Trauma, Attachment, and Spirituality: A Case Study

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The goal of this article is to illustrate the interaction between trauma, attachment, and spirituality, and to demonstrate how to address this interaction in long-term attachment-based psychoanalysis. Toward that end, this article briefly summarizes the convergence of attachment theory and psychoanalysis, and then reviews literature on attachment to God and trauma, including complex traumatic stress. We then present an in-depth case study of a patient with symptoms of complex traumatic stress that was treated from a long-term attachment-based psychoanalytic modality. Finally, based on the case that is presented, recommendations are made to practitioners about dealing with trauma and spiritual issues from an attachment-based perspective.

In developing what came to be known as attachment theory, John Bowlby (1973, 1980, 1982) set out to update psychoanalytic object-relations theory with contemporary biology and ethology. In his research observations and clinical work, he saw the importance of real interactions in shaping personality and psychopathology. His emphasis on real interactions rather than the internal world, the sine qua non of psychoanalysis, caused the psychoanalytic community to reject his ideas (Holmes, 1993). As a result, attachment theory developed independently of the relational strand of psychoanalysis from the 1940s until the past few decades. This state of affairs led to attachment theory focusing more on research and less on applied clinical interventions.

In recent years, the rift between the trajectories of attachment theory and psychoanalysis has begun to converge, resulting in a more clinically focused theory of attachment. There are several influential factors in this development. This convergence was sparked by Mary Ainsworth's work on secure and insecure attachment types, which emphasize the subjective meaning of an infant's behavior (Ainsworth, Blehar, Waters & Wall, 1979). Then, a turning point occurred in the mid-1980s, when attachment theorists shifted from a focus on infant behavior to a focus on the dynamic internal representations in the infant and parent, partly as a result of the development of the Adult Attachment Interview (Fonagy, 2001; Main, Kaplan & Cassidy, 1985; Bretherton & Waters, 1985). Main, Kaplan & Cassidy (1985) moved from infant attachment behavior to the level of mental representation in adults by using the Adult Attachment Interview (AAI). In the past decade in particular, a number of clinical theorists have further developed the applications of attachment theory (Fosha, 2001; Mitchell, 2000; Wachtel, 2010; Wallin, 2007).

Attachment theory, broadly construed, is based on the belief that "what is believed to be essential for mental health is that the infant and young child should experience a warm, intimate and continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment" (Bowlby, 1982, p. xxvii). This caregiver-infant bond serves to meet not only the biologically instinctual drive for infants to maintain physical proximity to caregivers in order to sustain life, but also serves the second purpose of regulating emotional distress. Through processes such as attunement (Siegel, 1999) and the dyadic regulation of affect (Fosha, 2001; Tronick, 2007) caregivers are able to function both as a secure base from which infants and young children can explore the world, as well as a safe haven to which they can return when they face overwhelming challenges or feelings of distress. In dyadic relationships where this occurs, infants are
likely to develop a secure attachment style (Ainsworth et al., 1979).

Unfortunately, caregivers are not always effective at consistently providing attunement. In the absence of consistent attunement, infants and young children develop organized strategies of maintaining the attachment relationship. In the 1970s, Ainsworth devised the strange situation, which resulted in the now-ubiquitous classification system identifying these other organized, but insecure attachment styles (i.e., anxious and avoidant). A fourth attachment style, disorganized, was identified in 1980s by Main and Solomon (1986). In cases where caregivers are both terrifying and the only source of comfort in the face of terror, as in the case of trauma, no organized strategy can be developed. The disorganized attachment style, marked by dissociation and the inability to develop an organized strategy for managing the attachment relationship, has been significantly related to traumatic experiences, particularly traumatic experiences involving caregivers. A wealth of empirical literature has demonstrated that attachment styles are clearly identifiable by 12 months and persist into adulthood (Brown, 2009; Main, Kaplan & Cassidy, 1985; Sroufe, Egeland, Carlson, & Collins, 2005). The infant's style of relating, whether it is an organized or disorganized strategy, becomes internalized; at times, this pattern of relating to others has been called an internal working model.

