Conscious Life presents

HEALING TOXIC RELATIONSHIPS

Childhood Attachment and Adult Relationships

Guest: Dr Dan Brown

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[00:00:09] - Alex Howard

Welcome everyone to this interview, where I am super excited to be talking to Dr Dan Brown.

Dan's work in the area of meditation, attachment... Really one way I look at his work is the potential for human beings to live their best selves has been enormous in over many, many decades. Just to give people a few highlights of Dan's career, I've edited down his bio, you can read the full one below this video.

Dan Brown is Director of the center for Integrative Psychotherapy and has been on the faculty of Harvard Medical School for 40 years. He's the author of 23 books, and I have to say these are significant books, I've been diving into attachment disturbances in adults over the last few days, it's enormously comprehensive on this issue.

Part of what I think is also fascinating about Dan's work is in addition to having a very deep academic and practical experience in traditional Western psychology, Dan also has for many decades been a teacher, practitioner and researcher in the field of meditation and consciousness. He served as a translator and meditation teacher in the Indo Tibetan tradition for 48 years.

He's also just... Wrote *Translators of Consciousness* with Ken Wilber and Jack Engler and two books on the public dialogs of His Royal Highness the Dalai Lama.

In this interview, we're going to be exploring the area of attachments in relationship, and particularly the impact of unhealthy attachment in childhood and how that can show up in relationships as an adult and some of the practical things we can do about it.

I should say that Dan has Parkinson's and we may have points where it's not so easy to hear what he has to say, and it may be that we repeat a few things.

I really want to say, this is a really important interview that people... Of all the interviews in the conference, this is someone who has been a researcher, practitioner and teacher of this work for many, many years.

So, Dan, I'm really grateful to have you here. Thank you very much for joining us.

[00:02:30] - Dr Dan Brown

My pleasure.

Alex Howard

So, Dan, I'd love just to start with a broad introductional frame to when we talk about attachment, what are we talking about and why is childhood attachment so important in our adult lives?

Dr Dan Brown

Well, there are three types of relational problems that we have. The first is attachment problems for attachment disturbances, we call it. The second is what we call CCRT formulation, core conflict relational themes, it's the second map for attachment in relational disturbances.

The first map of attachment is recorded about 18 months, so about 18 to 20 months we develop an attachment map that determines whether we will have problems with relationships or not. That map is unconscious. It's preverbal. It can't be interpreted easily in the memory systems, there are two memory systems that develop.

The first is a behavioral memory system and the behavioral memory system is enacted. So if you read a child a book or you play a certain play sequence with the child, the child will remember it by enacting it. That's the first memory system, it's formed about nine months of age.

That's well formulated by the time that there's attachment maps that are developing by 18 months. So that child will enact the map, either express it in their behavior in terms of how healthy their attachment is, or how unhealthy the attachment is.

The second map is developed between the third and fourth year of life. That's much more complex development, it has to do with when a child can internalize cultural and family values and they develop internal belief systems or messages about what's possible or not possible in relationships. We call that the CCRT formulation, core conflict relational themes.

Those maps are interpretable. They have a lot to do with trouble within relationships. It has most to do with selection, that we repeatedly select for the wrong relationships. Even though we have the tools for getting attached, we select the wrong relationships.

And the third type of map can be formed both in childhood and adulthood. It has to do with trauma and abuse. And that's called a trauma bonding map. It's usually in an extreme relationship where there's a power differential in a relationship, such as a hostage taking situation, such as a history of family where there's domestic violence, when it's a cult organization it's the same thing. The person acts with too much power and sometimes they disempower the other person. And we can form an unhealthy map based on that kind of traumatizing relationship.

So those are the three types of relational problems that we have. Attachment problems first, core conflict relational problems second, and trauma bonding maps third. Each one of those requires a different treatment.

[00:05:45] - Alex Howard

And one of the things that I found really interesting as I was diving into your work is exactly that point you were just making, is that we need to diagnose which map where the issue is being created because that impacts then the treatment pathways that we're going to use, and that's something I'd love to come back to in a little bit.

But I'd love to as we open up some of this a little bit more, you did a fascinating study in an orphanage, which as I was reading about it, I was really struck by just how...

