day hypnosis course. She was a social worker by the name of Sarah Haley. She was one of the three founding members of the International Society the Study of Traumatic Stress.

And she took this hypnosis course and she was taken by the effectiveness of hypnosis and we made a trade. And the trade was that I would teach her hypnosis in exchange for which she would teach me about trauma. And, so we supervised each other's work and she sent me a lot of cases about trauma. And it was trial by fire because the cases that she sent me originally were kids in Operation Phoenix who were trained to be little killing machines, to kill an entire village by hand at night.

Dr. Dave: Oh, my goodness.

Adapted from Shrink Rap Radio podcast #649, July 4, 2019, *Working with Attachment and Trauma* with Daniel Brown, PhD. Initial Transcription by Sandy Lie.

Dr. Daniel Brown: That was my first exposure to trauma. And I worked with her for about 10 years. Then she developed a rapidly metastasizing breast cancer and died quickly. I promised her on her deathbed that I would carry on the trauma field for her and made a personal promise.



Dr. Dave: Oh Wow, wow! So beyond that connection, was there anything in your personal history that drew you to these topics?

Dr. Daniel Brown: I had been in four years of twice a week hypnotherapy with a male therapist and then I had done nine weeks on the couch four times a week with an analyst, a female analyst.

Dr. Dave: Oh, my goodness, yeah.

Dr. Daniel Brown: I got a lot of work out of the therapy but in those days, which was the 1960s, and 70s, none of the therapists knew anything about attachment. So, I think what changed me the most is when my mother was in her late 80s and early 90s and she had four heart surgeries and I took care of her when she recovered from the hospital. I brought her into my home and took care of her four times. I treated her as an attachment figure that I always needed. That was a very powerful thing. It freed us both up. I needed the relationship and that's when I started getting interested personally in the power of working on attachment across generations.

Dr. Dave: Well, I must say, you strike me as somebody who, when you get into something, you really dive into it and grab hold of it. And you've done that in a number of areas in your life. Back in 2016, you published an article titled *The Orphanage Study* on attachment and complex trauma. What do you mean by complex trauma?

Dr. Daniel Brown: Well, what evolved in the field was a distinction between simple versus complex trauma or what's now called type I vs. type II trauma. Type I or simple trauma is usually circumscribed as one act producing conditions like post-traumatic stress disorder, anxiety conditions, depression, and somatoform conditions. Those are the effects of single incident trauma or short repeated, single instance of the same trauma. But, then there's another type of traumatization called complex trauma. In addition to all those Axis I conditions, most people with complex trauma probably have a mixed or borderline personality disorder diagnosis, or an Axis II diagnosis. They have major dissociative symptoms, depersonalization, dissociative identity disorder, and they usually have multiple addictive

behaviors. So, if you treat people with complex trauma, you're talking about eight or nine co-morbid diagnoses.

Dr. Dave: Is part of what it implies as well, repeated traumatisations, as in childhood sexual abuse?

Dr. Daniel Brown: Most of the literature on what's called complex trauma assumes that incidences or repeated instances is what caused the traumatization but that's not what we found in our study, our orphanage study.

Dr. Dave: Aha... well take us through your orphanage study if you will, kind of give us a sense of the setup and what you found.

Dr. Daniel Brown: Well, it was really a study that we did by accident. I do a lot of expert witness testimony in the courts. I've done 70 priest-abuse cases against the Catholic Church, and lots of other abuse cases. When you go as an expert witness, it's war, and I like to go well prepared. So I do two full days of testing. I do a number of structured interviews. I do about an inch thick of paper and pencil normative tests. I do psycho-physiological testing, I do tests for symptom, exaggeration and malingering and I give them all the adult attachment interview (AAI) to find out attachment status. This is a database that I've collected over the years. But, I did an expert witness case, a series of cases, in New Orleans. In the 1950s there was a Catholic orphanage called Madonna Manor in the outskirts of New Orleans. The brilliance of the Catholic Church in those days was when a priest got accused of molesting somebody in church, they would transfer them. They transferred six paedophile priests to run an orphanage of children. Those priests hired mostly pedophile staff.

Dr. Dave: Wow.

Dr. Dan Brown: So, you can imagine...

Dr. Dave: That's so contemporary, I mean, this kind of thing is still in the headlines today.

Dr. Daniel Brown: Still happens, yes. So, I did detailed testing, two days of testing on all of the victims and we had 17 of them at the time. Most of them had not remembered, they had completely put out of their mind or partially put out of their mind anything about the traumatization. And then later they recovered the memories 20, 30, 40 years later. At the time these cases were coming out, I tested them, 17 of them, in detail. I gave them all the AAI, which is the gold standard in assessment of attachment. There are self-report instruments to measure attachment status, but the correlation between self report inventories and the AAI or the Adult Attachment Inventory is less than 1%. So, the correlations are so poor that mostly we think that the Self Report's status is not very accurate, because people can either think that they have worse attachment than they do or they can have

very good attachment status and not think they do. The AAI takes about two years to train in and be certified at a high level of accuracy. About 500 people in the world are certified in this. It was developed by Mary Main and Erik Hesse at the University of California, Berkeley. I took the training in it. I routinely gave



it to many of my trauma survivors and I gave it in an expert witness context with these orphanage survivors. What we found is that just about half the sample had disorganized, insecure attachment, which meant that all the developmental lines were disrupted. Some of those kids parents were alcoholic, there was a lot of violence in the home, parents were running a meth lab in the house or a brothel in the house and sometimes the kids will be picked up on the streets foraging for food. So, they were from disastrous attachment backgrounds, what we call disorganized, and the other half of the population were from good Catholic families with six or seven kids. Since they had such a big family, the father often had to work two or three jobs to make ends meet, but it was a loving family. Often, the father would have to work on the oil rigs or some other dangerous job, in order to make enough money for the family. Some fathers would get in an industrial accident or killed and then the family, a loving family, would break up, and the kids would end up in the orphanage.