Internal Working Models and Ways of Knowing

The dynamic relationship between attachment theory and neuroscience has been highly influential, both in empirically confirming the theoretical underpinnings of attachment theory and in providing numerous rich directions for the continued refinement of attachment theory. One of the most significant concepts to emerge from this relationship has been that of two distinct ways of knowing, or processing systems. The explicit system (Siegel, 1999), also called the verbal (Bucci, 1997), cool cognitive or "know" (Metcalfe & Mischel, 1999), C, and reflective (Lieberman, 2007) system, processes information serially, slowly, and consciously; it is responsible for intentional behavior, propositional knowledge, and episodic and semantic memory. In contrast, the implicit system (Siegel, 1999), also called subsymbolic and nonverbal symbolic (Bucci, 1997), hot emotional, or "go" (Metcalfe & Mischel, 1999) X, and reflexive (Lieberman, 2007) system, processes a massive of amount of information in parallel, rapidly, and unconsciously. This system is particularly responsible for processing social-emotional information; that is, for computing the meaning of relational experiences for a person's well-being.

Attachment-related information is encoded largely by the implicit system. Implicit knowledge about ourselves-in-relation-to-others has been termed implicit relational knowledge, (Stern et al., 1998), representations that are generalized or RIGS (Stern, 1985), emotion schemas (Bucci, 1997), mental models (Siegel, 1999), and internal working models (Bowlby, 1973). Regardless of what it is named, one's implicit knowledge of how to be with an attachment figure is at the core of one's attachment style. Implicit memory has been referred to as an attachment filter because it operates outside of conscious awareness (Hall, 2007). The filter itself is not experienced; rather, relationships are experienced through the filter. By its very nature, people struggle to identify their implicit attachment filters; instead, they are communicated "between the lines" so to speak in the way people tells their story, rather than the content of the story per se (i.e., explicitly).

It did not take long for attachment theory to make its way into the psychology of religion. Parallel to Ana Maria Rizzuto's prior work applying object relations theory to understand people's experiences of God (Rizzuto, 1979), researchers quickly realized that people experience God as an attachment figure, and subsequently began applying attachment-based categories to describe attachment to God. Research in the area of attachment to God has clustered around two distinct hypotheses, termed the correspondence and compensation hypotheses, respectively. The question, as posed by Kirkpatrick and Shaver (1990), is whether one's religious and spiritual experiences correspond to their internal working models of human attachment figures, or whether they in fact compensate for the lack of secure attachment relationships with humans. Both the correspondence and compensation models of attachment to God have received empirical support (correspondence—Beck & McDonald, 2004; Brokaw & Edwards, 1994; Hall, Brokaw, Edwards, & Pike, 1998; Hall & Edwards, 2002; Merck & Johnson, 1995; Rowatt & Kirkpatrick, 2002; compensation—Granqvist, 1998; Granqvist, 2002; Granqvist & Hagekull, 1999; Kirkpatrick, 1997, 1998; Kirkpatrick & Shaver, 1990), creating a rather inconsistent picture of how one's attachment to God relates to one's attachment style with close human relationships.

Hall, Fujikawa, Halcrow, Hill, and Delaney (2009) suggested that this inconsistency was due to lack of clarity regarding the correspondence and compensa-
tion models, and applied the distinction between implicit and explicit knowledge to spiritual functioning. Essentially, they hypothesized that at an explicit level, one's attachment to God may appear to compensate for insecure human attachment; however, at an implicit level, they predicted that attachment to God would indeed correspond to the human attachment style. They found correspondence for implicit aspects of spirituality, supporting their hypothesis. Fujikawa (2010) conducted a follow-up interview study using implicit coding methods for human and God attachment, and found, yet again, strong support for correspondence at the implicit level. These findings suggest that the best indicator of attachment to God may not be self-report or explicit measures, but rather implicit measures. For some, their explicit account of their attachment to God invariably matches their implicit experience of attachment to God. But for others, there may be a disconnection between their explicit report of and implicit attachment to God. Why would such a disconnect occur between ways of knowing? The literature on trauma may provide some insight to this phenomenon.

Trauma and Ways of Knowing
Although there are multiple definitions and viewpoints about how to define trauma, for the purposes of the present discussion, trauma can be thought of as anything that exceeds one's ability to cope. Although the DSM-IV-TR (American Psychiatric Association, 2000) defines trauma as an event that represents a threat to life or personal integrity (as in physical and/or sexual abuse), trauma can also be experienced when children are faced with a caregiver who acts erratically (as in substance abuse or severe mental illness), emotional and/or physical neglect, and exploitation.

