Psychology Talk Podcast: Interview with Daniel Brown, Ph.D. on Dissociative Disorders & Attachment

Interviewer : Scott Hoye

Interviewee : Dr. Dan Brown

Dr. Hoye

Welcome to the *Chicago Psychology Podcast.*

Music Playing

Dr. Dan Brown

We have the person imagine that they grew up in a family different from the family of origin and we have them imagine they grew up in a family where the parents were ideally matched to them and they're nature, and did all the right things in terms of attachment figures. We call that the 'Ideal Parent Figure Protocol.'

The reason why we do that is because if you look at existing attachment treatments that are out there, like the work of Jeremy Holmes and Pat Sable and the work based on Bowlby's work, all of those assume that the therapist become a good attachment figure and provide a safe haven for which the patient could explore their own mind.

That assumption assumes that every parenting model, the therapist should act like a good parenting figure. There are two things wrong with that assumption:

1) Many times, the therapist can't act that way realistically, so there are a lot of therapeutic ruptures and breaches in the treatment.
2) It shows a misunderstanding of the fundamentals of attachment. Attachment behavior starts in the first minutes of life. What really changes and is significant in terms of development is the development of an internal model or attachment representation. That takes place at about 18 months and instead of attachment representation it has an organizing effect on all lines of development like;

    - Self-development
    - Relation development
    - Emotional development.

What we try to do is, develop a technique by which the person can continue to repeatedly visualize an ideal parent figure and positively remap a stable positive template for attachment relation.

Dr. Scott Hoye

Hello, this is Dr. Scott Hoye. On today's episode of the *Chicago Psychology Podcast,* I speak with Dr. Dan Brown. Dan joins me to discuss association, trauma, and attachment theory. Dan is the author and co-author of numerous books, including the award-winning *Memory Trauma Treatment and the Law,* and more recently *Attachment Disturbances in Adults, Treatment for Comprehensive Repair.*

Dan and I discussed Association, Trauma and Detachment Disorders based on his work with a team that organized the '*Three Pillars Model of Attachment Treatment*.' This treatment is an integrated model of psychotherapy based on many modalities and theories including, hypnosis, metalization treatments and collaborative approaches for working with patients.

Dan Brown is a rich source for diverse information across the fields of neurology, psychology, psychology, and contemplate practices. So, needless to say this is information heavy in discussion. If you're looking to expand your mind and knowledge base on the issue of Attachment and Psychotherapy this episode is for you. Now here is the interview.

Music Playing

Scott Hoye

Welcome everybody to the *Chicago Psychology Podcast.* It's my pleasure and honor to be interviewing Dr. Dan Brown. Dan is the author of *Attachment Disturbance in Adults, Treatment for Comprehensive Repair.* He's the co-author of that book with David S. Elliot, I want to give him credit as well. He's also the author of numerous other books, one of which has won an award I believe for forensic work with hypnosis and trauma. Is that correct?

Dan Brown

It's called *Memory Trauma Treatment, & The Law*. It won seven awards and one was the *Good Mark Award* from the American *Academy of Psychiatry in Law and the American Psychiatric Association* for the best legal contribution.

Scott Hoye

For those of you who are interested in those subjects I would recommend picking it up. Today Dr. Brown and I will be discussing Dissociation, Trauma, and Attachment in human-beings. Maybe we can just kind of launch into that and start the discussion.

Dan Brown

There are two things I want to start with about Dissociation, the first is that Dissociation is sometimes an important part of traumatization and sometimes it is not. Some of the best work on that was done by neuroscientist Ruth Lanius in Ontario.

What she found was there are two different types of traumatization. About 70% of people who were traumatized present with what she calls 'Hyper-aroused Predominant PTSD.' The dominant symptoms are;

- Re-experiencing symptoms of unwanted memories
- Unwanted flashbacks, unwanted feelings about the traumatization.
- Hyper-arousal symptoms: high physiological arousal: response to triggers to the trauma: startle sensitivity; things like that.