It sounds like a terrible word to use because nothing was fortunate about what these children or these adults had gone through as children, but there was something quite magical, in a sense, if you were going to design a study, you couldn't have designed a more kind of perfectly balanced study in terms of the different groups.

I'd love to just to say a bit about, and I should say for people that have got backgrounds of trauma, some of what we talk about might be a little triggering because there was a lot of abuse that was part of that.

But I'd love to hear you talk about a bit about the study and what you learned from what you observed from it.

Dr Dan Brown

Well, it was an orphanage called Madonna Manor that was in the great New Orleans area in the 1950s. In the 1950s, we didn't understand a lot about pedophilia. We didn't understand it very much at all.

And the solution of the Catholic Church was to take pedophiles and put them together running the same church or the same orphanage. So these were people who had been accused of being pedophiles and the brilliance of the Church was to put them together, five priests all running the same orphanage. The stories are rather sordid.

So the kids were physically and sexually abused on a regular basis for up to five years, and there were literally many kids who were abused. I do a lot of expert witnessing stuff in the courts around child abuse.

I've done over 200 cases against the Catholic Church. All those cases in the movie *Spotlight* were cases that I worked on the grand juries for. And I worked on nailing George Pell, the Archbishop in Australia. I worked as a consultant to that committee and he got life, and then in the appeal he got off. Go figure.

But I worked at this a long time. The Catholic Church has a bounty of unlimited funds to take me out as an expert, I take a certain perverse pride in pissing off the Church that much. But I am fiercely protective of children. I'll fight it no matter what it takes.

So in the orphanage study, we started with 24 kids that I had done expert witnessing stuff on as an expert for the defense, mostly for the prosecutor, for the civil cases mostly for the plaintiffs. And what I do is when you go to do something on expert witnessing, it's a war.

The other side is going to go after you, so I do thorough testing. I do two days of testing. I won't take on a case unless I could do two thorough days of testing.

[00:09:22] - Alex Howard

I was struck by that. 16 hours of interview per case that you were working with. Yeah. That's something.

Dr Dan Brown

And one of the things I give is the adult attachment inventory, it's the gold standard for measuring attachment. It's two year certification process to become certified in this. I was one of the ones that certified, I use it a lot in my research. And what we found was quite amazing that what's called complex trauma isn't complex trauma.

Complex trauma usually means that there's a series of repeated traumatic incidences or abuses to the individual. What we found was that that wasn't true at all. What we found was that almost all of the subjects that we attested had disorganized attachment, there are four types of attachment, secure attachment, which is healthy, and there's three types of insecure attachment, there's dismissing attachment, where you deactivate the attachment system.

There's anxious, preoccupied attachment, where you deactivate the exploratory system and you get clinging in the attachment system. There's disorganized attachment where you deactivate both the exploratory system and the attachment system, that's more severe. We found that almost all of the survivors of this severe abuse in the orphanage had disorganized attachment and it was later compounded by the sexual and physical abuse, but it wasn't the cause of it.

In other words, what we found that disorganized attachment affects all developmental lines, it affects relational development, it affects self development, it affects emotional development. The big three developmental lines. So you get developmental arrests along all three developmental lines and that's all in place before the abuse happens.

Alex Howard

And one of the things that struck me as well with the research was you ended up with a fairly even split between two different sample groups.

Those that had been in the orphanage since pretty much birth and those that had started off in a fairly, hopefully, loving, stable home, but for some reason, perhaps due to the loss of a parent or financial difficulty, those children might have had a more healthy attachment, but then had ended up in that.

Dr Dan Brown

Yes, that's true. Let's look at a slide on that if we can. This was the original orphanage study. What we found was that F means secure attachment, DS means dismissing attachment, E is anxious preoccupied attachment, CC means disorganized attachment.

Those are the four types of attachment unresolved trauma and abuse, whether the trauma is resolved or not.

[00:12:19]

And what we found was that almost all of the variance was accounted for by two things. One was disorganized attachment, that's the CC formulation, the second was unresolved trauma and abuse. The trauma wasn't completely worked through and that combination caused disorganized attachment.

