

Section: Modern PPT practice

ATTACHMENT, TRAUMA, AND WAYS TO INNER CONFIDENCE IN POSITIVE PSYCHODYNAMIC THERAPY



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Abstract

Traumatic experience changes health, relation patterns and conflict reactions. Threatening events can cause desperation and can profoundly damage personality structure capacities and bonding qualities like trust. A structured process of treatment back to confidence and a balanced everyday life starting with stabilization phases, leading to integration is described.

Keywords: traumatic experience, stabilization, therapeutic alliance, despair, attachment, positive psychotherapy

A man came upon a tall tower and stepped inside to find it all dark. As he groped around, he came upon a circular staircase. Curious to know where it led to, he began to climb, and as he climbed, he sensed a growing uneasiness in his heart.

So, he looked behind him and was horrified to see that each time he climbed a step, the previous one fell off and disappeared. Before him, the stairs wound upward and he had no idea where they led; behind him yawned an enormous black emptiness

- Anthony de Mello (1998)

Introduction:

“The word ‘trauma’ means ‘injury’ in everyday language. In psychopathology and psychotherapy, the term is used both for the triggering event and the immediate reaction of the person affected and also for any traumatic stress that may remain after the incident. Conceptually, it is clearer to speak of traumatic experiences, traumatic processing, and subsequent trauma sequelae.” (Boessmann & Remmers, 2022).

The term trauma usually is used when an existential feeling of safety is damaged or destroyed. Post traumatic life quality depends greatly on former life experience in several developmental phases. The abilities such as trust, acceptance, love, patience, tenderness

are needed in a normal development of structural attachment and bonding qualities. Continuing experiences of attachment in early development can become a strong basis for coping, trust, hope and confidence in later life and in relations. In traumatic developmental conditions, the opposite experience of the client existed, as in threats, being rejected, hated or treated in a harsh and wounding way, and, therefore, resulting in a lack of an internalized safe person, place and feeling as well as in vulnerable and fragmented structural capacities of the personality.

Traumatic experience changes health, relation patterns, conflict reactions and activity. Threatening events can profoundly damage the personality structure capacities: The perception changes and focuses now on safety and threat;

the impulse regulation and actions follow the needs of physical safety; the emotional communication is limited to the trustful part that remains. The strongest damage is caused to basic trust, hope and bonding as qualities of attachment and separation needed in relations. Consecutively, the self as such, the self objects, the inner objects and representations can be changed. The imagination of formerly safe persons and situations change, and this again influences the perception, impulse reactions and emotional communication: A vicious circle of post traumatic personality pattern starts after life-threatening traumatic experience, and formerly safe relations are challenged by the change.

Methodology

2.1. The situation of mental traumatization: pathogenetic and salutogenetic bases of despair.

Three basic principles of salutogenesis and coherence described by Aaron Antonovsky (1979) are challenged in existentially significant ways in the situation of despair:

- Comprehensibility
- Manageability
- Meaningfulness.

Social support and the existence of helpful individuals, animals or objects can be added, that can become inner representations of safety to cope with an upcoming dangerous situation.

A previously experienced context of meaning and safety can become dissolved by a situation that is perceived as irreversibly threatening or guilt-ridden. In despair, the situation can no longer be understood, can no longer be classified with the previous concepts of experience. This results in a dilemma that is perceived as insoluble: any further action would intensify the potential for conflict, but refraining from action also leads to a worsening of the experienced situation. This situation of partially unconscious conflicts is characterized in psychodynamic as an inner conflict. It represents an inner drama whose resolution must always lead to conflict intensification.

"Trauma of helplessness of the ego" is what Bibring (1953) calls the state of powerlessness, paralysis, despondency, helplessness and hopelessness, torpor, lifelessness, lack of feeling, lack of relationship felt in it. All these feelings occur in despair.

In psychosomatic medicine, the *giving-up-*

given-up complex describes helplessness as *giving-up* with still passive appeal for help from outside. *Given-up* describes hopelessness as lonely, objectless despair with the feeling: 'Everything is too late' (Schmale & Engel, 1967).