So, they were all abused by the same abusers for the same amount of time, both physically and sexually, but the variable was attachment status. We ran some numbers on that and found that the ones who had secure attachment before they went to the orphanage and then were abused, had post-traumatic stress, somatoform symptoms, anxiety and depression symptoms. None of them had a major personality disorder and none of them had major dissociative symptoms like dissociative identity disorder. Mostly they had, if any addictive behaviors, only one addictive behavior. But, the ones who had disorganized attachments in addition to those diagnoses, all of them had either mixed or borderline personality disorder diagnosis, all of them had major dissociative symptoms, which meant the existence of parts, and all of them had multiple addictive behaviors, two or three addictions. We began to think that what was called complex trauma in the field was not really complex trauma. It was really a disorganized attachment, aggravated by later abuse in childhood or later childhood. We began to rethink the whole approach to treatment: that we needed to treat the underlying attachment disturbance. What happens with disorganized attachment is that the three major developmental lines all get disrupt-

ed early, in the first two years of life. The three major developmental lines are emotional development, self-development, and relational development. That manifests in the late teens or 20s, in the form of a personality disorder emerging...

Dr. Dave: Aha,

Dr. Daniel Brown: ...and then, if they have disorganized attachment, Frank Putnam, Mary Main and others have shown that kids who have disorganized attachment tend to have many more dissociative symptoms and behaviors in childhood. Then, if they are abused in later childhood, they fixate the dissociative strategies as the main strategies they use to cope with the abuse. So, later, in adolescence or adulthood, they develop major dissociative symptoms, like a depersonalization disorder, or full dissociative identity disorder. Dissociative identity disorder is really the double whammy. It's disorganized attachment, aggravated by later abuse which causes them to overuse the dissociative strategy as the main strategy to cope with the abuse.

Dr. Dave: Yeah, you mentioned that sometimes the memories didn't emerge until later in life. Hasn't that been a big debate in psychology? Whether or not memories, traumatic memories can be repressed and have there been lots of court cases around those sorts of issues?

Dr. Daniel Brown: Yes, I've been an expert witness in many cases on what are called Daubert hearings, where you have to prove the scientific evidence that there is such a thing as dissociative amnesia, the term used for repressed memories. I've been involved with a number of those cases. In the last 10 years we're beginning to win most of those cases, for two reasons. One is because the science is developed. There are, as of today, 110 articles on people partially or fully forgetting childhood sexual abuse. In other words, the science really revealed in every one of those studies that there's some percentage of people who don't remember. Not a great percentage, but some percentage of people who don't remember childhood sexual abuse. So, the "false memory" people saying that it doesn't exist is simply wrong, according to the data. The second reason, and the more powerful reason, we began winning in the courts, the Daubert hearings, was because of neuroscience, mostly coming out of Europe and Germany.

There have been a number of studies on what's called dissociative amnesia. In ordinary emotional memory, we store and retrieve the memory through to two different neural circuits. One is the right temporal parietal system. That's where long term autobiographical, emotional autobiographical memories are stored. The second is the medial prefrontal cortex, which is the sense of self. So, when you retrieve a trauma, two things happen, there are two circuits that get activated, the right temporal parietal system, which is the retrieval of the emotional memory, and the second is the medial prefrontal cortex, which means that the memory is about the self. Then we can say that this is an

emotional experience that I had because it happened to *me*. In fact, the neurosciences exactly mirrored a point that Piaget, the grandfather of dissociation, said 150 years ago, that when you recover from traumatic memory, two things need to happen, one he called realization, making the memory emotionally



real and the second is personification. That is, you have to say this is an experience that happened to me. People can come up with a memory, but it's not emotional - they distance themselves from the emotion. Or, you can come up with an emotional memory, but you can't say it happened to me. Those two processes, personification and realization, exactly mirror what the neurobiology of dissociative amnesia shows, because either the sense of self goes offline, or the emotional memory circuits that retrieved the memory go offline.

And since that's well established, particularly in Markovich's work and others in Germany, then we began to introduce that as testimony in the court. So, people who have dissociative amnesia is not something that's iatrogenically suggested, it's a real diagnosis with clear neurobiological routes. People who have that capacity for dissociative amnesia are at a disadvantage in the courts. Consider the two women who get sexually abused and molested by their own father in an incest scenario. One of them has a dissociative coping style and one of them has an externalizing coping style. The one with the externalizing coping strategy will act out in school, have a lot of behavioral problems and symptoms, and probably get recognized in childhood as being abused. The one with the dissociative coping style will put it out of their mind, they won't remember it for years, often decades. They'll have better grades in school, they have more friends in school, and then sometime in adulthood, they'll recover the memory and they become disorganized at that point in time. It depends whether you want to pay for the abuse at the beginning, right after it happened, or you want to pay over a layaway plan. Either way you pay for it.

Dr. Dave: But where does the term "narrative memory" fit into what you're saying?

Dr. Daniel Brown: Well, most people who get traumatized have an implicit memory for the trauma but not a narrative memory for the trauma.

Dr Dave: So, in other words it's unconscious, it's working unconsciously.

Dr. Daniel Brown: We see behavioral memory for the trauma occurring in three forms: avoidance

behaviors; and dissociative re-enactments; and strong feelings when they get triggered, but they don't want to know what the feelings were about.

Dr. Dave: You've gone on to create a therapy training that's called *The Attachment Project* in which you went through an extensive review of all the various kinds of interventions theoretical and applied that have been used to the repair attachment and you've developed your own approach that you refer to as "the three pillars of comprehensive attachment repair." You outline four kinds of attachment, secure attachment, dismissing attachment, anxious attachment, and disorganized attachment. You've already spoken a bit about secure attachment and disorganized attachment. Take us through either the remaining two or all four for a little bit.