The other groups of people which is about 30% of people have 'Dissociation Predominant PTSD.' What she found is the neuro-circuitry of both of those groups are quite different from one-another. For example, in the hyper-aroused group the main neuro circuitry of trauma is an unremitting Amygdala response, which is the fear arousal center of the brain.

The failure to dampen that by the media pre-frontal cortex which is usually associated with sense of self so you don't get top-down regulation over Amygdala of the fear response part of the brain, so you get unremitting fear response.

The 'Disassociation Predominant PTSD' has completely different circuits involved with it. If the main aspect of the Disassociation is dissociative amnesia for the trauma then the circuitry associated with Emotional Memory goes down. There are two integrated circuits involved with Dissociative Amnesia;

1) The right Temple Parietal System which is Emotional Memory. So, when you activate an emotional memory from long-term memory that system gets activated and it retrieves the memory

2) The other is Sense of Self, which is the medial Pre-frontal Cortex. So, when you have a memory two things happen;

- You remember the memory of the emotional event and you can say 'this happened to me.' Those two circuits go back online, the medial pre-frontal cortex and the right temple parietal system.

- However, when somebody has ‘Dissociative Predominant PTSD’ then they have strong Dissociative Amnesia they either, don’t activate their right temple parietal system, which means there is no emotionality of the memory. They might activate the left temple parietal system, which is the Semantic memory, so they have an abstract idea about the memory but no feeling about it

- Or they won’t activate the medial pre-frontal cortex, which mean they’ll have the memory and they can’t say ‘it happened to me.’

Now what ‘Dissociative Predominant PTSD’ shows in terms of neuro-circuitry is, something that Pierre grandfathers Dissociation said 150 years ago. He said, “When people dissociate from a traumatic event, they make the event unreal emotionally and they can’t say it happened to me, and they distance themselves from it.

Sp. he thought the essential features of treatment were what he called Personification and Realization, Personification means you can say that this trauma happened to me, this event happened to me and Realization means you can bring forth the memories and all the reality of that into your mind.

[0:08:13.2 SP] in terms of the science has corroborated with Pierre Janet’s said 150 years ago about what goes off line in terms of the neuro-circuitry of Dissociative Amnesia. One other thing I should add is there is a fair amount of research on people who have major dissociation phenomena, like (DID) Dissociative Identity Disorder.

The main neuro circuit involved in that is the medial orbital front-cortex. The medial orbital front cortex is associated with three things in science;

- Emotional salience to phenomena

It’s the center for all the positive emotions in the brain, it’s the center for social connectivity. When people get major dissociative amnesia, they can only remember negative traumatic memories, they have no positive experiences, they are emotionally numb, the lack the emotional salience for things, they are emotionally numb most of the time; they disconnect from themselves and from other people. In ‘Dissociative Predominant PTSD’ you either get the dissociative amnesia or you get dissociative identity, and both of those circuits are involved in those as I have mentioned.

One more thing I would like to add about this is, there are these two types ‘Dissociation Predominant PTSD’ and there is ‘Hyper-arousal Predominant PTSD.’ The neuro-circuitry is quite different in each case.

In one of the studies that Ruth Lanius did was very convincing along those lines. She had a couple that underwent a life-threatening motor vehicle accident and they scanned them after the accident and one had 'Dissociation Predominant PTSD' and showed the neuro circuitry for that. The other had 'Hyper-arousal Predominant PTSD' to the same event; two different people experienced it with different neuro circuits involved. That's a pretty convincing finding I think. What were you going to say?

Scott Hoye

I was going to comment the same circuitry is involved with people based on how they are hard-wired so to speak, right? If they have Dissociative Amnesia later in life or if it's earlier in life which I think is associated more with Dissociative Identity Disorder, right or a proclivity for that?

Dan Brown

Still the same circuits that are involved.

Scott Hoye

But the difference is the etiology of DID is usually intense childhood trauma?

Dan Brown

Well, I don't agree with that. I think the etiology of DID is disorganized attachment in early childhood which disrupts all developmental lines aggravated by childhood and later abuse, later childhood trauma.