Essentially, implicit and explicit memory systems become dis-integrated in an attempt to cope with the overwhelming terror of trauma. Bucci (1997) calls this the process of de-symbolization, in which painful meanings get de-symbolized, or separated from symbols and language, in order to cope. Although the process of de-symbolization may sound like a conscious, volitional process, it is occurring primarily at the physiological level, and is completely outside of one's control. When traumatic events occur, the brain does not process them explicitly (i.e., verbally). In fact, the sequence of physiological events that follows exposure to trauma makes it extremely difficult to access traumatic memories explicitly and/or by choice.

When faced with an overwhelming and traumatic event, the body releases glucocorticoids, or stress hormones. This is very adaptive, because these stress hormones mobilize needed energy and inhibit processes that get in the way of coping with immediate danger and terror. However, when one is chronically exposed to trauma, an excessive amount of stress hormones are released and can damage hippocampal neurons. Research has demonstrated that the prolonged stress experienced by war veterans and survivors of childhood sexual abuse results in high levels of glucocorticoids (Schacter, 1996). The body then adapts to the experience of chronic stress, which leads to elevated baseline levels of stress hormones, and to abnormal rhythms of hormone release.

High levels of stress hormones and abnormal rhythms of hormone release can lead to impairment in episodic memory due to hippocampal dysfunction (via inhibition of neuronal growth and atrophy of the receptive components of dendrites). Brain imaging studies have shown decreased hippocampal volume in patients with posttraumatic stress disorder, further strengthening the link between trauma and hippocampal impairment (Bremner & Narayan, 1998). The hippocampus is the primary mechanism for encoding memories; therefore, it seems likely that hippocampal dysfunction may be a key mechanism of the repression of traumatic memories and the memory disruptions common in those suffering from traumatic stress. Posttraumatic flashbacks, which are repetitive and stereotyped, "are not subject to the assimilating and contextualizing properties of the hippocampal memory networks" (Cozolino, 2002, p. 97). When the hippocampus does not work in concert with the amygdala to record events with a sense of self and context, memories are still encoded (implicitly), but not in a form that leaves them accessible to conscious and/or volitional recall.

Without the normal functioning of the hippocampus, stress and trauma have a profound impact that is difficult, though not impossible, to heal. Traumatic experiences in these situations are encoded in an emotional, bodily type of memory called implicit memory. These memories take the form of habits and gut-level expectations and relational styles and they continue to influence one throughout life. Therefore, in significant ways, posttraumatic stress disorder can be understood as a disorder of memory. The dissolution of memory systems and ways of knowing is even more marked in people who have experienced a particular type of trauma, termed complex traumatic stress, or complex trauma.

A unique set of symptoms, either in addition to or in place of those listed in the DSM-IV-TR (2000), have
been identified as constituting complex posttraumatic stress disorder, resulting from "exposure to severe stressors that (1) are repetitive or prolonged, (2) involve harm or abandonment by caregivers or other ostensibly responsible adults, and (3) occur at developmentally vulnerable times in the victim's life, such as early childhood or adolescence (when critical periods of brain development are rapidly occurring or being consolidated)" (Courtois & Ford, 2009, p. 13). One of the most notable features of complex traumatic stress is that it often involves failure of the caregivers to protect the child (the betrayal wound; Courtois & Ford, 2009). Herman notes that "the absence of a protective parent or the presence of passive bystanders is felt as palpably as the presence of the perpetrator... the 'characterological' features of complex PTSD start to make sense if one imagines how a child might develop within a relational matrix in which the strong do as they please, the weak submit, caretakers seem willfully blind, and there is no one to turn to for protection" (Herman, 2009, p. xiv).

The 'characterological' features of complex PTSD to which Herman is referring include affective dysregulation, structural dissociation, somatic dysregulation, impaired self-development, and disorganized attachment patterns (Courtois & Ford, 2009). This is unsurprising, given the wealth of data showing the connection between trauma and disorganized attachment (Carlson, 1998; Ogawa, Sroufe, Weinfeld, Carlson & Egeland, 1997; Sroufe et al., 2005; Stalker & Davies, 1995). Main, Kaplan, and Cassidy (1985) identified disorganized attachment as being closely linked to unresolved trauma, which they defined in terms of ongoing disoriented states of mind and lapses in discourse and reasoning with respect to the abuse.