So it caused us to rethink our treatment approaches because we normally treat complex trauma with phase oriented trauma treatment. Phase oriented trauma treatment means you provide stabilization skills, and once the person has got a set of tools to work with, they have a set of stabilization skills, then you uncover and work through the abuse.

Then you work through the split off representations about being the abuser, then you get them back on... The third phase is you get them back on a normal developmental track, you enhance self development, you get healthy relational development, and you get them have healthy emotional development.

Those are the three phases of treatment, the preliminary treatment, the working through of the abuse memories and the representations about the trauma. And thirdly, getting them back on the right developmental track.

What we found was that most of that treatment emphasized processing trauma memories. We found that processing trauma memories actually made people worse because they got more disorganized, not less disorganized.

And it's not useful to process the trauma unless they have some degree of coherence of mind. We'll come back to that a little later.

Alex Howard

Yeah, I think that's a really important point though, that the sequencing of treatment is so important.

Dr Dan Brown

So you treat the disorganized trauma, you make them better so that they have a healthy attachment and then you treat the trauma. That's what we found.

Alex Howard

If we come into a bit more something you said earlier about these different maps, I think is also an important point relates to this that there's a difference between difficulty with relationships and difficulty in relationships.

Dr Dan Brown

Yes.

[00:14:34] - Alex Howard

Can you just explain that difference? Because I think again, this links to the different stages of potential attachment issues in childhood and how that then impacts people later in life.

Dr Dan Brown

Well, if you look at dismissing versus anxious preoccupied attachment, people either connect too little dismissing attachment or too much anxious preoccupied attachment or they disconnect entirely, which is disorganized attachment. So that's trouble with relationships.

But if they have secure attachment, they can still get trouble with selecting relationships healthily. They might select for a partner that's abusive. They might select for a partner who's unavailable in many ways. They might select for a partner who they have a lot of conflict with, select for a healthy relationship.

So we always work from the bottom up developmentally. If there's a significant attachment problem, you treat the attachment. Once they get better, then you treat the core conflict relational teams. And then the final part of the treatment is what we call secure intimacy. You help them have healthy attachment and a healthy relationship and that you make a positive map.

Alex Howard

Yes, I want to come back to that piece in a little bit. Something that struck me as I was reading your work earlier as well was in attachment work, a lot of the emphasis is towards the role of the mother and the bond that the child has with the mother, and a lot of the early research that was done was around when the mother leaves, how does the child respond to that?

But I was struck by a line that you wrote around the role of the father and yeah, maybe just say a little bit about what fathers can bring that potentially is different for the child in attachment.

Dr Dan Brown

Yes, there are two aspects of attachment. One is, as Bowlby said in the 1940s, attachment is an interface between two systems. One is the attachment system and the other is the exploratory system.

So the nature of the human paradox is the more healthily attached you are, the more you separate and become independent. Because healthy attachment, secure attachment leads to healthy exploratory behavior which is how one develops a strong sense of self. So that's the paradox of human attachment.

The more secure you are, the more you become independent, the more you explore. Now, people who are insecure, there are three types. There are people who are dismissing, they dismiss attachment relations, they don't form relationships and they work very well on their own independently. They have healthy exploratory behavior but not as part of relationship, it's separate from the relationship.

The opposite of that is people who are anxious preoccupied. They get too worried about the state of mind of the other. And they're always giving up their own needs to go along with the needs of

the other. And they have a weak sense of self, never develop a sense of self that way and they have inhibited exploratory behavior, so they don't really develop that much.

[00:17:54]

The third is people who disorganize attachment and they deactivate both these attachment system and the exploratory system both. Usually they're the ones that have trauma and abuse in their backgrounds.

So those are the three types of attachment, you get too involved or not at all involved, over and under involvement. With attachment system and also over and under involvement with the exploratory system. You need both to have secure attachment.

You have to have healthy attachment and you have to be able to explore and develop a strong sense of self that way. So that's the first problem. They might not have a positive relational map for secure attachment, so we remap it. And the trouble we have with treatment is that if you look at the history of treatment the therapists put themselves in trying to be a healthy attachment figure, what about all the times they fail at that?