Scott Hoye

So, maybe that's a good way to Segway into *Attachment Theory and Dissociation.*

Dan Brown

Well, we did an orphanage study which I should mention along these lines. It started as a forensic examination. There was a Catholic orphanage in the greater New Orleans area called *Madonna Manor* in the 1950s and the brilliance of the *Catholic Church* was whenever a priest got accused of been a pedophile, they transferred them to all the same Catholic orphanage running a school for boys and girls. There were six pedophile priests who all ran that *Madonna Manor* and they hired a pedophile staff, so you can imagine what happened to the kids.

After the media exposure in Boston and about a decade after that some people started to remember memories of the sexual and physical abuse of this Catholic orphanage *Madonna Manor* about three or four decades later after it happened.

I was involved as an expert in testing, I tested about 30 something victims all who had recovered memories. When I do forensic testing's, I do two days of testing. I do a number of

structured interviews and a number of paper and pencil normative tests that give certain kinds of symptoms. I do psychophysical testing, I test for response validity and malingering and all of those things. I also gave people the Adult Attachment Interview which is the gold standard for measuring Attachment in adults.

What we found is that about half that group had secure attachment on the Adult Attachment inventory, that meant they grew up with big Catholic families where there were six or seven kids and the father often had to work three jobs to make enough money to raise a family that large. This meant working on risky jobs, like working on the oil rigs outside of New Orleans. Often at times the father would get killed or physically disabled from an industrial accident and the family would break up and the kids would go to the orphanage, but they had a good secure attachment history.

The other half of the kids were kids who were from extreme deprivation and traumatization where there are lots of violence and alcoholism in the home. In some of the cases the kids were forging on the streets collecting food because they weren't been feed at home.

In one case the father was running a meth lab out of the basement, in another case the mother was running a prostitution brothel in the house. So, these kids were very poorly attended to and on the Adult Attachment Inventory they all had disorganized attachment.

What we have here is a unique situation where we had 30 something adult survivors of childhood traumatization, half of which are secure and half which are disorganized. We found very different presentation in each of those groups even though they were abused by the same abusers for the same amount of time in the same way, so the variables attachment status.

Scott Hoye

Which is formed earlier on in life in a secure home and secure attachment.

Dan Brown

Correct! The way we study Attachment in early childhood is what is called 'A Strange Situation Paradigm' developed by Mary Ainsworth. You bring your child into a play group or play room, an unfamiliar environment where there are two chairs in the room and toys on the floor, and you don't give any instructions to the mother and you let the child and the mother explore the play room for three minutes. Then a cohort to the researcher comes in and you see the child's reaction to the stranger. How that affects the play behavior.

Then after three minutes the mother is asked to leave and you see what it is like for the child to be alone with a stranger. How that affects the play behavior. Then the mother comes back and you see the reunion and the stranger leaves and you see how it affects the play behavior when the mother is back in the room.

After three more minutes the mother is asked to leave and the child is left alone for three minutes and you see how it affects the play behavior. So, you get all the possible combinations here, it's a laboratory direct observation of what the grandfather of an attachment John Bowlby says about attachment "Healthy attachment is an inter-play between healthy attachment looking at the attachment figures as a secure base or a safe haven. The more safe and secure you feel around the attachment figure the more exploratory the play becomes, so you get more independent and more exploratory and the play behavior gets more and more complex."

So, securely attached kids have a clear preference with a mother over the stranger of been alone. They can play with the toys under all the circumstances without disorganization and they can continue exploratory behavior and make a healthy protest when the mother leaves and they reunite easily and then go back to the play behavior again.

Kids who grow up with what we call Dismissing Attachment deactivate the attachment system, they just do the toys they don't have any preference for the mother, stranger or of being alone with just the play with the toys. But often they play very aggressively with toys.

Kids who have what we call Anxious Preoccupation have the opposite, they inhibit the exploratory system then they get very clingy to the parent and once the parent leaves, they get so disorganized in their play they can't continue it. So, they're always clinging and they are kind of inhibit exploratory development which is the vehicle of self-development, because playful exploration is how we develop a strong sense of self.