Dr. Daniel Brown: The grandfather of attachment was John Bowlby in the 1940s and he said that healthy attachment is an interplay between two factors. One is secure attachment behavior, and the other is healthy exploratory behavior. The paradox of human attachment is that the more secure the child feels with mother as the safe-haven or secure base, the more of an independent explorer they become. So, it's an interplay between healthy secure attachment, which lasts for several years, and the way that child explores the world and they develop a strong sense of self. It was Winnicott who said that playful exploration is the vehicle of self-development. So, the first empirical test of Bowlby's theories was Mary Ainsworth's work in Baltimore. She developed what was called a *Strange Situation Paradigm*, which is a standard test. You take children at the ages of 12 to 24 months, bring them into a playroom, where there's toys on the floor, and a big plastic box filled with toys. There's some negotiation between the mother and the child to open the box. There are several chairs in the room and no instructions. The child is observed for three minutes, along with the mother, with no instructions, in this unfamiliar environment. Then a stranger comes in unannounced who is a confederate to the research, and they interact for three minutes and you see how the child's play behavior is affected by the stranger's presence. Then after three minutes, the mother is asked to leave, and you see the child's response to the mother leaving and how that affects the play for three minutes with the stranger in the room. Then the mother comes back and you go another three minutes and there's a reunion period. The mother leaves the second time the child is left alone for three minutes in the room and then the mother comes back for a second reunion.

Four patterns emerge. The first pattern is secure attachment. The more the child feels secure in the strange environment, with the mother as a safe haven, the more they get into the toys and they explore the toys. If they explore too much and get a little bit fearful, they'll come back and connect with the mother and then go right back to exploration again. So, it's a healthy interplay between exploration and attachment behavior. When

the mother leaves, there may be a clear protest and they show clear preference to the mother over the stranger or being alone, but none of those variables interferes too much with the exploratory behavior.



Whereas, kids who have dismissing attachment or what in childhood we call avoidant attachment (we call it dismissive attachment in adulthood), they have deactivated the attachment system. They don't care whether the mother's in the room, the strangers in the room or they're alone, they just go for the toys. They often get really frustrated and can't play easily. They are extremely dependent.

Kids who have anxious preoccupied attachment or we call it resistant attachment of kids and anxious preoccupied attachment in adults, do the opposite. They have deactivated their exploratory system. So, they get very clingy in their attachment behavior. They cling to the mother in the strange environment, they can't explore the playroom. When the mother leaves, they are basically inconsolable and can't play after that.

Dr. Dave: Aha

Dr. Daniel Brown: They get too clingy. Disorganized attached kids do both. They deactivate the attachment system and the exploratory system.

Now, in the original classification by Mary Ainsworth, there are three classification systems. Secure, insecure, anxious preoccupied, and insecure dismissing. There's about twelve 12 percent of the people who weren't classified. 10 years later, Mary Main asked for that data and she re-analyzed it and came up with a fourth category called disorganized attachment. We now know, many years later, that the ones with disorganized attachment have the greatest psychopathology in adult life. That's what we found out in the orphanage study. The ones who have disorganized attachment accounts for most of the variants of adult psychopathology. So, we want to give some special character treating of disorganized attachment.

These attachment patterns are well set up by 18 to 24 months. They don't change much after that. 75 percent of people who have insecure dismissing attachment will be dismissing in adolescence and adulthood. Seventy-five percent of those who have anxious preoccupied attachment in childhood will have the same in adulthood. Same with dismissing attachment. But, there are some people, some children that we've studied over time, in this field, who developed what's called "learned security". That was a term put

forward by Mary Main, who was my teacher. Some people will have a Grandfather or an Uncle or an Aunt who was a good attachment figure or a teacher in school and they remap the attachment. So, they end up with secure attachment where otherwise they would expect them to have one or more of the three varieties of insecure attachment.

Dr. Dave: Yeah. So that would also suggest, I'm thinking of therapy or the kinds of interventions that you've been developing, that it's possible to remediate, or reprogram, if you will, the attachment style. Is that right?

Dr. Daniel Brown: Yes. It takes some time and the right approach, but usually in somewhere between one to three years, you can completely remap the attachment style, and they'll select different kinds of relationships more healthily.

Dr Dave: Wow. Psychotherapy has been predicated on the idea of growth and change, although always not with the same degree of precision that you're describing.

Dr. Daniel Brown: We're finding that we're getting complex trauma patients better in three years by focusing on the disorganized attachment and not focusing on the trauma. The trouble with focusing on the trauma is that if you just process trauma with complex trauma patients, they get more incoherent of mind. The phase-oriented trauma treatment, which is the standard in treating trauma, doesn't work for people with complex trauma. You have to treat the disorganized attachment first.

Dr. Dave: Now, in your treatment model, you outline three pillars as you call them. Pillar 1 is called the *ideal parent figure* or *IPF Protocol*, Pillar 2 is fostering a range of meta cognitive skills, Pillar 3 is focusing, collaborative non-verbal and verbal behavior. So maybe you can take us through those three pillars and give us a sense of what each entail?

Dr. Daniel Brown: Attachment behavior begins in the first days of life with the child's recognition of the caregiver and reaching out to the caregiver. But, that fundamental thing, from a developmental perspective, is not attachment behavior. It's a representation of attachment that Bowlby called the development of a positive internal stable working model for good relationships. So, most of the attachment treatments in the 1980s and 1990s, were under the presumption that what the therapist should do is be a good attachment figure. But, for the patient, that's a bit of a trap, because in the times that we're not good, attachment figures caused a significant rupture, and this can cause a similar rupture in the therapeutic alliance. It's hard to repair it but I think it's a misunderstanding of the way attachment works. Good attachment means that the child has repeatedly had good enough experiences. And during the second year of life, it's no accident attachment representations start in about 18 to 24 months, because 10 to 20 months, 24 months is when representational thinking develops.

