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Review Article

Attachment and Trauma in Therapy: A Neuroaffective Developmental Perspective

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Introduction

In psychotherapy, attachment and trauma are not abstract concepts—they are felt realities that enter the room through the body, the relational field, and the therapist-client interaction. From the perspective of *neuroaffective developmental psychology* [1], both attachment and trauma are seen as embodied processes that unfold across three interconnected levels of functioning: the autonomic – arousalregulating and sensing level, the limbic – emotional level, and the prefrontal – selfcontrol and emotional intelligence systems. This article offers an adjunct to the article *Dances of connection: Neuroaffective development in clinical work with attachment (2015).* It is a brief sketch of how psychological trauma and attachment patterns interact, and how these dynamics show up in therapy. The neuroaffective approach helps clinicians work not only with what clients say, but with how they *regulate*, *feel* and *relate* moment to moment.

Three Levels of Neuroaffective Functioning

This felt reality of attachment and trauma is particularly noticable when the client suffers from severe trauma, neglect or abuse in childhood. On a CT scan, the brain of the client with severe history is smaller than the brain of a normally attached person. This is not primarily because there is a lack of neurons; we are born with most of our neurons already developed. It is instead because the wiring between those neurons has not developed [2]. The neuroaffective model describes human development as unfolding, a growth of neuronal connections, through interaction between child and caregiver at three brain–body levels:

1. **The Autonomic Level** – This is the body's basic regulation system: arousal, movement, safety/danger detection. Trauma states generally show up as chronic hyperarousal, exaggerated startle responses or collapse, or disconnection from the body. When this level is intensely activated, either through trauma or through severe neglect or abuse, the limbic and prefrontal levels are shut off. In severe cases of childhood dysfunction, the basic neuronal growth is inhibited [3].
2. **Limbic Level** – This level governs affect regulation, social bonding, and emotional resonance. Relational trauma, common in early insecure attachment, will intensely activate this system. In these circumstances, there is a deep disruption in emotional resonance. This may cause relational insecurity, intense agitation or a strong desire to control the beloved other.
3. **Prefrontal Level** – This level is responsible for self-control, executive function, language, reflection, values, and mentalization. The autonomic trauma response can make it difficult to manage daily chores. It can also fragment identity, so the person feels like floating pieces instead of a person, activating intense fear of going insane. Trauma and severe attachment dysfunction also impairs the ability to mentalize, i.e have insight into, one's own or others' inner states.

When trauma or insecure caregiving occurs—especially in early attachment relationships—it interrupts the integration between these levels. Throughout life, the person then develops strategies that keep them functioning but block relational depth.

Attachment Patterns and Trauma Responses

Attachment systems are our embodied adaptations to our early relational environments. Traumatic experiences shape how these systems become wired into our neural network (Table 1).

Table 1: Attachment patterns and trauma responses.

Attachment Pattern	Somatic Tone	Emotional Signature	Relational System
Secure	Regulated	Trusting, flexible	Open, responsive
Avoidant	Controlled	Flat, disconnected	Self-sufficient, distant
Anxious ambivalent	Hyperaroused	Overactivated, upset	Preoccupied, ruminating
Anxious dependent	Hyperaroused	Overactivated, fearful	Clingy, fearful
Disorganized	Freeze/collapse	Fear-without-solution	Fragmented, chaotic

Disorganized attachment is often a marker of severe complex or developmental trauma, where the caregiver is also the source of fear [4]. This creates internal conflict with no solution—a condition that easily repeats itself in therapy.

How These Patterns Show Up in Therapy

Clients do not "talk about" trauma and attachment—they *live* them. In the session, therapists may encounter:

- Sudden shifts in presence or affect (dissociation, collapse or severe startle-response)

- Fear of closeness
- Intense attachment bids
- Sudden conflict and complete loss of trust
- Idealization followed by devaluation
- Somatic cues like tension, dissociation, fidgeting or holding breath

These responses are not 'resistance'—they are self protection responses as the client literally is living in the map from the past instead of in real time. Therapists, too, may be drawn into these reenactments—emotionally pulled into being caretaker, overwhelmed, rescuer, rejector, or withdrawing. Being aware of these dynamics in the client and in onself is central to effective therapy.

Healing Approach

The key to healing attachment trauma is not primarily insight or technique. It is a relational experience that will allow the nervous system to integrate (Table 2).

Table 2: Healing approach.

Level	Clinical Focus	Tools and Interventions
Autonomic	Safety, arousal regulation	Breath, grounding, containment, music, somatic tracking, synchronisation
Limbic	Co-regulating emotions and emotional activities	Voice tone, eye contact, emotional mirroring, shared activities and games
Prefrontal	Impulse control, reflection and mentalization	Playing with self-control, mentalizing questions, value clarification

The therapist must become a regulating presence, offering consistent, attuned responses – especially when the client mistrusts the relationship. Repair after rupture or conflict is often the most powerful healing moment [5].

Final Reflections

Neuroaffective developmental psychology reminds us that trauma is not only remembered. It is where the client lives. The therapist's job is to become a "regulating other", offering what was missing: safety, resonance, repair and mentalization. It is not about what we do, it is about who we are while we are doing it. Through this embodied, attuned presence, clients can begin to reorganize their inner experience—and gradually, resolve trauma responses and earn secure attachment from the inside out [6-10].

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