Symptoms of complex traumatic stress overlap with those of disorganized attachment, and in the case presented, the client had experienced complex trauma and displayed many of the symptoms of both complex traumatic stress and disorganized attachment. Whether a clinician identifies the presenting problem as complex traumatic stress or disorganized attachment is less important than how they conceptualize the underlying cause of the distress. In both complex traumatic stress and disorganized attachment, unresolved trauma has led to a dis-integration between memory systems, and thereby the inability to construct a coherent story by which to live, including a spiritual story.

The goal of therapy therefore becomes bringing the two ways of knowing into alignment, which will have significant effects in both close human relationships and (likely) the client's relationship to God. Trauma, especially complex trauma, significantly shapes one's attachment style, and because internal working models correspond implicitly with spiritual attachment, this includes attachment to God. The goal of this paper is to illustrate the interaction between trauma, attachment, and spirituality, and demonstrate how to address this interaction in long-term attachment-based psychoanalysis.

Case Study

The case described below is presented with the express permission of the client, although identifying information and some aspects of personal history have been changed. These changes were made to maintain the privacy of the client, and do not significantly alter the content of case. The first author (L.E.M.) worked with "Maggie" as the primary therapist, but received supervision from the second author (T.W.H.) throughout the case. At the time this article was submitted, Maggie had been seen twice per week for 20 months (approximately 160 sessions) from an attachment-based psychoanalytic modality.

Identifying Information & Reason For Referral

Maggie was a 26-year-old, Caucasian female who worked full-time as a receptionist at a Christian radio station. She was self-referred to a local Christian counseling center following a missions trip to Guatemala. During this trip, Maggie worked with many recovering alcoholics, and stated during intake that these experiences evoked feelings about her own alcoholic mother that were troubling to her, and she wished to process the experience.

Relevant History

Maggie suffered chronic and severe trauma throughout her life at the hands of her two primary caretakers. Maggie was born to an alcoholic mother, and it is likely that during Maggie's very early development her mother was both a source of fear and a source of comfort. Infants who are faced with this situation, often termed fright without solution (Main & Hesse, 1990), are likely to feel caught between impulses to avoid and approach the caregiver, resulting in a predominantly disorganized attachment style. However, as Wachtel (2010) has pointed out, attachment is always dimensional despite the use of categorical language that is often used for its heuristic value. Therefore, although Maggie displayed characteristics of disorganized attachment in adulthood (such as dissociation), she also displayed some characteristics of a preoccupied attachment style (such as fear of abandonment and hyperactivation of the attachment system).
Maggie's mother was not the only parent who caused terror in Maggie. Maggie's father began sexually abusing her at approximately age seven, and this abuse continued into her adult life. At age 15, Maggie's mother left her father for another man. Although Maggie continued to live with her father for a short time, the situation became unbearable to her and she soon moved in with her mother and her mother's boyfriend. Shortly after Maggie made this move, however, her mother's boyfriend began sexually abusing Maggie as well. The onset of this abuse precipitated Maggie's first suicide attempt at age 16. Although Maggie swallowed what she believed to be a lethal amount of pills she became terrified of dying shortly after ingesting them and induced vomiting to avoid an overdose. Until the therapy described here, Maggie had never disclosed her suicide attempt.

During Maggie's adolescence, she continued to spend weekends with her father and began drinking excessively, a behavior that often precipitated newly traumatic experiences and provided ample opportunity for further victimization by peers. After graduating from high school, Maggie began working as a cashier at a local grocery store. Several years later, at approximately age 25, Maggie was invited to Harvest Crusade by a co-worker and had a conversion experience. Although Maggie's parents identified as nominally Christian, Maggie identified herself as becoming a Christian at that time, and desired to change her life as a result of what she believed to be God's gracious salvation of her. Maggie quit drinking and did not engage in any sexual contact with men following her conversion. She joined a local church and within a year of her conversion the Great Divide: Disparity Between Implicit and Explicit Ways of Knowing

In Maggie's initial clinical interview, she described her family of origin and past experiences in positive terms and denied any history of trauma. This is not at all uncommon with clients who have experienced trauma, and their initial denial of exposure to traumatized in no way rules it out as a possibility. What was uncommon about Maggie's initial clinical interview with me (L.E.M.), however, was the amount of discrepancy between Maggie's explicit and implicit communication. Although Maggie spoke about her family positively, her muscles became visibly tense while answering my questions about them. Additionally, Maggie clearly displayed fearful behavior with me (e.g., glancing frequently at the door, psychomotor and vocal shakiness, shortness of breath), although she calmed somewhat at my assurance that she was free to leave whenever she wished and free to choose what to share with me. After several sessions dominated primarily by silence, punctuated only by Maggie's self-criticism for not being able to speak more freely, I suggested that Maggie consider coming to see me twice each week. To my surprise, she agreed.