So, what's necessary for human development is not attachment behavior by the parent, but how the child represents it, the working model it develops. So, we began to think about that we could change the internal work and model and remap it. Actually, it's an idea that I got from my 48 years in Tibetan



Buddhism. In Buddhism, the Abhidharma is their theory of mind. They say that the methods to work with negative states of mind and the methods to work with positive states of mind complement each other, but they're not reducible to each other. Most of Western psychology deals with negative states of mind and if you use those methods effectively, you should expect a reduction of or the absence of negative states, but the absence of a negative is not a positive. What's necessary is to develop a positive internal map for healthy, stable relationships. Incorporating all the dysfunction in relationships isn't going to develop a positive map. So that influenced my thinking that what we needed to do is use imagination to develop a positive new map.

Dr. Dave: Yeah,

Dr. Daniel Brown: So, we say something like, imagine that you grew up in a family different from your family of origin, with a set of parents ideally suited to you and your nature. Imagine them providing you with a sense of absolute security in the attachment relationship and then, in an open-ended suggestion like that, have them imagine what an ideal situation with the parents would be with them in an ideal situation, and then we flesh it out from there. There are five major functions of attachment. First is safety and protection. Imagine ideal parent figures providing you with absolute sense of safety and protection. The second is attunement. Imagine these parents being carefully attuned to everything about what you do, but more importantly attuned to your internal state of mind. They really see you and know you. Imagine parent figures who can sooth you when you're emotionally upset. That's the third function of attachment. The fourth major function of attachment is what we call, "express delight." Imagine these parents being openly expressive of everything, taking joy in everything you do, but more importantly their joy and delight in your being, because "express delight" is this the source of healthy self-esteem.

Dr. Dave: That one really impacted me for some reason, probably something to do with my own attachment history, I don't know, but that idea of expressing delight is an interesting and powerful idea.

Dr. Daniel Brown: Well, I got the idea from Jo Sandler at the Hampstead Clinic in London. And he says that in terms of self-esteem, self-esteem is the linkage, the developmental linkage of positive emotions to the self-representation. That's a developmental achievement. Now what causes the child to associate positivity to the sense of self is the parents expressively being positive about the child and delighted in everything that child does.

Dr. Dave: Yeah...

Dr. Daniel Brown: And if that doesn't happen, when you invoke your sense of self, you evoke the sense of self against the backdrop of no feeling, which means that there's something fundamentally wrong and you can't pin it down to what it is. We call that narcissism in the West, where you evoke the sense of self against the backdrop of negative feelings, but we call that depression. What you can't do is evoke the sense of self against the backdrop of positive feelings. That's what's missing because it never happened. And the reason why narcissism and self-esteem and chronic self-esteem failure is such a problem in the West, is because parents are too busy in the *job*. They involve themselves in the *job* of parenting but not the *joy* of parenting. That's why I think it's a failure in Western society.

Dr. Dave: Yeah. Right now I'm aware of how many parents are looking at a screen of a cell phone, instead of looking at their child and reflecting something back to the child. You see that so much.

Dr. Daniel Brown: That results in anxious preoccupation. There are several predictors in the research of what causes anxious preoccupation. Mary Main said it was that they get over involved in being responsible for the mother's state of mind, so they develop an outside-in orientation. They're always regulating the mother's state of mind, rather than focusing on their sense of self. That interferes with self-development and interferes with the development of regulation of emotions, and it makes them chronic caretakers of other people's states. It turns out that is in some of Mary Main's original data. One of the best predictors in the home visits, not in the lab where they did the strange situation paradigm, but the best predictor of who became anxious preoccupied were kids whose mother was multitasking. She put the child on her hip and cooks dinner and watches TV with the kid or cleans the house with the kid on her hip. But, that's not really attuning to the child, that's doing what you're doing and getting the child to attend to your behaviors. That kind of multitasking is one of the roots of involvement in the mother's state of mind and trains the child to have anxious preoccupied attachment.

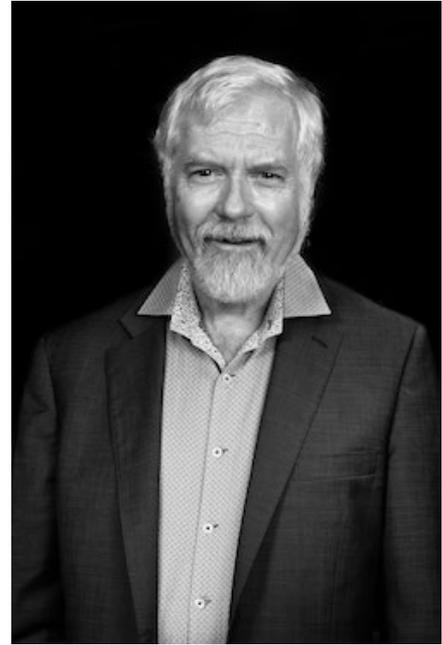
Dr. Dave: Interesting. Okay, so you have taken us I think through the ideal parent figure protocol of imagining...

Dr. Daniel Brown: You can do that many times. Every time you keep shaping it in a different way

and after a while you individualize it to the client. You do that once a week and we do therapy once a week or once every other week. We also put it on their iPhone now or their mobile device and have them listen to the tape each day, so they can practice during the week.

Dr. Dave: Yeah, and I have the impression that, at least some of the time, you use hypnosis as part of that?