Kids who have Anxious Preoccupation have three things wrong with them;

1) Highly anxious most of the time, particularly in connection with other people.
2) They have inhibited self-development.
3) Poor sense of self.
4) They get easily addictive in compulsive care-taking role in taking care of other people's needs at the expense of themselves.
5) Disorganized and they deactivate both the attachment systems and the exploratory system and they get very much disorganized in the play behavior.

What we know about the etiology of these three subtypes of insecure attachment are for Dismissing Attachment the main etiological factor is repeated rejection of attachment. These are the are on the part of the parents, so that the child basically shuts down the attachment system, disconnects.

For Anxious Pre-occupation the main etiological factor is continuous involvement in the parent's state of mind. The parent uses the child to regulate their state of mind rather than the other way around. So, the child never learns to regulate feelings, they have a weak sense of self because they never discover exploratory behavior and they get compulsive care-taking of other people's

needs at the expense of themselves. They get very needy, clingy, and dependent relationships, over dependent.

In the third group, Disorganized Attachment the main etiological factor is, that the source of attachment becomes the source of terror. These are parents who abuse or insight fear in their child and the child would normally go to somebody when they feel afraid to the parent to sooth them and comfort them, but they can't. It's literally an impossible dilemma for the child, the source of comfort is, the source of fear so they can never get comforted.

So, these attachment types are developed in the second year of life concurrent with development of representational thinking. By eighteen to twenty-four months, we develop what Bowlby called an 'Internal Working Model for Attachment,' it becomes a template for all future connections after that. It's well in place by the eighteenth to twenty months after life and 75% of the people who develop those attachment maps by the second year don't change it after that.

If they have an aunt or uncle or grandparent or teacher later in childhood they can remap and develop a positive map for attachment. This is what we call 'Earned Secure Attachment' and that's where psycho-therapy comes in, you can remap the system.

What we found was that in our orphanage study the ones who had the secure attachment when they were traumatized later in childhood at this orphanage physically, and sexually that they had access one circumscribed symptoms. Most of them had PTSD, they had depression, they had anxiety symptoms, and they had somatoform symptoms and maybe a sexual desire disorder.

None of them had a significant personality disorder, none of them had major dissociative disorder and none of them had multiple addictive behaviors. In the group that had disorganized attachment in addition, to post-traumatic stress, anxiety, depression, somatoform disorder, sexual desire disorders, and in addition, to all that all of them had a mix of borderline personality disorder diagnosis.

All of them had DDOS or (DID) major dissociative disorder and most of them had multiple addictive behaviors, which suggest the early disorganized attachment disrupts the three big developmental lines; self-development: relational development: and emotional development. That will manifest in later childhood or early adulthood as a personality disorder. If they get traumatized later in childhood and they use dissociation as the main strategy to cope with dissociation they'll end up in early adulthood with a major dissociative disorder. So, major dissociative disorders like DID are a combination of early disorganized attachment aggravated by later childhood trauma. That is what we found in this study.

It causes rethink trauma treatment because we can't just process the traumatic memories, because people who have disorganized attachment when you process the traumatic memories they get more and more disorganized in the mind. They have what we call 'Local Coherence' of mind in attachment terms, so they get worse rather than better.

If you treat the disorganized attachment as a result of effective treatment and get coherence of mind at a high level then you can process the trauma in the way you process any kind of trauma with short-term cognitive behavior processing of it, then you don't have to go through all this work of working with parts.

Scott Hoye

It's almost like you're reverse engineering the assumptions about … well maybe not reverse engineering but you're actually going back to the early childhood interpersonal issues and that's the foundation for trauma treatment that you're presenting?

