

# 34TH ANNUAL INTERNATIONAL CONFERENCE ON THE PSYCHOLOGY OF THE SELF

excerpts from Chapter

Publication 2012

## **Thursday, October 13<sup>th</sup> Panel and Workshop Session B-2 Meet the Author: Self Experiences in Group -- Revisited: Affective Attachments and Intersubjective Regulations Creating Pathways to Human Understanding Judy McLaughlin-Ryan excerpts**

### **Do not duplicate**

Pg. 6 Research on and Rationale for Group Treatment of PTSD/AD

As suggested, group treatment can offer a condensed version of healthy attachments, with all of the benefits of belonging and having a welcoming place in which to turn to. Groups provide regulatory experiences, within a social developmental secure attachment and affiliative context, and include opportunities for encoding, processing, and modulating interactional and interpersonal information, both verbal and nonverbal, as well as modeling and mirroring complex social action skills that enhance the mastery of intimacy. In other words, groups teach the regulation that is necessary for improved intimacy skills and help create improved neuroadaptation required for those regulatory skills. Quimette, Moos, and Finney (2003) found that, when patients suffer from PTSD and comorbid addictions, participation in a twelve-step program early in the treatment process decreases the likelihood of relapse. Patients with substance use disorders and PTSD (PTSD/AD) who received focused treatment for PTSD immediately following initial stabilizing treatment for the substance use disorder, along with participation in a twelve-step program during the first year of treatment, were more likely to experience long-term (five-year) remission from the substance use disorder. In this chapter case examples are utilized to illustrate group interactions that contributed to healthy attachment patterns. These examples illustrate the pervasiveness of isolation as a predominant feature of PTSD/AD.

Pg. 7

Group experiences, early on in treatment, for those with PTSD/AD have been shown to be the most significant predictive factor for a positive treatment outcome. With the treatment of PTSD both analysis and studies indicate that

positive group support is the strongest predictive factor for a decrease in the severity of the PTSD symptoms (Guay, Billette, & Marchand, 2006). The analysis and research of the links between social support and the effects on PTSD of Guay, et. al. (2006), Lepore (2001), Lepore, Silver, Wortmann, & Wayment (1996), and Joseph, Williams & Yule (1997), indicate that positive group experiences are defined as non-critical, supportive, non-blaming group interactions which contribute to the decrease of symptoms of withdrawal and isolation, and increase the potential for assimilation and the enhancement of coping mechanisms. Conversely, negative group experiences, characterized by blaming or stigmatizing interactions, have the potential to further exacerbate PTSD symptoms of avoidance and isolation.

The similarities between the constellation of symptoms of PTSD and AD, supported by research findings, point to the necessity of integrating social support into the treatment. Twelve-step group support and/or psychotherapeutic group support offers reparative experiences in the areas of regulation, attachment, and brain functioning. The individual therapeutic relationship can reinforce and further develop the patient's exposure to understanding and interpretation of traumatic based reactions, as well as a dyadic regulatory experience. This exposure, along with the group experience, builds an increased internalized experience for securely based attachment patterns. As the psychobiological secure interactive experiences build and increase, the need for the patient to isolate is likely to decrease. While the group experience helps the patient build secure attachments, it also informs, educates and interactively demonstrates the balancing of affect and state experiences that move towards ongoing closeness to others. The psychotherapy group, or twelve-step group, in which members have had the actual real life historical personal experience of trauma and addiction in their lives outside of the group, gives group members the unique potential to share with one another an experience-based wisdom and altruistic service to one another. The patient's development of internalizing the ability to experience closeness to others increases, while the impulse to isolate decreases. The interactive experience further develops affiliative behaviors.

pgs. 7 – 8

### Sociability and Affiliation

Groups comprised of patients with PTSD/AD offer a sense of belonging and understanding. Maguar, Knight, Vogel, Mahmood, Laudet, & Rosenblum, (2002), conducted a longitudinal study of those diagnosed with PTSD/AD, which focused on mediators of the effectiveness of group treatment. Well-documented social models were utilized to analyze the indicators of group treatment efficacy. This study found that the variables that stood out more than any other in regard to group participation and to successful treatment outcome were sociability and affiliation (Maguar et al., 2002). Patients with PTSD/AD need to receive encouragement to engage in groups in order to practice and learn behaviors which increase the affective and state experience of understanding and/or

empathy. Because patients with PTSD/AD usually experience such acute feelings of isolation, they may need to learn what it feels like to be understood, and what it feels like to belong.

#### pg. 8 Attachment

Schore describes how the early relationship with the caregiver and infant, as well as the social environment, is transmitted through affective transactions that are nonverbal, followed by communications with others that prosodically and interactively respond to internal states of arousal and modulation. This experience is then paired with movement from this nonverbal affective state to verbal processing. Early social events are imprinted into the biological structures, which have long-enduring effects.

#### Pg. 9 Attachment

Beebe (2004) describes the attachment bond formation as an interactive experience of facial mirroring, vocal rhythm coordination, matched facial dialogue, which occurs during the search for deep mutual bonding with both infants during development and with adults in the interactively driven therapeutic relationship. Beebe (2004) describes the experience dependent facial/visual responsiveness of another, as an experience of being seen and recognized.