Then it leads to therapeutic ruptures which are hard to repair with attachment patients. So you get into constant binds with the patients about failures of empathy. So we did a little differently. We said that rather than the therapist getting into the bind of trying to become a healthy attachment figure, we'd have the patient represent in imagery healthy attachment. And it works.

Alex Howard

It's interesting, one of the things that... I'm not going to be able to quote this perfectly, but one of the things that really struck me when I was doing my research for this interview, was that resolving...

You said something like resolving negative states alone is not enough. And a lot of therapeutic work, particularly more traditional therapeutic models, have this very big emphasis on trying to resolve negative states, but that's not enough.

You talk a lot about the importance of cultivating positive states. Say more about that because I think that maybe perhaps to some of the professionals that are listening to this, perhaps a surprise, but I felt was a really important piece of the jigsaw.

Dr Dan Brown

We call that positive remapping, so what you have to do is you have to remap a healthy attachment system. They have to visualize it over and over and over again until they can form it as part of the structure of their mind. And then they start operating out of that.

They start referencing that attachment system, that positive system, rather than the old dysfunctional system. And then the feedback is compelling on that. They feel much better, so it works, so they keep doing it more.

[00:20:29] - Alex Howard

And it also doesn't create a dependency upon a therapist in the same way as well, which I think sometimes is quite frustrating.

Dr Dan Brown

So we call it ideal parent figures. So imagine a scene where you grew up in a family different from your family origin, with a set of parents ideally suited to you and your nature, you bring to mind the way that they're being with you that would lead to feeling absolutely secure in the attachment relationship.

We leave in open ended like that and we have them imagine all the details of that over and over and over again. And then we record the sessions and give them the recording so they can practice at home during the week. And somewhere between six months and then two years later, they've completely remapped a positive attachment system.

That's the first pillar of treatment, we evolved a treatment called the Three Pillars Treatment. The first pillar is positive remapping of the ideal parent figures. The second is metacognitive skills. Metacognition is important. It has to do with thinking about thinking, or even better, awareness about state of mind.

In neuroscience, the left dorsolateral prefrontal area is thinking about thinking. The right dorsolateral prefrontal area is pure awareness of state of mind. So you can do it either with thoughts or you can do it with pure awareness.

One way or the other, they have to observe your experience and observing that experience has an organizing effect on that experience. There's a whole treatment developed in London at Tavistock called mentalization based treatment.

It's based on developing metacognition because Howard Steele was one of the people who helped us with our orphanage study, said that they never found a patient who scored above three on a nine point scale in terms of reflective capacity or what they call metacognition.

That two groups of people who were remarkably lacking in metacognition. One group are personality disordered patients and the other are dissociated disordered patients. So they developed a whole treatment called mentalization based treatment to reintroduce metacognition to these patients. And they have the best outcome data that we have so far in the field by training metacognition.

Only what they train is what we would call childhood types of metacognition. There's a whole post formal metacognition development that starts around early adulthood. There are seven stages to metacognition. Most of it has to do with perspective taking of one sort or another.

I think those more mature types of metacognition have profound implications for mental health. So we introduce all that to the patients early on.

[00:23:21] - Alex Howard

And what are some of the strategy... Well, let's complete the Three Pillars and then I'd like to come back to it in a bit more detail.

Dr Dan Brown

They look beyond the information given, they look deeper into things, they go beyond the relativistic perspective where everything is organized in the mind. They take perspective, they can contextualize, they can see where their parents, rather than same old, same old, seeing there's something missing, they can understand why their parents couldn't have done that.

Alex Howard

So there's a cultivating of a level of empathy and, I guess, almost compassion for other in a sense.

Dr Dan Brown

Compassion, yes. So those are all important metacognitive skills to take on the context of the larger purpose in one's life that'll move self development forward in significant ways. So these are some of the metacognitive skills we try and teach.

Alex Howard

Which is interesting, it strikes me Dan, that one of the dangers of some traditional psychotherapeutic approaches is one gets more deeply fixated on their own perspective and they go deeper and deeper into their own feeling, and actually they're cultivating the opposite of what you were just speaking about.