Dan Brown

For that particular group yes. For those with Disorganized Attachment you have to treat the disorganized attachment. We have two kinds of treatment that we offer. In the book (1) the generic treatment which are called the *Three Pillars of Attachment Treatment*. The first is:

- Ideal Parent Figure
- Fostering A Range of Meta Cognitive Skills
- Fostering Collaborative Behavior in and Outside of Treatment

Then we have specific treatments for each of the subtypes of insecure attachment: one for dismissing attachment one for anxious pre-occupied attachment, and one for disorganized attachment that we'd highly recommend.

So, there's both a generic treatment and a treatment specific to the subtype of attachment disorder the person has.

Scott Hoye

Maybe you can touch base on what it looks like those three pillars? How you roll out the treatment as explained in the book?

First, we have the person imagine they grew up in a family different from the family of origin. We have them imagine that they grew up in a family where the parents were ideally matched to them and their nature, did all the right things in terms of attachment figures, we call that the 'Ideal Parent Figure Protocol.'

The reason why we do that is because if you look at the existing attachment treatments that are out there, like the work of Jeremy Holmes and Pat Sable and work based on Bowlby's work, all of those assume that the therapist becomes a good attachment figure and provides a safe haven for which the patient can explore their own mind.

That assumption assumes that every parenting model the therapist should act like a good parenting figure. There are two things wrong with that assumption;

> (1) Many times, the therapist can't act that way realistically, so there are a lot of therapeutic rupture and breaches in the treatment.
>
> (2) It shows a misunderstanding of the fundamentals of attachment. Attachment behavior starts in the first minutes of life, but what really changes and what is significant in terms of development is, the development of an internal working model or attachment of representation that takes place at about eighteen months.
>
> It's that attachment representation that has an organizing effect on all lines of development, like self-development, relational development, and emotional development.

What we try to do is develop this technique by which the person can continue to repeatedly visualize an ideal parent figure and positively remap a stable positive template for attachment relationships. Then after a while after maybe one or three years they learn to operate out of that positive map and whatever, the dysfunctional or inconsistent maps where they become irrelevant. So, there is much more to be gained out of seeing they can operate out of that positive internal working model when they select for working healthy adult secure relationships.

So, that's the first of what we call Positive Remapping, so Ideal Parent figures that they do in the hour and then we often tape record the sessions with their mobile devise and let them listen to the hour and practice it every day. The more time they practice it the more they learn to develop a new internal working model, a positive stable model more quickly.

Scott Hoye

You were mentioning an hour so it's not just a portion of the hour you're allowing them to listen to the whole interaction between the therapist and themselves and also the ideal parental imaginary?

Dan Brown

Correct, they listen to the whole hour but we want them to focus on the imaginary mostly.

Scott Hoye

Interesting, it's kind of the opposite in many people, myself included will record relaxation training or hypnosis but only that portion not the entire hour, but it seems like there is more of a focus on the interaction.

Dan Brown

Well, because when they listen to it a second or third time, they're going to develop some Meta Cognitive insights into their own state of mind, so we want them to listen to the entire thing because those are some of the other Pillars.

Scott Hoye

It's like a Meta of psycho education almost.

Dan Brown

Yeah.

Scott Hoye

Yeah, interesting. What about the Second Pillar?

Dan Brown

The Second Pillar is 'Foster a Variety of Meta Cognitive Skills.' There are four generations of work along that line, the first was Mary Main and Erik Hesse developed 'Adult Attachment Interview,' they had a scale for Meta Cognitive Abilities; based on simple things, like 'Appearance Reality Distinctions.' "It seemed to me that I was angry as a child but I might not have been. It seemed to me that I was angry as a child but my sister says she wasn't angry at her mother at all, so we had a different view on this."

So, all of those means we are constructing a relative reality and we can appreciate what we construct is relative. That was the first Meta Cognitive scale that was part of the (AAI) Adult Attachment Interview.

The second was much more systematically based and it came from the *Tavistock Group* Peter Fonagy, Howard Steele, Valerie Sinason, Mary Tyler and others. They did a lot of research on what they called a 'General Capacity for Meta Cognition' which they call a 'Reflective Function on Metalization.'