Dr. Daniel Brown: Yes. Hypnosis, as you know, is a state of heightened attentiveness. That's what the neurobiology says. It's a state of where the anterior cingulate cortex is activated, which is the attention center of the brain, where you can concentrate with sustained concentration and tune out distractions. So, it's not the approach to treatment, it's the medium of treatment. It's easier to do this in a less distracted state with more sustained focus. That's why we use hypnosis. But you can do it without hypnosis, just by having them close their eyes and relax. I was into hypnosis for many years with this, and then I invited Jeff Young who does schema therapy, to teach in my program on several occasions, and Jeff didn't know anything about hypnosis, and he would simply say to his patients, "close your eyes and relax and imagine" and it worked just as well so I didn't spend much time on the induction ceremonies after that.



Dr. Dave: Sure. Pillar Two: Fostering a range of metacognitive skills. What do you mean by metacognitive skills?

Dr. Daniel Brown: Metacognition was discovered by John Flavell, the Piagetian psychologist in Stanford, in 1976 in a seminal article in *American Psychologist* and he called it, unfortunately, "thinking about thinking." What it means is that you are aware of your state of mind, number one, and you're aware of the strategies you're using when you're solving problems. So, people with metacognition can change their strategies and make them more effective when they're solving problems and they can be aware of their state of mind. It's a critical element of human development. And, there are four generations of metacognitive work. The first one was in *Mary Main's Adult Attachment Inventory* and it has to do with being able to step back and see that all knowledge systems are relative, that the way things appear is the not necessarily the way we construct them in our minds and that everything is a mental construction. She promised to develop that scale much more,

but never did. The people at Tavistock did that and it was Howard and Miriam Steele and Peter Fonagy, and Mary Target and Barry Lee Sinus and they developed what's called a reflective function scale. It's scored from -1.0, to +9.0. Most people in the general population, if you give them a scale of metacognition score about 4.5. That means that they're mildly metacognitive. People who've been in years of analysis are highly metacognitive and trained themselves to observe their own states of mind, so they get 8 or 9 on that. What Howard Steele told me, who collaborated on our statistics in our orphanage study, is they never found a person at Tavistock on the inpatient unit, who had a personality diagnosis or a dissociative disorder diagnosis, whoever scored above 3.0 on that scale. They were so low in metacognition that they developed the whole approach to treatment called MBT (Mentalization Based Treatment), a whole approach to treatment designed to introduce a variety of therapeutic strategies to increase metacognition.

And their outcome studies are very impressive. In a study of traditional treatment of borderlines, transference-based treatment, which is Kernberg's approach to the metacognitive tradition, in two years treatment, the MBT group, treatment effect size doubled compared to the traditional Kernbergian approach to borderlines. That outcome data raised my eyebrows. So, training people to develop metacognition seems to help them overcome personality disorders, and they've developed a good program with that.

Dr. Dave: How does that relate to say cognitive behavioral therapy or mindfulness training? Wouldn't those be about working with metacognition?

Dr. Daniel Brown: I'll give you the third school of thought and then I can answer the mindfulness question.

Dr. Dave: (laughs) OK

Editor's Note:

We continue this fascinating conversation with Dr Daniel Brown in the April Issue. There is so much information to process and I feel that it would be helpful to have time to review this first part of the conversation before moving into the last of the 3 Pillars.

WORKING WITH ATTACHMENT & TRAUMA

PART 2

Dr David Van Nuys Interviews Daniel Brown, PhD.

INTERVIEW

Dr. Daniel Brown: The third school was developed in Rome with The Rome Institute of Cognitive Therapy by Tony Dimaggio, Giovanni Liotti and others. They developed what I call a *condition-specific approach* to metacognition. There are different metacognitive skills. Some patients have division and some are aware of the other, so there's not simply a general capacity like reflective capacity. You have to tailor the types of metacognition that are missing for that given patient. For example, they had three types of major metacognition. One was called meta cognitive awareness, the capacity to be aware of your own internal state of mind, mostly your feelings. The second is meta cognitive regulation, the capacity to be aware in such a way that it has a regulatory effect on the state of mind. That's very different. They found that borderlines are not deficient in metacognitive awareness, but they are deficient in metacognitive regulation. They're very much aware of their feelings and feelings of others, but they can't regulate the feelings. And the narcissists are the exact opposite. Narcissists have good capacity for metacognitive regulation, they can dampen their feelings and they're not aware of other people's feelings very much but they... they've got good regulation, but they they're not much aware of their own feelings and certainly not aware of other people's feelings at all. So, what they suggested in their research was that one needs to be much more specific about training metacognitive regulation for borderlines and metacognitive awareness for narcissists. Not all the treatments are the same.

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They developed a third method, which was more important, called metacognitive integration organization. If I say to you on a 1 to 10 scale, 1 being completely disorganized, and 10 being completely organized, and the number is somewhere in between, give me a number right now that tells me your state of mind? If I do that with a borderline patient or a dissociated patient, like people with DID (Dissociative Identity Disorder), and I do that six or seven times in an hour, six months later, they have remarkable coherence of mind. I can shape their metacognition in such a way that it has this effect on coherence of mind. So that was the third-generation approach.

The trouble with mindfulness which Marsha Linehan put together and DBT, Dialectical Behavioral Therapy, is it represented her own interest in mindfulness but to say that borderlines are not aware of their own state of mind is too simple, because it's somewhat refuted by the research that shows that you have to do it in a certain way. You have to be aware of your state of mind in a way that has a regulatory effect on it. It's too simple to just be aware of it. You be much more precise than that.

And the fourth generation of metacognition was the work of all the people like Komment and Richardson, Ken Wilber and others who focus on adult metacognitive development. Piaget's model of intelligence stops at adolescence. If we think that cognition and intelligence stops growing in adolescence, we're in trouble as a species.