Dr Dan Brown

Right, and the more you cultivate a larger perspective, the more interconnected you feel with a larger universe of people. Sort of gets you out of yourself.

Alex Howard

Yes.

Dr Dan Brown

So I would agree with that strongly. We build that into the treatment.

Alex Howard

Yes. And just to speak to the third pillar, just so we've got the kind of the bigger map, and I'd like to come into a few more specifics around it.

[00:24:58] - Dr Dan Brown

The third pillar I learned from Giovanni Liotti, who is my friend in Italy that I spent a lot of time studying with, he died just two years ago, so I'm trying to honor his work. And he said that the behavioral system is different from the...

Collaborative behavioral system is different from the attachment system. And for example, if the therapist tries to get into the role of being a good attachment figure and they fail at that, which is inevitable, and there's a therapeutic rupture, Giovanni would say you can't repair that within the attachment system.

The more empathic I say about this, I really feel sorry, I had a failure of it lapse in my empathy. No matter how much you try and repair that, it gets worse. But if you shift to a different language, you start talking about being a good team and let's try and understand this reach together as a good team.

You put them back online as collaborative behavior and then they work out of the rupture. He introduced me to the social anthropologist's work, Michael Tomasello, who spent years in a primate lab studying collaborative behavior in primates like gorillas, silverback gorillas.

Dr Dan Brown

Silverback gorillas will collaborate in getting food, but they won't share it. Only humans will share projects together, and abstract projects like, we're going to team together around some internet project. Only humans can do that. So what Michael Tomasello found is that normally secure attachment kids have healthy collaborative behavior.

They cooperate better in preschool years. They're more sensitive to the needs of other kids because they become part of a team. But insecure kids of one sort or another, dismissing kids, anxious, preoccupied kids, and disorganized kids take the collaboration offline. They learn to stop being collaborative so they have to relearn it again.

So even it comes down to treatment frame issues like how to get therapeutic contract to work, like showing up on time and doing the homework, those become necessary things to address in terms of collaborative behavior in terms of nonverbal skills, whether dismissing patient will ever look you in the eyes, make eye contact with you. These are things we teach them.

Alex Howard

And what would be some of the strategies or some of the tools to do that?

Dr Dan Brown

We teach them verbal nonverbal means of collaboration. We teach them how to involve themselves in a treatment frame so that they can give voice to their needs. And then during refuge, we used collaborative behavior, we switched to collaborative language.

So there's a variety of skills that you can teach patients to become collaborative. Now, if they address all these three pillars, they should end up with secure attachment, they should end up

with healthy range of metacognitive skills, and they should end up with healthy collaborative behavior. So they get along easily with others.

[00:28:05]

They fundamentally change in that sense. So that's what we look for. Now, the art of this, which is different, is we started by developing a generic treatment, the three pillars treatment. Then we found that for each type of insecure attachment, there are three types, dismissing attachment, anxious preoccupied attachment, and disorganized attachment.

We had to develop a separate treatment for each of these. It took 20 years to do that, but we did it and we got good outcomes databased on that now. It's the only treatment out there that addresses the difference between dismissing and anxious preoccupied and disorganized attachment.

Alex Howard

It strikes me as, well, that therapeutically, there's very clear intention of what you're doing and why you're doing it with the patient at particular points in the treatment path, which I think...

Sometimes I think what can happen therapeutically is there can be a little bit of people do what, therapists do what is their particular preference, the thing that they find interesting, or it's almost like slinging mud at a wall and seeing what sticks, and there's something that's very methodical about the map that you're describing, which I find very impressive.

Dr Dan Brown

I've done this for 50 years. My role in the medical school was in continued education, so I had to read all the outcome studies. So constantly updating the outcome studies, so I know the field well.

I know what the literature is well. And because of that, I got more impatient. In other words, there's a map, for each each diagnosis there's a map. We know where people need to get we need to get them there.

I work as hard as I can to get people there best as I can. I don't waste time. Life's too precious and short at the moment.

Alex Howard

I'd love to actually come a bit to your treatment outcome study, just to talk about some of the results that you found in building the evidence base around this map.