As time marched on, Maggie grew more comfortable with me in our sessions and was able to disclose details about her current life and struggles, including her spirituality. As noted above, research suggests that spirituality is no exception to the two ways of knowing; therefore, although I listened carefully to Maggie's explicit content in her descriptions of her relationship with God, I also listened for information that would indicate her implicit attachment to God. By all of Maggie's accounts, it appeared that Maggie was able to successfully use her relationship with God to compensate for her chaotic and abusive relationships with her parental attachment figures. Early in treatment, Maggie would describe God as the "good father" who would never abandon or abuse her. All the while, however, something wasn't sitting quite right with me. I didn't feel that Maggie was being insincere in these descriptions or reports of her spiritual experience; it was more as if there was a part of the story that wasn't being told yet, some part of Maggie that wasn't present in these spiritual experiences. When I would probe in this direction, however, Maggie would dismiss my questions and return to her descriptions of the good father.

The Floor Falls Out: Past and Present Collide

Approximately four months into treatment, Maggie was raped. Following a particularly devastating interaction with her mother that triggered many of Maggie's unresolved traumatic memories, Maggie had sought solace from an old friend only to find herself re-victimized. Although Maggie had suffered sexual trauma prior to this incident, this was the first traumatic event that had occurred since her conversion to Christianity and during the course of our work together.

The rape continued to ripple through Maggie's life for months, in flashbacks, in trips to the free clinic for STD/HIV testing, and perhaps most profoundly in her now hollowed-out spirituality. Several months after the rape, during a particularly difficult session, Maggie described her experience by saying:
I feel like the floor fell out from under me, and I'm still dropping. I don't feel loved by God. I mean, I know I'm loved by God in my head, but I don't feel loved by God. I can't remember what it feels like to feel that, and I don't know if I'll ever feel it again. [Crying] Do you feel loved by God? I mean, do you really, actually feel loved by God? [emphasis added]

My eyes became teary as I sat with Maggie, silently. I ached with my own desire to meet Maggie's need, to be able to give her something firm to stand on again. Perhaps this was a moment when self-disclosure was warranted, but my own spirituality had recently been razed and I doubted my ability to instill hope in Maggie when I was in such shortage myself. Maggie and I sat together in silence for the remainder of our session.

This was a terrible time for Maggie, for both of us in our journey together; but at a deep level change was happening. In the quote above, although I have italicized certain words for visual effect, Maggie was clearly referring to a disconnection between her explicit and implicit knowledge of God. Maggie's explicit knowledge of God told her that she was loved; but at a gut-level, Maggie's implicit experience of God was much different. She felt abandoned by God, angry with God, and at times even fearful of God. Being able to identify the great divide between her implicit and explicit experience of/attachment to God and access her implicit experience was the first step in addressing Maggie's insecure spiritual attachment and beginning to create a coherent spiritual story of Maggie's life.

The rape also served as a sort of solvent on the artificial distinction Maggie had made between past and present. This one traumatic event that occurred in our present ushered in years of dissociated memories and feelings from her past. Slowly but surely, Maggie began to disclose her traumatic history to me and connect more explicitly with her gut-level, implicit sense of herself as unlovable. As Maggie brought these past experiences into our present relationship explicitly, she became more aware of her felt sense that God did not love her. In doing so, Maggie was 

Loved Into Loving

Attachment-based psychoanalysis assumes that deep and lasting change in the client's attachment filter can occur through a corrective attachment experience with the therapist. It is certainly possible and not uncommon for clients to have corrective attachment ex-

periences with God directly, thereby changing their attachment filter; however, God often mediates His love for us through people. Therefore, it seems most probable that the client's attachment filter, after being changed through a new and corrective relational experience with the therapist, will also extend into their relationship with God. This is consistent with Hall's relational spirituality paradigm (2004) and subsequent research demonstrating that the psychological and the spiritual cannot be neatly separated (Fujikawa, 2010; Hall et al., 2009). Rather, they are intimately intertwined, and change in one inevitably means change in the other.