Dr. Dave: (laughs)

Dr. Daniel Brown: We've mapped out seven post-formal stages of cognitive development. The trouble with the Tavistock approach is that it has the wrong approach to meta-

cognition. It's all based on childhood forms of cognition and metacognition. We began to review all the adult forms, and most of it has to do with taking wider perspectives. When borderlines get out of themselves, or dissociate, and they can take in increasingly larger context and perspective, then it has an organizing effect on the mind. So, we began to shift to these post-formal ways of teaching metacognition and map out the types of metacognition and introduced that into the treatment because it was more efficient. It was working much better. That was the second pillar: training a variety of metacognitive skills, particularly post formal metacognitive skills. The third pillar was something I learned from the Rome group, from Giovanni Liotti. He talks about collaborative behavior. I went to Rome to study with him. He died this last year, so I owe him a debt in developing that pillar of our treatment and what I learned from him. He introduced me to the social anthropologist, Michael Tomasello's work. And Michael Tomasello spent ten years in the primate lab studying collaborative behavior in chimpanzees and silverback apes. He found that apes will collaborate around getting food in limited ways, but they won't collaborate on sharing the food. The huge evolutionary leap is for humans is that humans will collaborate on abstract projects. They'll develop teams and work on abstract goals together. The argument by Tomasello was that the human species, from an evolutionary point of view, is inherently collaborative. But, then he began to look at children who had insecure attachment compared to secure attachment in preschool behavior and what he found was that securely attached kids are naturally collaborative, they share their toys, they're sensitive to other kids who are upset in the classroom and they reach out to the other kids.

But, kids who are insecure, kids who are avoidant or resistant anxious, preoccupied or disorganized, they take the collaborative systems offline, already in preschool. Basically, they're going to grow up to be borderline or have complex trauma or major dissociative disorders. They've learned to be non-collaborative. So, you have to teach them how to be collaborative, both verbally and non-verbally. A dismissive attached adult in therapy won't look at you, they won't make eye contact. We take the time to educate them, to give them feedback, about that in a non-critical way, so they can shape themselves to live in the human world.

Dr. Dave: I see.

Dr. Daniel Brown: People with anxious preoccupied attachment can't take turns. They'll just talk over and keep talking over you. You have to slow them down and say, "Wait a minute, you've got to pause here and take turns in the conversation", and teach



them how to do that. We found that if we taught them a variety of collaborative and non-collaborative behaviors that affected the treatment frame, they settled into treatment much nicer. Nobody ever talked to them about developing this kind of feedback and showing them how to be team players. What I learned from Liotti is he talks about the collaborative system as being different from the attachment system, two separate systems. What he showed me was that if you have somebody who has a therapeutic rupture, he said, you can't repair that rupture in the bounds of collaboration. So if you make an insensitive comment in therapy, and you have a rupture with your complex trauma patient or your borderline patient, and you can't repair it, the more empathic you are, the worse it gets. It doesn't repair the system. But, if you step out of the collaborative system and stop trying to be empathic and focus on feelings, you can say, "Let's look at this as a team together. Something I did really deeply affected you let's step back and look at that together as a team." Then they start working in the collaborative system and that repairs the attachment system. Once that repair is done, which happens quickly, then you can go back and focus on attachment and talking about feelings again. It's quite remarkable.

Dr. Dave: So, we know that having an emotional experience is important, an important part of the repair experience. Where does that come into the three pillars?

Dr. Daniel Brown: It comes into the "felt" when you do ideal parent figures, it's always a feeling quality...

Dr Dave: Aha...

Dr. Daniel Brown: ...that comes into the relationship. We emphasize the underlying feeling quality of secure attachment. It's felt for attachment. Again, it's around team behavior when you're being collaborative, then you can get it to feelings and look at them and understand them and it settles down the intensity of feeling. This has a regulatory effect. Then you can go back and feel the feeling more fully in the context of a collaborative relationship, and it fits in the relationship. You can go back to be empathic again at that point.

Dr. Dave: Aha...

Dr. Daniel Brown: You repair it first before you can get to the feeling, because the feelings are too raw, too intense.

Dr Dave: Yeah. I understand that you've done an outcome study on this approach to see how effective it is. Is that study completed at this point or is it still in progress?

Dr. Daniel Brown: We did a pilot study with 11 subjects and we measured three things. We measured coherence of mind on the Adult Attachment Inventory, because people who have secure attachments on a 1 to 9 scale score 7 to 9 on the coherence of mind. We looked at the degree to which they developed a reflective capacity using the Reflective Function Scale from Tavistock. The third thing we looked at was whether or not they met the criteria for secure attachment on the AAI. Those are the three major measures. And we found that all three measures were met by all 11 of the people that had been in one to three years of treatment, three years max.

So now we're doing a major outcome study where we pooled that data to a larger group of about 50 people, that we're finishing now. I needed a control group, so, I linked up with George Haas in Los Angeles, who's taking a second training in the AAI right now, he's just finishing it with Mary Main. And he was interested in my attachment work and he developed an attachment training program that went for 12 sessions. It's a didactic psychoeducational program for people in the Los Angeles area, who were therapists. It turned out to be an interesting control group of 24 people. Most of them got interested in the attachment class because they had some variation on the theme of insecure attachment. They worked for 12 sessions, and then they had 12 sessions of mindfulness, but they didn't have the three pillars treatment. So, we have a psychoeducation group where they know a lot about attachment. Many of them have been in mindfulness, so they have some kind of metacognitive training. They have some intervention, but it's not the three pillars treatment. We've finished pretty much analyzing the control group, and almost none of them changed in the three years of the time cut off. What's unique about the population is they all have insecure attachment.



The majority of the people in that sample were anxious preoccupied. A few were dismissive, but the rest were either anxious, preoccupied or disorganized. We only had one secure person in the control group. None of them changed over time, even though what changed remarkably was their level of metacognition, but they were still insecure attached and didn't change their attachment status, and they didn't become more collaborative.