The body-feeling, the holistically acting affective quality as of a bodily perception evaluating character, becomes in the despair of the traumatic situation the threatening feeling up to maximum paralyzing fear with the needs switching off. In the safe situation, on the other hand, the body-feeling is perceptible as physical calmness, enjoyment and security with balanced affectivity.

Despair is described as an innate affect, which is activated in the separation situation in humans and animals after the phase of protest before the eventual derailment of physiological regulation (Köhler, 1997) up to psychogenic death. Despair is thus not only an emotional-psychic affective phenomenon, but closely linked to the physiological regulation processes. These are influenced in their regulatory quality in the interaction with the mother or the closest emotional caregivers, so that a cortical representation emerges that eventually makes the child independent of the caregiver (Köhler, 1997) The quality of being lost and abandoned is again present in the situation of despair, as we find it e.g. before a suicide attempt.

Seen from the functional, final point of view, despair is the ability to abandon oneself to fate in the situation. In contrast to depression, actual despair in a subjectively traumatically experienced situation initially contains a very high energy potential, which is expended to the point of physiological exhaustion: "hair pulling" and hand wringing are body language expressions of autoaggressive self-blame, of energy without meaningful purpose. This enormous energy, amplified by guilt conflicts and feelings of isolation, eventually leads to a suicidal tendency as an attempt to escape guilt and the need to act, to perceive all possibilities after life as more suitable than life itself.

2.2. Despair in the therapeutic situation: Counter transference and psychodynamics

In the situation of despair, conflict and conceptual themes that can be grasped in terms of content can be described by abilities such as doubt, certainty, trust, hope, acceptance, faith, so-called "actual capacities" as contents of conflicts and concepts according to Peseschkian

(1987). They cause specific counter transference phenomena in the encounter with the guest. Conclusions can be drawn about the basic conflicts and basic themes.

Hubert Speidel (1996) gives an example of this: He had taken on an asthma patient. He describes: "In the first two sessions I hardly got any contact with the patient. I felt helpless, unhappy, wondered why the colleague had worked with him at all; in any case, I didn't know what to do with him, found him unproductive and boring, and had pessimistic expectations regarding further work. He did not come to the third session. Instead, a doctor from our intensive care unit called me: The patient had been admitted there as an emergency; he did not have status asthmaticus, but he was not breathing properly, although there was no reason for this. He, the doctor, did not know what to do. We had both witnessed a "giving up." The patient died shortly thereafter in the intensive care unit. He had, what we usually know of old people, apparently decreed his death, presumably because he had been abandoned by his central object of transmission." *Speidel* further explains that in this case the patient's appeals had not been perceived in time. The sensations triggered in psychotherapist and physician, the so-called counter transference, reflected the patient's unspoken inner state of mind: "*perplexed, unhappy, wonder why, pessimistic expectations, don't know what to do at all.*"

Psychodynamically, this may express the insufficient attachment experience that a patient unconsciously re-experiences in the current trigger situation of an object loss.

When feelings of indifference toward the patient in the presuicidal syndrome (Ringel, 1953) appear as countertransference in the practitioners, they are signs of advanced despair, the risk of suicidality is then very high. Hidden in suicidality is the thought of murdering offending, emotionally significant persons. This aggressive energy can be directed against alternative objects or against oneself, as in Sophocles, the tremendous murderous energy of Aias against the cattle instead of the murder of his comrades-in-arms who offend him in the Greek mythology.

2.3. Despair, resources and resilience

The development of the resources of the distressed person, the encouragement is in the foreground especially of the trauma-related

therapy. After the acceptance of the suffering as justified, the supportive accompaniment, entering into interaction, the broadening of the perspective and the directing to the existing, to strengths, to previous coping experiences is in the foreground through the conversation.

2.4. Treatment strategies of affective quality despair

*Christian Reimer*⁹ describes three phases of emotional processes in the substantive psychotherapeutic approach to crisis intervention:

1. grief / despair
2. protest/rage
3. distancing/reorientation.