Therefore, it is not surprising that the next shift in Maggie's attachment to God occurred not so much in the context of a direct spiritual experience with God, but through numerous rupture-repair cycles with me (L.E.M.) that finally culminated in a tipping point (Gladwell, 2000) spanning several sessions. A portion of the transcript from the first of these sessions will help to illustrate this. Maggie entered our first hour of the week already angry with me. Although I observed this aloud, invited Maggie to explore the meaning of this feeling, and attempted to empathize with it, Maggie dismissed my attempts to connect with her. In fact, my (increasingly pressured) attempts to make relational contact with Maggie only served to increase her agitation with me. Twenty minutes into the hour, Maggie had reached her breaking point and informed me that she wanted to leave as soon as I gave her the receipt and intended to cancel her second appointment for the week. Explicitly Maggie was clearly pushing me away; and yet somehow, implicitly, I sensed deep ambivalence from Maggie—as if she were doing this against her will. Maggie was fighting back tears as she demanded the receipt from me, again. I took a risk and tried responding to the gut-level fear I sensed from Maggie:

Therapist: I will care about you just as much if you come once a week, once a month, or every day. I will care about you.

Client: Well you don't need to, 'cause I'm ok. Actually, don't. I don't want you to care about me.

Therapist: I think it scares you how much I care about you. [eyes watering]

Client: Oh my gosh, are you going to cry? Don't cry. [Maggie rolls eyes]

Therapist: I think it scares you. Maybe it scares you because of how good it feels. But maybe you want to back up for a little bit, until you're sure that it's safe, and that's ok too. [handed Maggie receipt]
Maggie walked out of my office without saying goodbye. I felt so confused; clearly Maggie wanted to distance herself from me, and yet I couldn't shake the overwhelming feeling that this was out of fear—that what Maggie really wanted was to be close. Maggie was being faced with the choice between a painful but familiar way of being with me, and a potentially positive yet unfamiliar way of relating. In our final interaction depicted above, I was fighting to balance Maggie's conflicting attachment needs for connection and autonomy, but I remained doubtful about which was primary in this moment. I knew from past experience that on occasion after difficult sessions Maggie would go to the bathroom in the clinic and cry until she felt ready to drive home. After several minutes, I went looking for Maggie but she was nowhere to be found. I worried she might be gone in more ways than one; would Maggie ever be able to risk a new way of being with me?

Later that night, Maggie left an apologetic message on my voicemail and asked to schedule our second hour of the week. When I returned Maggie's call, she sounded surprised and excited.

Client: I can't believe you called me back.

Therapist: Maggie, I will always call you back.

In our next clinical hour, Maggie and I spent the majority of our time exploring the meaning of the previous session. Interestingly, Maggie identified both the last few minutes of the previous session and my return phone call as significant experiences for her.

Client: I felt like me and you was, for a second, this replication of what God does for me, how here you are and I am not the greatest and you're here with me in this. And then I turn, and I leave. I literally left. I left. But then you looked for me! Not only did you look for me, then I called you and you're like "it doesn't matter, I'll still be here no matter what" and despite my running and turning to other means of avoiding, and whatever, you still were here. I couldn't believe you didn't say "ok peace out, good luck, see you never." . . . And that is the thing that I felt on Monday; I felt like for the first time I have a tangible example and experience of what that looks like. And it was this moment, this day. In a sense, I'm not comparing you to God, but that relationship dynamic was just like it.

Maggie had let in the new experience of me, and her attachment filter was changing. These sessions marked a turning point in our relationship; they laid the foundation upon which we have built other positive experiences. In the process of providing Maggie with a new experience of relationship, not only did our relationship change, but her relationship with God changed too. Maggie now had a new experience from which to relate with God.