Dr Dan Brown

Let's have the slide on that, if you could. Go down to next... Use this one. Okay. Well, we had a control group that was from Los Angeles area. And these were people who George Haas assembled, he's a mindfulness teacher.

They all had twelve sessions of mindfulness meditation which they learned generic metacognitive skills, they learned looking at the state of mind. And they had twelve sessions of psycho education

about attachment, but not attachment based treatment. This treatment lasted for 1.5 to three years. That's what they got in that time frame. There are 25 subjects. We have to say that none of the subjects changed in the control group. And we started with 20 treatment subjects. They did for one and a half to three years, three pillars treatment and this is what we found.

[00:31:30]

This is the first treatment. We gave them the AI at the beginning of treatment, the adult attachment interview, which is the gold standard for measuring attachment, and we gave it at the end again. All of the subjects in the control group remained in the insecure group. None of the subjects in the treatment group remained in the insecure group. They all achieved some status of secure attachment. That's a 0.001 statistic.

We didn't publish the study yet because we're doubling the treatment group size. We're waiting to score up the final data. So that's the first part, that looks at attachment status. So most of the patients got better and I might add that most of them had disorganized attachment, which is the hardest type to treat. This is coherence of mind. Coherence of mind is a general measure of metacognitive skills. I'm sorry, this is coherence of mind, this is a general measure of how organized the mind is.

So we can measure the organization on a one to nine scale, one means no disorganization at all, no organization at all and nine means completely organized. In order to be in the secure range you have to score seven or above on the scale. So you can see that the treatment group all achieved, most of them achieved secure coherence of mind, none of the control groups did. The control groups didn't get organized in their mind but the treatment group did, the three pillars treatment.

Okay, the next slide. This is reflection function scale. The control groups didn't change at all in this capacity even though they had twelve weeks of mindfulness. So obviously the metacognitive skills involves much more than just general mindfulness.

It involves the capacity to be aware of your state of mind, be aware of inner state and you have mastery over it. Be aware of how much disorganization organization of mind there is at any given moment. Be aware of whether you're self oriented or other oriented in any given moment, these are important metaconal skills that we taught the whole range of them as patients. And you can see that the treatment group got better.

Pre post is a significant change in the slide. So they didn't get high metacognitive skills but they got... About five is the mean. So that's out of nine points. So they're in the mid range of metacognition on the scale. What were you going to say?

Alex Howard

I was just going to say that one of the things that really strikes me is... Something that's a personal kind of interest of mine is sequencing of intervention and personalization of intervention. And one of the things that really strikes me is just taking the example of control group doing a mindfulness approach, a lot of people will get into a particular approach, both practitioners and laypeople, and they'll be really interested by, they'll find a piece of the jigsaw and they'll invest all of their hope and their efforts and their energy into that, and then they'll wonder why things haven't changed and haven't improved.

[00:35:07]

And I think research like this where you've got an active control and you're demonstrating that that alone actually isn't creating the change but adding in the sort of personalized piece that is needed is then making the change. I think it's really important.

Dr Dan Brown

It's important. Thanks for emphasizing that. You're good at this.

Alex Howard

Say again?

Dr Dan Brown

You're good at this.

Alex Howard

I'll say Dan, I do a lot of interviews and I enjoy interviewing lots of people but there aren't that many interviews that really get me excited in my kind of thinking mind like this. I think that this is something that is really important for...

I'm thinking about people that are watching this interview who may have done a lot of self development work and they may have done a lot of therapeutic work and feel frustrated and feel stuck because they've put the effort and they've put the energy in, but they haven't got the outcomes thereafter.

And I'd love to hear a bit from you, because I'm sure you've worked with many of those people over the years that come in disillusioned, frustrated, perhaps feeling like nothing's going to help them because they've tried so many things but actually they haven't applied the map which helps them figure out what they need.

How do you help those people re-engage with the therapeutic journey and reconnect to what's possible for them?

Dr Dan Brown

Well, when they start doing the idea of parent visualizations, it works. So they learn very quickly that it's going to work. They stay with it and then they're required to do the homework. Some do it more than others, but they learn after a while that the function of how better they're getting is a function of how much they're practicing.