So, what it suggests is that the ideal parent figure is a necessary point to change the representational map. You can do other kinds of psychotherapy and get insight, but the insight alone doesn't change the attachment status. What we're finding is, with the three pillars, because of the emphasis on the primary pillar, the ideal parent figures, by reworking and reworking a positive map for attachment until it's stable, and they cooperate on that map, then they have a different map and they just select relationships differently on that positive model. It works. So, what it suggests is that insight alone in psychotherapy isn't enough. You need to change the attachment representation, which is what Bowlby said, way back in the 1940s when he pioneered this work.

Dr. Dave: Yeah, so I'm thinking of Milton Erickson, since hypnosis has been an area of interest for both of us and I'm wondering how his effectiveness in working with people, maps to what you've been talking about? I feel like there's a connection, an important connection there somehow.

Dr. Daniel Brown: Well, as you know, Milton was a master, and no one could do what Milton did.

Dr. Dave: Yeah, right...

Dr. Daniel Brown: ...He just had a remarkable ability to see what nobody else could see, because his disability was such that he mostly observed people in life very carefully. He developed his capacity to really see what people needed and respond to that. In that sense, he was seeing into the nature of their needs in a deep way. Most people who were treated by him felt deeply seen and he was always seemed to get the right approach.

Dr. Dave: Ah, fascinating. Well, certain number of therapists will see and hear this interview. What if they're interested in finding out more, getting training in this approach?

Dr. Daniel Brown: There are two levels of training. One is that if they wanted to learn about attachment as an approach there is a two to three-day workshop that we have online now. It's a psychology attachment project. *The Attachment Project* goes through the four types of attachment and gives the protocols, the three pillars protocols. It tells what to do with the ideal parent figures and how to use them over time. It gives an overview of attachment and the effects of attachment and the clinical manifestations of attachment. It covers treatment approaches, and the rationale for the Three Pillars Treatment.

The value of that particular site is, rather than developing just a general approach to attachment called the three pillars, which took us 20 years to do, we developed separate approaches for each of the three types of insecure attachments. There's one approach for dismissing attachment, there's another approach for anxious preoccupied attachment and there's a third approach, quite different, for disorganized attachment.

So, the course has both the assessment on it and the treatments. You can get continuing education credits for that, if you want to take a two- or three-day workshop, and you can get all that online. However, there are a number of people who want to get certified and we're developing a model, we haven't quite finished it yet. It will involve three levels of certification. The first will be this class that you take online. The second will be a core study group that meets maybe once a month, where people are actually supervised by somebody that we've trained in your local area or online or something like that, where someone can review cases with you as you actually practice this stuff. The third level of certification will be a masterclass with either myself or my co-authors on the book, where we review and make sure that it meets the standards of treatment integrity. That is, that what you're actually doing is what we think you should be doing. You get the three pillars to work with and then you get certified in it.



That's the model that we're trying to develop. It will all be on the attachment project site.

Dr. Dave: Okay, now, I want to come back to trauma. Where do you see this in relationship to the massive problem of trauma in our society?

Dr. Daniel Brown: I divide trauma into type one and type two – simple and complex trauma. Simple trauma, you can handle with some sort of cognitive behavioral exposure treatment. Whether you do classical CBT for trauma or something like EMDR, or whether you do what I like, comprehensive exposure treatment and working with beliefs, which is Patty Resick's cognitive processing therapy. Those are the models for simple re-traumatization.

The trouble with phase-oriented trauma treatment for more complex trauma is that if you have somebody with disorganized attachment, it doesn't work. They get more disorganized the more you try to process the trauma. So, you have to treat the disorganized attachment first. Whether you need to address the traumatization will come later, but the standard treatment for trauma is phase-oriented trauma treatment. I reviewed that in my book *Memory, Trauma Treatment and the Law*, in some detail, some 10 years ago as the standard in the field, but we made several exceptions to that: It doesn't work with people with disorganized attachment, you have to do the attachment work first; and it doesn't work with people who are victims of sadistic sexual abuse, because when people who are victims of other kinds of sexual abuse, the offender will minimize what they do because they have an addiction. They're not interested in the state of mind of the of the victim and therefore, validating their memories is

part of the treatment. Sadistic sexual abuse isn't about sex, it's about power and domination. It's often accompanied by degradation, verbal degradation, physical violence. Abusers pride themselves in knowing the mind of the victims and taking over the mind of their victims. So, what happens with victims of sadistic sexual abuse is they start with phase oriented, trauma treatment, they feel safe and then they start to work on the memory processing after they feel safe and they develop some stabilization skills.

Then it can complicate because when they start to get to the processing of the trauma, they back off from the treatment because to be known is to be taken over. So, you have to switch out of phase-oriented trauma treatment to good old transference-based work. You have to say, in a here-and-now transference, "The dilemma for you is it if you let me know you then you're afraid I'm going to take over your mind and I'm going to do all the things – the mind games that the sadistic abuser did to you." You can see how that keeps getting played out in the relationship. That's how you give them emotionally corrective experience. We have to adjust the trauma treatments according to the mixture of the population we're working with. That's what we've tried to do over the years for this approach. This is the best match for this type of traumatized individual, for another traumatized individual there will be quite a different match.

Dr. Dave: Okay. Is there any other last thing that you'd like to say?

Dr. Daniel Brown: One final comment is that there are three relational maps. There are the attachment maps, one for about the first 18 months. Then there's another map that covers the development of relationships at the third and fourth month when people have the capacity for complex ideas, they internalize family and cultural beliefs. We call that a CCRT map – core, conflict, relational themes map. That's more accessible. So we can say the difference between those two maps is that the people who have attachment problems have trouble *with* relationships, whereas people who have core conflict relational themes have trouble *within* relationships. They select the same old dysfunction from relationships. The way you develop a CCRT formulation is you get a history of all the intimate relationships in their life, how they started, what happened over time and how they ended. What you see is that they're not all over the map. There's usually, like a complex music score, there's one or two central themes and infinite variations on the same two or three themes. Their relationship behaviors always pattern that way, so you can interpret those maps and change the maps. That's called a CCRT formulation.