In that same session, several other important processes were unfolding. First and foremost, Maggie and I were exploring our relational experience, the we realm (Fosha, 2001). Second, by encouraging Maggie's awareness and experiential elaboration of the positive interaction with me, Maggie was mentalizing, a key component of intersubjectivity (Fonagy, Gergeley, Jurist & Target, 2002). Third, I invited Maggie to reflect back on her relationship with God throughout the course of our therapy from this new perspective. Maggie and I recounted together her initial, explicitly positive relationship with God, though it failed to connect with her deep, implicit experience; the abandonment and fear she felt with God as a result of her recent rape, and the way this helped her integrate her spirituality with her past trauma; and finally, this new way of being with me (and by extension, a new way of being with God). Maggie and I were constructing her spiritual story and connecting her implicit process with explicit, verbal knowledge; her two ways of knowing were becoming synchronized, thereby allowing her to tell both a logical and emotionally meaningful story.

Discussion

These sessions by no means resolved Maggie's insecure attachment to either me or to God. At times, Maggie still feels abandoned by God or fearful of connecting with me. But Maggie is also now able to relate to both God and me in the midst of those feelings, and is able to admit new experiences of us. Maggie's implicit and explicit knowledge of God has converged, and is in the process of transforming to incorporate all of her past and present experience.

Also, though not included explicitly in the case study, Maggie has experienced a significant amount of dissociation, both in and between sessions. Structural dissociation is a key feature of complex traumatic stress, and must be dealt with carefully. Care should be taken to limit the client's need for dissociation as a coping mechanism, and when dissociation occurs focus must shift to reorienting the client to the present and restoring their ability to function effectively.

Recently, Maggie shared with me (L.E.M.) a prayer she had written. We include some excerpts here to demonstrate some of the changes in Maggie's relationship with God.
I don’t know why I lived through all of this, I don’t know why I survived, I don’t know why I’ve been given this second chance at life... I don’t know why you didn’t intervene and stop it all when I was little, and I don’t know why you didn’t spare me from all of the abuse and exploitation and violation and abuse and hurts...

First and foremost, Maggie can both implicitly and explicitly acknowledge her past trauma and express her authentic emotional reactions to that. She expresses her confusion at God’s motives for not intervening without any hint of fear that God will respond dismissively or punitively.

I’m starting to think that maybe I won’t ever be healed completely from all of this. Maybe it’s about learning to live with the permanency of it all. I’ll strive for healing, I’ll strive to be made whole and endure all this pain, but while I do that I’ll have hope. I’ll have hope because I know that there will come a day when it won’t hurt like it does right now...

Here, Maggie is able to use her relationship with God to help her regulate strong affects, such as hopelessness at the permanency of the effects of her trauma. Maggie acknowledges that she may carry scars, both physical and emotional, from her trauma throughout her life. However, Maggie expresses a hope that one day, she will experience final relief.

I know better than them; sin is sin. But I ask you to help me see just how powerful the cross is, especially when it comes to the vile sins and transgressions that they committed against you and against me. I pray that I could forgive them, for they don’t know that I am made in your image. As a human, made in your wonderful image I have worth and value. I should be treated with respect and kindness. Help me to see that in them. Help me to see all those men who have taken my soul away from me as creatures and persons made in your image. Lord I ask for justice, I ask for your vengeance. You are my defender and protector; help me to know that, even though it’s hard for me to see it right now.

And finally, Maggie experiences, both implicitly and explicitly, that she has value and worth, and can assert this freely in her relationship with God. The acknowledgement of her worth leads Maggie to ask for God’s protection, much like a safe haven.

Based on our work with Maggie and other trauma survivors, we recommend the following five points for consideration in dealing with spiritual issues with trauma survivors from an attachment-based modality.

1. Expect a greater discrepancy between the implicit and explicit. Although most people with insecure attachment styles have a discrepancy between their implicit and explicit ways of knowing, expect that the discrepancy will be larger in traumatized persons. Most often as a way of continuing to survive and function in the face of overwhelming terror, trauma survivors have learned to dissociate from their implicit, gut-level knowledge. This dissociation extends even into their spiritual relationships. As a result, the divide between implicit and explicit ways of knowing is often greater than one would expect in other forms of insecure attachment (e.g., preoccupied or avoidant). Helping trauma survivors re-integrate their implicit ways of knowing is a lengthy but essential process in helping to heal the wounds of trauma.