They correspond to the formulation of three stages of human communication: Attachment, differentiation, detachment according to Peseschkian (1982). Therapeutic strategies that can be applied to the quality of despair are derived from this by Reimer (1996):

- In the first phase, *while* still experiencing full despair, the focus of the encounter is on connecting with the despairing person, accepting and encouraging the expression of grief and despair without reservation.
- This prepares the second phase of discernment, protest, anger, in which the energy of despair is rechanneled, the expression of aggressive and angry affects becomes possible.
- The third phase of emotional distancing, detachment, reorientation and integration enables reflection on the experienced traumatic state, it can be talked *about*.

The experience of despair itself can act as a driver for the development of resilience, understanding, action, faith, and a sense of meaning on the way from doubt to security. The focus is on finding meaning after the crisis of despair.

Discussion

3.1. Therapeutic practice and therapeutic relation

As therapists, we want to understand the history of continuing micro-traumatic experience, mono-traumatic or complex multi-traumatic life events, and, on the other hand, to understand the qualities of internalized objects of attachment, preventive factors, resilience and coping capacities to accompany our guests. Still,

we have to be careful: Concerning *Thomas Gruyters*⁴² that the: “anamnesis may trigger fragmented trauma memories and arousal and dissociative states. In the absence of prior information, the triggering of these states during anamnesis is in itself a criterion for the possible diagnosis of “trauma sequelae disorder.” ...”If the presence of PTSD, mono- or complex traumatization is suspected, it is recommended to conduct a “gentle” stress-resource anamnesis. The patient needs the feeling of security and stability also and especially at the beginning of a therapy and thus also during the anamnesis. It is a tightrope walk on the edge of traumatic experience, a careful sounding out, grasping and labeling of traumatic experiences without immediately going too deeply into them.” ...“There are considerable differences in the approach between (acute) monotraumatized persons and complex traumatized persons. While the former are often able to talk about the incidents quite quickly and under moderate stress, the risk of decompensation increases with increasing degree of multiple traumatization and an early point in the traumatic experience in the course of life. Patience and attentiveness are necessary to ensure that the patient remains in the “window of tolerance” as far as possible, even during the history-taking process.

One of the methods that has proven successful is timeline work: On the timeline placed on the floor in the middle, the positive experiences are recorded and placed on one side of the line and the negative, traumatic experiences on the other side, using colored index cards. This prevents the focus from being too much on the negative and desolate, and the patient from being flooded with both the traumatic experiences and an associated feeling of extreme helplessness and despair. Another method is a systematic inquiry into positive and negative events during individual stages of life (0-5, 5-10 years, etc.). The nature and extent of the traumatic material revealed in this way have a significant influence on therapy planning and further treatment steps.” (Gruyters, 2022)

Therapeutic relations represent in trauma treatment a safe relation at a safe place in a safe environment, comparable to one's safe, own room in childhood. Differently from conflict or structural therapy, we need phases of stabilization before reaching the possibility of working with traumatic history and the involved subjects. “If there are conflict pathologies or

structural deficits in addition to the trauma sequelae disorder, these should only be treated psychodynamically after a successful trauma therapy phase has been completed. In trauma therapy, compared to the treatment of other disturbance patterns, a stronger structuring of the process is necessary. The therapist is more active, designs the process overall very transparently, and strives to name and resolve possible transference phenomena as early as possible. It is important to establish a solid relationship with the patient, a very clear working alliance and a very clear orientation in the here and now. The following structure of therapy is recommended across schools: Stabilization phase, trauma confrontation, integration.” (Boessmann & Remmers, 2022) It is important that as a therapist I do *not* try to understand what I did not experience myself, instead of that to give feedback to the guest how I can describe his or her feelings.

3.2. Therapeutic approaches in the trauma treatment process

1. Stabilization starts with a first phase of body and senses: An inner safe place can be created by hypnotherapeutic affirmations like imagination of an inner safe place, an inner helping object, a therapeutic safe as a place for the traumatic events (Reddemann, 2004) until the client is ready to open it. In this phase the body and senses need an environment of safe smell, colors, positions, sounds or movements.