So there was that group, also in Budapest did they this child study showing 'How do children develop a good capacity for Meta cognition?' This means they passively reflect on their own state of mind and see it accurately for what it is. He found that Meta Cognition developed in children better when parents actively wondered about the child's state of mind and were systematically curious about the child's state of mind.

They always were attuned to the child's feeling state or what the child was thinking and they wanted to know that. So, the child learned to develop and internalize their own capacity to observe their own state of mind. They also found in that group that people who have a borderline or mixed personality disorder diagnosis on the one hand or dissociation of any disorder diagnosis on the other hand are extremely low in Meta Cognitive capacity.

If you score a Meta cognition on a Reflective Function Scale on a 1-9 basis most people in the general population score about 4.5 and that means we are sort of mildly Meta cognitive. People who have been in 20 years of analysis are high on the list, they get about an 8 or 9 because they've learned a skill of observing their own state of mind very carefully.

People who have a personality disorder diagnosis or dissociative disorder diagnosis never learn that because they didn't grow up in a family where parents were attuned to their own state of mind. In fact, the parents were oblivious to that or clueless about it.

Howard Steele once told me that he, "never found anybody at Tavistock in the dissociative disorder group or the general psychiatric unit who had a dissociative disorder diagnosis ever scoring above 3 on the 'Reflective Functions Scale.' And because of that the developed a whole treatment based on fostering Meta cognitive skills. There are two versions of that:

(1) A version that John Elle developed at Tavistock called 'Therapeutic Stance' you're always constantly taking the stance of wondering out loud about the patient's state of mind, then eventually they internalize that and they start observing their own state of mind better.
(2) The other was by Tony Bateman from the same group, he's a behaviorist so they have a list of skills you learn, Meta Cognitive skills that all contribute to raising the general of Reflective Capacity' in people who are poor in that trait

They have very impressive outcome data that show in Metalization-based treatment of one outcome study they compared randomly assigned patients to either, mentalization based treatment or to current traditional treatment for borderlines.

What they found is the treatment affects eyes and the metalization base and we've doubled over the traditional treatments for borderlines in a year and seventy percent of the individuals in the mentalization base who no longer met sufficient criteria of a borderline, but all people in the current variable groups still met the criteria for borderlines.

So, the outcome data speaks for itself, the fostering Meta cognitive skills in one way or another we don't know how it does it but it increases the overall organization of mind of what we call 'Coherence of Mind' in attachment terms.

Scott Hoye

How did they're study results compare to say DBT (Dialectical Behavioral Therapy)?

Dan Brown

Well, DBT is a nice idea but there is no study that shows that it effects the diagnosis or effects the capacity to stick to treatment, it effects self-mutilation and suicidal behavior, it effects drug involvement and all the ancillary things to treatment, but the patients still at borderline.

There was a study comparing mentalization to DBT and again, the majority of the people in mentalization based treatment no longer met the diagnosis after two years, but all the DBT people still had the diagnosis, so the outcome data speaks for itself, it's a good treatment.

Scott Hoye

I'm surprised that it isn't used more often or elements of it in the states.

Dan Brown

That's because people don't really think of it outside of the U.S. I read all of the European journals and the masters in the original languages like Pierre Janet and people like that. My European friends when they teach me say, "You're not American you read all the Masters."

--*Laughter*

Scott Hoye

I'll have to pull out my reading list and brush up on my French and German so I can catch up with you, I don't know if I'll be able to.

Dan Brown

So, the second pillar, the second generation of that is Reflective Capacity is a general capacity for Meta Cognition. The third generation was the work of the *Rome Institute of Cognitive Psychotherapy*. Tony and others they had what they call a Molar, I call it a condition specific approach to Meta Cognition.

What they identified is that in certain diagnostic groups of patients there is certain Meta cognitive skills that are deficient and you have to target the treatments specifically to those condition specific Meta cognitive skills that are missing. For example, they make a distinction between Meta Cognitive Capacity and Meta Cognitive Regulation. Meta Cognitive Capacity is the capacity to be aware of feeling states in yourself and others. Borderlines are not deficient in that, but in terms of Meta cognitive regulation borderlines are very poor in that.