So it's like any other kind of learning, it takes practice. So those who are motivated to learn it the best. The ones that practice on a regular basis so they get better quicker. But we found that there's certain people who have a difficult time with this Three Pillars Treatment. People who are victims of sadistic abuse, they don't do well with it, they don't do well with anything, and you have to work off the transcripts.

[00:37:30]

They can't really disclose their practice because in their experience... Because they're afraid you're going to take over their mind and you have to play it off the here and now transference, you can't talk to me because you're afraid I'm going to take over your mind.

Let's look at the ways in which you fear that right now, and you deal with the here and now transference that work with that. So that's one modification that we've worked on significantly.

Alex Howard

It's interesting... I'm mindful of going off on a tangent for my personal interest, make sure I bring the audience with us, but I produced about four or five years ago, a documentary series on, I don't know if you know Andrew Cohen, who was a spiritual teacher and had a community, and the whole thing became a cult effectively, and we produced a documentary series about that.

And one of the things that struck me in the participants that we filmed with and we got quite into their stories and the impact is when you've experienced abuse or you've experienced trauma from a spiritual teacher who ultimately for you is your gateway to the divine or to God, it's almost a deeper trauma and violation than sexual abuse or physical abuse because it interrupts one's pathway to what actually may be their way out. Just because you spoke to that issue, I'm really curious to hear your thoughts on that.

Dr Dan Brown

I agree with you. Their experience is usually worse and they can't trust anybody. So it's hard to repair that and they may repair it, but we switch to treatment here now, transference. We talk it moment by moment about how they experience us in the relationship as controlling them or reading their mind or whatever else, they have fantasies about what we're doing.

Infinite variations on the theme of being controlled. And eventually they see that they're not being controlled, the patient inquiry into that changes in the relationship so that they actually have the learned experience or the emotionally corrective experience that they're not being controlled. And the therapist is actually working quite carefully for them.

Alex Howard

Yes.

Dr Dan Brown

I had a guy come in who never saw before and he paced the office. He said, I can't work with you, you're too controlling. I hadn't said anything yet. And he walked out and then I never saw him again.

Then six months later, he called me up and he said, I thought about the interview, you were actually trying to work hard to understand me, I think I was set on the treatment now. And he came back, he settled into treatment and he got better working with the here and now transference.

[00:40:16] - Alex Howard

That's beautiful.

Dr Dan Brown

I wouldn't have thought that in a million years. But there was something that happened in the interview that touched him.

Alex Howard

Something, I'm mindful of time, Dan, but something else that comes to my mind, and I'm asking this particularly for practitioners watching this interview, but I think it'd be interesting for others as well, but we've talked quite a lot around some of these maps and obviously this is a very short introduction to a much, much deeper topic, but working therapeutically as a practitioner there's always that balance between using maps and figuring out where someone is and where to go with ones, which I think what you just described is a bit of an example of this, of one's in the moment instinct of what somebody needs.

And I'm interested when, in your own clinical life but also when you've been teaching other practitioners, how you help people navigate that balance of to put it in very simple language, mind and intellect with heart and instinct therapeutically.

Dr Dan Brown

Well, I emphasize the treatment outcome literature, I read it all. So I try and keep up with the developers in the field and I think we owe a duty to our patients to know the literature well and not introduce our personal interests or therapeutic approaches that we're trained in, but to know everything thoroughly enough that we can introduce whatever is necessary for that given patient to get better. So that's what takes 50 years of being in the field to develop that overview.

I worked hard at it so it doesn't take long to see what people need. But then once you see what they need, you also have to individualize it. We start with an attachment treatment with the generic attachment. Imagine a scene with these other parents of providing you with absolutely secure attachment relationship.

Then we go on from there to the five prototypes of secure attachment. Safety and protection, being soothed and confident, careful attunement to both behavior and state of mind. The fourth one is called Express Delight. Healthy parents enjoy their kids. They get involved in not just the job of raising kids, but the joy of raising kids where most parents err in the sight of being involved in the job of raising kids and not the joy of raising kids.