#### Pg. 10 Attachment

Bowlby's work illuminated these disruptive attachment patterns and described them as forms of dissociation and disorganizing attachment patterns. This explains the symptomatic residue that those with PTSD/AD experience. Those with PTSD/AD become dissociated and, as a result, their attachment and relationships with others becomes disorganized. Attachment patterns involving dissociative states are part of highly disorganized patterns. These patterns occur due to the desire of the "other" to effect the patient who has dissociative qualities. Without their awareness, those around the dissociated person begin to make more forceful attempts to "get the person to listen, respond, or just notice them." However, the dissociation only becomes more acute and/or a switch to a fight-or-flight mode may occur. Thus, there is a tendency for those attempting to communicate with the patient with PTSD to feel helpless and confused.

#### Pg. 11 Neurobiology

##### Neurobiological Adaptive Effects of PTSD/AD on Secure Attachment

Addictions implicate stress responses, which have a cascading effect on the PTSD neurobiological response, which, in turn, may trigger the addictive drug craving response. To be fully understood by the patient with PTSD/AD, these

stress-related reactions need to be addressed with immediacy through attachment regulation of others. This provides a pause, a moment, which may inhibit the stress-response cycle. Stress-induced experiences exacerbate the stress cycle. Part of the stress cycle begins with activation of the amygdala. This activation happens rapidly and unconsciously, without the patient's ability to slow it down for reflective thought. Not becoming blindsided by this response is one key to treatment efficacy. The amygdala causes corticotrophin releasing factor (CRF), which is the hormone involved in the stress response. High CRF is found in both PTSD and AD. This CRF stimulates the release of norepinephrine in the amygdala. This stimulating effect causes the release of CRF, which is found to be high with PTSD and causes fear-related behavioral responses. Additionally, CRF is also found to be high with addictions and has been found to mediate high levels of arousal and hyperarousal as well as to contribute to the risk of use of substances. This may reinforce the enhancement of properties of some substances of abuse, worsen withdrawal symptoms, and exacerbate PTSD. The cycle continues back to the release of CRF, which is operative during the stress response (Sinha & Brady, 2005). In addition to the corticolimbic response, other pathways activated during times of stress are those that include dopamine and other noradrenergic pathways that modulate prefrontal cortical function when there is an increased need for cognitive functioning as well as increased emotional demands. These systems also affect working memory. These stress systems, which activate CRF, also affect the dopaminergic systems. Notably, emotional stress and negative affective experiences have been shown to activate drug cravings with drug dependent individuals (Sinha & Brady, 2005). Furthermore, dopamine has been indicated as the chemical connected with self-administration of drug use and implicated as the mechanism of reinforcement for almost all drugs of abuse (Sinha & Brady 2005). Subsequently, the PTSD/AD cycle continues while the patient's attachment patterns become increasingly impaired.

PTSD (Semple et al., 1992) and alcoholism (Adams et al., 1995) both show evidence of structural impairments in orbitofrontal activity. Schore's (2003a) work suggests, "these functional vulnerabilities reflect structural weaknesses and defects in the organization of the orbitofrontal cortex, the neurobiological regulatory structure that is centrally involved in the adjustment or correction of emotional responses" (p. 24).

Pg 17 + 18

Accompanying both the importance of the development of secure attachment patterns and developing psychobiology within the treatment of PTSD/AD, current research supports that there are plastic capacities of the brain over the life span. In adulthood, the brain continues to remain involved in learning, cognitive-emotional interactions, and memory (Barbas & Pandya, 1989). Furthermore, theorists such as Stolorow and Lachmann (1980) describe the

important value of the psychotherapeutic process whereby the patient's historical developmental arrests are directed towards the mobilization and completion of formerly interrupted processes. These state and affective shifts can be observed through synchronized or unsynchronized attunement (i.e., timing of engagement), volume, prosody of vocal responses, gaze, mirroring facial expressions, responsiveness, engagement versus disengagement, body positioning, breathing, pupils, saliva and/or dry mouth, heart rate, sweat, and watering up of the eye as well as other responses. Infant research describes the interactions that promote neurobiological systems of regulation based on secure attachments. These regulatory experiences are described in terms of ruptures and repairs, under the pretext that this interaction fosters what becomes secure attachment.

### Taking Action

With those who have PTSD/AD, emotions are often not read at all, reacted upon appropriately, or utilized for life supportive, action-oriented behavior. Often time's emotions occur in the context of a traumatic interpretation, connected to the emotion that was experienced surrounding the original trauma. Van der Kolk (2006) discussed the necessity for the patient with PTSD to learn how to take effective action. For example, after one is stressed, the reaction to run towards a loved one for comfort and safety is a predictable response. With those who suffer from PTSD, this mobilization response may be impossible. Because many with PTSD experience chronically overwhelming emotions, they often lose their capacity to use emotions as guides for effective action. Van der Kolk states: "Unable to gauge and modulate their own internal states, they habitually collapse in the face of threat or lash out in response to minor irritations. Futility becomes the hallmark of daily life (p. 282)." Van der Kolk further describes the necessity in treatment to address "the experience and interpretation of disturbed physical sensations and preprogrammed physical action patterns" (p. 282). In other words, before one can take an effective action, one must have a sense of what is going on inside of his or her body and develop the capacity to act upon these sensations appropriately and not only from the perspective of the traumatic response.

Patients' increasing internal awareness, while learning to understand themselves, metabolizes the activation of the capacity to look for or to find a safe place in which to go (Siegel, 2007), (van der Kolk, 2006).

Those who have PTSD, when in a fight, flight, or freeze response in regard to a triggering event, need "a place to go," "a place to which to run," "a place of hope." This running towards hope metabolizes a reparative primitive response to the traumatic experience or memory. This is one of the significant values of immediate access to twelve step group meetings and access to other members on an as needed momentary basis.