The first two are both developed in childhood. The third map is developed under conditions of high fear arousal. You can develop a new map as an adult, or an adolescent. We call those *trauma-bonding maps*, like in the case of the Stockholm Syndrome, or the case of childhood incest, or in case of battered women. Under the conditions of high fear arousal where intermittent powers, and caregiving is given in the relationship, they form a new map that rewrites the old-world healthier maps in the direction of unhealthy trauma bonding maps. So, when you start with treatment for a relational disturbance, we need to know what the map is that we're going to fix, because they require quite different approaches.

Dr. Dave: Okay, wow. Well you have packed in so much information, and I'm so impressed by the degree to which you're able to slice and dice all of these ideas hold it all together and articulate it. It's very impressive. So, Dr. Dan Brown, I really want to thank you for being my guest today on Shrink Rap Radio.

Dr. Daniel Brown: And thank you. Pleasure to meet, finally, I've always been a fan of your work.

Dr. Dave Commentary:

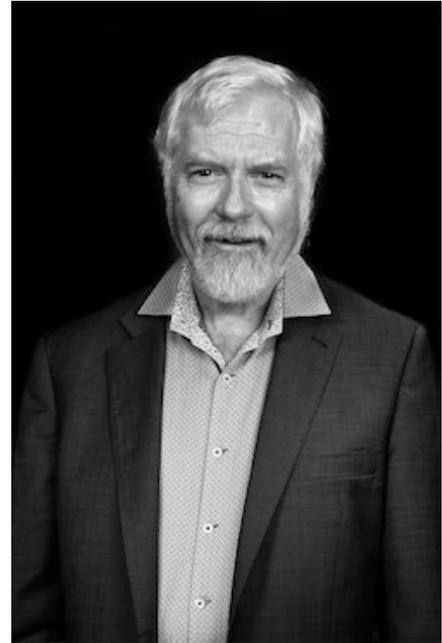
Today's interview with Dr. Daniel Brown on understanding and treating attachment disorders was nothing short of amazing. Actually, it's Dan Brown himself who strikes me as a sort of superhuman in terms of all that he's accomplished. No wonder that he's been a Harvard professor for 38 years. His work on the understanding of attachment issues, and the treatment of attachment disorders, is truly pioneering. His investigations into the dynamics of attachment is more

nuanced than anything I've previously encountered. He's reviewed the literature from Freud, on through Bowlby, Ainsworth, Winnicott and progressively more recent theorists to develop his own conception of both underlying theory and clinical applications. He has a mind-blowing command of the details of names of everyone in the field. In our conversation, his expertise came out in such a torrent of detail, that I could scarcely track it to make intelligent comments. As if I didn't already have enough evidence of his prodigious memory skills, he complimented me on my doctoral research from 1970. Almost no one remembers that research, even I have trouble recalling it. Part of the reason he does recall it is that it bears on another area of his deep expertise, which is hypnosis. Here's some of what I was able to glean from today's conversation.

There's a clear but complex relationship between an individual's attachment orientation, and their response to trauma. In other words, not everyone is going to respond to a given trauma in the same way. Both the details of the traumatic experience and their habitual attachment orientation will mix to create their own unique reaction. In our conversation, we discussed the four major types of attachment, secure attachment, dismissing attachment, anxious attachment and disorganized attachment. And of course, he was able to expand on each of these in considerable detail. Then we went on to his treatment model, the three pillars of which are pillar one, the ideal parent figure protocol, pillar two fostering a range of metacognitive skills, and pillar three fostering collaborative, nonverbal and verbal behavior. I was particularly intrigued by the first pillar, which involves prolonged and repeated imagining of the ideal parent figure, the one they never had. An important component of this imagining is the ideal figure prizing the patient. This portion of the treatment may go on for as long as a year and this is the portion that will create a corrective emotional impact. This phase of the treatment is inspired by Dan's experience and experience in hypnosis. Although he shares that he later dropped any formal hypnotic induction. Dan's research on his three pillars approach encourages him to continue in this direction. He finds that it's possible to "reprogram the brain to a state of secure attachment," However, this is not a quickie panacea. Treatment may last up to three years.

As if mastering trauma, attachment, and hypnosis were not enough, Dan has spent years cultivating expertise in Tibetan Buddhist philosophy and meditation practices, even to the extent of learning to read Sanskrit, so as to get it unfiltered. We discussed this area of his work after the interview, and I discovered he has several websites devoted to this part of his life and teaching. One of his several

websites on Buddhism and meditation can be found at pointingoutthegreat-way.org where we read “in graduate school at the University of Chicago, he studied Sanskrit and also studied Tibetan Buddhist’s Sanskrit and Pali languages in the Buddhist Studies Program at the University of Wisconsin.” Dan told me that today’s preoccupation with mindfulness doesn’t go far enough. The practice must continue on to awakening. Dan Brown does not do things in halves, rather his mode seems to be all or nothing.



Winner of the 2018 International Society for the Study of Trauma and Dissociation (ISSTD) Pierre Janet Writing Award.

A comprehensive treatment approach for the repair and resolution of attachment disturbances in adults, for use in clinical settings.

With contributions by Paula Morgan-Johnson, Paula Sacks, Caroline R. Baltzer, James Hickey, Andrea Cole, Jan Bloom, and Deirdre Fay.

Attachment Disturbances in Adults is a landmark resource for (1) understanding attachment, its development, and the most clinically relevant findings from attachment research, and (2) using this understanding to inform systematic, comprehensive, and clinically effective and efficient treatment of attachment disturbances in adults.

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This book is a comprehensive educational resource and a deeply practical clinical guide. It offers clinicians a complete set of tools for effective and efficient treatment of adult patients with attachment disturbances.