2. A second phase of stabilization means to create a safe place where the client lives: To find out what means safe at home, to have an order and reliability that can be controlled by the client (not by others any longer).

3. The third phase of stabilization means to change the environment outside to avoid and change possible triggers or threats, like having no contact with traumatic memories, triggers or triggering persons.

4. After stabilization it is possible to start working through the time axis and events of the trauma experience like in a movie, under the control of the client as a movie director and with the therapists as assistants. In this phase the different trauma techniques such as EMDR can be applied.

5. The integration of the post-traumatic growth in everyday life is the last phase in therapy: To confront oneself with challenging situations and persons, to reflect everyday life

with the therapist, to find out the formerly-avoided chances in life and development.

The five phases of a helpful therapeutic alliance can describe at which point in therapy we are, in which phase we are in our therapeutic relation, which attitude and methods can be applied. Tools of potential orientated psychotherapy for the specific needs of our clients can then be chosen, based on a humanistic background, finding a clear and understandable way of counseling, treatment, concerning social environment and self help.

Questions for therapists in treatment of traumatic stress

1. Concerning developmental phases, attachment, safety, conflicts and challenges, the balance of safety and frightening challenges: "Can you describe a safe situation with your parents or other important persons in a difficult/dangerous situation?"
2. The four areas of safety can be applied to find out resources for stabilization:
 - a. Body and feeling (physical wellbeing, needs, body interaction, somato-psycho compensation):
3. "What makes your body feel well, thinking of all the senses, as to smell something that calms you down, to taste something you like, to listen to something that brings you in a good rhythm, to feel something that you like to feel with your body and skin, or a situation that gives your body a good feeling?"
 - a. Achievement and activity:
4. "Which activity gives you a feeling, that you can be safe and can control the situation?"
 - a. Relations and interaction:
5. "With which person, which animal, plant or situation do you feel safe and understood?"
 - a. Imagination, hope and spirituality:
6. "Which ideas, stories, rituals, movies, prayers feel safe and are good for you?"
7. What works well in our encounter, which different kinds of resources can we find out with the experience of our guest?
8. What does trauma mean, what does attachment mean for my guest, and how do i understand that as a therapist? Which are the actual post traumatic symptoms, and what are their functions for the patient?
9. In which way can I myself, as a therapist, become stabile 'like a rock on the seaside' when my guests tell me about threatening traumatic events?
10. Which types of conflicts does my client have:
 - a. Wishes/desires vs. rules (ambivalence conflicts, possibility to understand them: Stable structure),
 - b. Existential needs vs. absence of support (the ability to fulfill needs is not developed, a conflict of deprivation exists: Vulnerable structure)
 - c. Threatening existential images and situations (There is no possibility to cope with the existential threat: A post-traumatic conflict of life or death exists, a question of existence and absence of safety: The structure of the personality is damaged and vulnerable for triggers and interaction).
11. Which are the specific defense mechanisms of my client as coping strategies, and how can they be used and understood as related to the three types of conflict?
12. Which had been former post traumatic symptoms or disorders developed after the events, such as general anxiety disorder or somatoform disorders?
13. Treatment plan: How can we start self help activity and start the stabilization of the patient? At which point is a more specific individualized trauma treatment needed? How do i experience my therapeutic position, the alliance and my transference role? How can i accept my client and myself in the relation with my guest? How can I be with the guest and being a neutral observer to accompany patients with macro- or micro-traumatic experiences, that I can not understand it in the way in which the client experienced all of it? In which of the phases of the therapeutic alliance are we now?

Conclusion

To create a strong therapeutic alliance in trauma therapy it is important to understand the role of despair, the need for stabilization phases, and to address the specific necessities of the client. Traumatic experience can change the pattern of attachment, personality structure and protection mechanisms. In treatment we address the traumatic symptoms as well as the abilities of the personality structure, including attachment and relation pattern. In this way the

structured five step process of posttraumatic treatment and a catalogue of questions for therapists, help to understand the clients situation and to moderate the therapeutic process.

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