And I think that enthusiasm and joy is where kids see that all that joy is about themselves and that's where they develop healthy self esteem. Healthy self esteem means that when you conjure up a feeling about yourself, you feel good about yourself. All that positivity comes from the parents Expressed Delight.

That's the fourth and the fifth is the best, most secure parents bring out the strongest and best self development in the child. They do not threaten by having a strong child. Those are the five

prototypes of secure attachment and we introduce all five of those, emphasize which ones are missing in that particular person.

[00:43:22]

Then we emphasize the research based approach. For example, in dismissing attachment the main problem is if the attachment system rejected all of the... When a child reaches out, they're rejected by the parents. So you need idle parent figures who are constantly reaching out, reaching the child.

So it's emotionally correctively felt so that you're always repairing the attachment system by having parents who like attachment and comfortable with it. That's a good thing.

Develop a strong sense of self.

Alex Howard

It's also where bad attachments get passed down through families, right?

Dr Dan Brown

Preoccupied attachment is where the child gets too involved in the state of mind of the mother or the father. They learn to regulate the state of mind of the other at the expenses of their own self development and their own anxiety management. So they're constantly become caretakers in relationships at the expense of themselves and they inhibit the exploratory system which is how the child develops a sense of self.

So you have to have ideal parent figures who are comfortable with focusing on a child, intune to the child and then when the child focuses on them, they remind the child to focus back on their own experience. And you do that over and over again, they'll eventually repair it. And also you have to involve the parents in encouraging exploratory behavior in lots of different ways. And then they develop a positive map which doesn't emphasize the problem of getting involved in other people's states of mind.

Disorganized attachment the trouble is the source of comfort is the source of fear. So normally children are programmed to expect the parents to comfort them when they're upset, but in this case the parents are abusive, so it's an impossible dilemma for the child.

So we introduce ideal parent figures who are as a source of comfort for the child and the child eventually slowly develops an internal map, a positive map for soothing. They expect that the ideal parents figures to soothe them, comfort them and they can take it in and that repairs the whole disorganized attachment system and then you get them involved in healthy exploratory behavior with it being encouraged actively by the parents, then they get better. So what we're trying to do is use the research on failed parenting for each of those sub attachment types and figure out what the research tells us we need to focus on most.

In the case of dismissing attachment, you have to focus on activating the attachment system. With easy priority attachment you have to focus on activating the exploratory system. With disorganized attachment you have to activate both the attachment system and exploratory system. So this is

what we found and we developed methods to do that effectively. That's what the outcome data shows.

[00:46:29] - Alex Howard

What strikes me is it's a beautiful marriage of a deeply evidence based approach with a very personalized approach based upon where that particular client is.

Dr Dan Brown

Yeah, lastly what we take is we take the negative adjectives they develop in the process and the adult attachment inventory, you have them describe the relationship with the parents and you do five adjectives you give them. Most of them are highly negative.

We individualize the approach because we take the positive opposite of those negative adjectives and they have to visualize being raised by other parent figures who have all those positive opposite qualities. So it's very tailored specifically to positively mapping that way.

Alex Howard

Dan, I'm mindful of time. I'm also very keen for people to be able to explore your work further. Obviously, your website will be listed with this video. Any recommendations in terms of books? I think for practitioners what we've been...

This book, *Attachment Services and Adults*, is a fantastic resource to dive deeper into this. For lay people that are watching this that would like to dive further, what would be your recommendation?

Dr Dan Brown

Well we try to put everything in that book. I had a disagreement with the publisher about it. They wanted to cut out all the introductory stuff, and I said, no, most practitioners are too busy. They want one source, they get everything in one place.

And they wrote me back and said, we're persuaded by your argument, we're going to publish the big book. So they did, and it turned out to be the right thing to do. Because everything's in there people need to know.

Alex Howard

Fantastic. Dan, thank you so much for your time and for sharing. I've greatly enjoyed this interview and I'm excited about people finding out more about you and your work.

Dr Dan Brown

Good. Thank you for doing it so effectively. You have good overview of the field and you have good insights about things, so I'm impressed by what you did the interview. You've always done lots of interviews and we've been a good match together.