2. Be prepared for more frequent and more powerful enactments. The term enactment refers to scenarios that are jointly created by the therapist and the client, and that reflect the internal, unconscious experience of both parties (Wallin, 2007). Enactments translate internal experience into relational action. One key feature of enactments is that they reflect the unconscious experience of both the client and the therapist. Attachment-based psychoanalysis assumes that therapists are no less vulnerable to the influence of the unconscious than their clients, although it is hoped that therapists are more skilled at identifying and exploring it. As noted, the discrepancy between the implicit and explicit, verbal and nonverbal, experiences of trauma survivors is greater. Because of this greater discrepancy, the enactments between therapist and trauma survivors will be more intense and happen more quickly. Therefore, it is of the utmost importance in practicing long-term attachment-based therapy with adult trauma survivors that therapists remain acutely aware of their own attachment style and vulnerabilities.

3. Recognize that traumatic events have spiritual significance. Trauma survivors must make sense of their traumatic experiences throughout their lives. At each new developmental stage, they must re-negotiate the meaning of the trauma in light of new developmental capacities and their ever-growing knowledge of themselves and their world. Spirituality also has a developmental trajectory for our clients, and therefore the spiritual implications of their trauma must also be re-negotiated as their spirituality develops. Most obvi-
ously, trauma raises questions about the existence of evil and God's omnipotence. As spirituality develops, however, these more existential and ultimate questions often fade into the background. In fact, in the prayer Maggie recently shared with me (LEM), she writes, "I think I've been asking the wrong questions this entire time. I always ask 'Why?' and 'What was the purpose?' 'When will I be healed?' But maybe you've already given me the answers to those questions." As existential questions recede, more personal spiritual questions emerge as significant (e.g., why does God continue to let me suffer now? Why won't God just take this burden from me?). Each survivor must resolve these questions for him or herself in the context of their unique relationship with God.

4. Support survivors' efforts to integrate their story within a spiritual community. Herman (1992) summarizes a tripartite model of recovery stages, including (a) safety, (b) coming to terms with the trauma narrative, and (c) repairing and enlarging social connections and relationships. For religiously committed individuals, the third component of recovery, repairing interpersonal connections, may happen largely within their faith communities. However, their attempts to do so may be complicated by the implications of their trauma for both their faith and the faith of others. Preparing survivors for the possibility of resistance to acknowledging their experiences and helping them resolve the pain from this resistance are important first steps in helping them integrate their story within a spiritual community. Perhaps one of the best ways to help survivors re-engage with their faith communities is by helping them identify safe people within their faith communities who are willing to engage them in the process of exploring the significant implications of trauma for spirituality. Although not available in all churches yet, there is an increasing number of trained spiritual directors available to be of service to parishioners; spiritual directors have received explicit training in tolerating exposure to painful affect and experiences, and are more likely to respond supportively to disclosure of past trauma. It is likely that sharing one's experience with others who share their religious beliefs may be a significant form of healing.

5. Facilitate education of spiritual leaders about the impact of trauma on spirituality. Trauma has a well-documented effect on spirituality. Walker, Reid, O'Neill & Brown (2009) identified and reviewed 34 studies of child abuse that included information on a total of 19,090 participants. Although child abuse is only one form of trauma, it is unfortunately one of the most pervasive. They found that the majority of studies indicated either some decline in religiousness or spirituality or a combination of both growth and decline. Unsurprisingly, "abuse survivors are more likely to experience spiritual struggle around anger toward God as a result of their abuse, blaming God for their suffering and in addition for turning a blind eye to them" (p. 141). Religious leaders should be made aware of this effect to prepare them to respond appropriately if or when their parishioners disclose traumatic histories. As both research (Walker et al.) and the present case study demonstrate, maintaining an open, and supportive but neutral stance toward survivors' spiritual experiences is essential in allowing their spirituality to develop in such a way as to fully incorporate their traumatic experiences.

Conclusion

In this article, we have attempted to illustrate the interaction between trauma, attachment, and spirituality, and demonstrate how to address this interaction in long-term attachment-based psychoanalysis. Literature on attachment and spirituality has clearly demonstrated that people's attachment to God is not exempt from the influence of their early experiences and non-verbal ways of knowing. Just as attachment is relevant to spirituality, so too is trauma. The experience of trauma raises essential questions about the goodness and omnipotence of God that demand an answer. We hope that the case study presented here and the recommendations that followed demonstrate that change is possible, and that light can enter places where there was only darkness. In our experience, work with trauma survivors dealing with issues of spirituality is one of the deepest ways we can participate in the redemptive work of Christ. We are grateful to all the brave survivors who have allowed us to walk with them through their journey of healing, and we hope this article empowers you to experience the same blessing.

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