In other words, they can be aware of their own feelings but they can't regulate them. In their study they found narcissist were the opposite and narcissist are quite incapable of regulating their own feelings but they're not very good at recognizing the feelings in themselves and certainly not good at recognizing feelings of anybody else. So, a borderline narcissist if you continue you get different Meta cognitive skills that are required.

They developed a third skill, which I think is more important which is what they called 'Meta Cognitive Integration Organization.' If I say to you or a patient on a 1-10 scale (1) been completely disorganized and ten been completely organized with the other number somewhere in between, look at your state of mind right now and tell me how organized and disorganized it is? They might say two or they might say five or they might say eight, and if I do that 3X a session and I do that for six months it leads to overall increase in coherence of mind. There is a significant increase in coherence of mind, just by observing it gets more organized. That's a very important skill that we want to teach our borderline patients for example our DID patients.

So, that's the third generation, it targets specific Meta Cognitive deficiencies in certain patients with certain psychiatric diagnoses. The fourth generation is the work that I've been working on. I've been influenced by the post -World War II research on levels of intelligence.

Pierre Janet model of intellectual development goes as far as adolescence with formal operational thinking. If we think that intellectual development stops at adolescence, we're in trouble as a race. Some people have said that we need to look at and map out the stages of post-formal development beyond adolescence, and there are six stages of cognition or intelligent intellectual development beyond formal operational thinking of adolescence.

And each of those six stages has specific Meta cognitive skills associated with it. It involves moving beyond a world of relativism, which is the Reflective Function Skill that's based on scoring relativism, but there is a unified universe where everything is interconnected beyond that and that

has profound implications for mental health. There are larger systems of perspectives that are beyond that and were trying to open up all those post-formal Meta Cognitive skills. Most of them have to do with perspective taking and things like that because they have profound implications for mental health and the organization occurrence of mind.

So, that's what I would say about the second Pillar. We introduce a variety of Meta cognitive skills quickly into the treatment so they can observe their own state of mind and lean to become increased, careful, and accurate in their observations with a variety of Meta cognitive skills as part of the treatment.

In the third Pillar, I learned from Giovani Liotti from that Rome group, it's called 'Collaborative Behavior' and he introduced me to the work of Michael Tomasello, the social anthropologist who did ten years in a primate lab. He found that if you look a chimpanzees and silver backed guerillas, they can collaborate in collecting food, but they don't share if very much.

Whereas, in humans there is a huge leap in evolution because humans will collaborate around team projects, abstract ideas, like going to the moon or have put together a group of NASSA. Everybody will collaborate on this remarkably abstract project and it actually works. Humans had this unique capability of human collaboration.

What Tomasello found later in his work is that he looked at human development and that kids who had secure Attachment are inherently collaborative, they're the ones in pre-school that get empathic to the kids who are having a hard time. They will go over to them and comfort them and make friends with them and they'll share their toys with those kids who were lonely.

What Tomasello also found is that kids who have one version of the three types of insecure attachment take the collaborative behavior offline, so they don't collaborate in the pre-school with picking up the toys. They take toys from other kids and butt in when they're not supposed to and they don't take turns in all these kinds of stuff so they engage in all sorts of forms of non-verbal and verbal un-collaborative behavior.

I was influenced by Liotti's work and decided that we would try to include it in our treatment as teaching people collaborative behavior. For example, people with anxious pre-occupied attachment have notoriously bad verbal collaborative behavior, they never take turns, they talk over you, and they never get a word in edge-wise so the therapist easily gets irritated, because they never let the therapist talk.

If you try to talk, they will talk over you. We are not doing the patient any favor with that, so we'll explain to them that they have never learned 'Collaborative Verbal Behavior' and we'll explain the rules of discourse and turn-taking and teach them how to develop more Collaborative behavior over time.

I started when I was an intern some 45 years ago, I worked at *McLean Hospital* and I did 10 years of intensive psychotherapy with Schizophrenias mostly. I remember bringing my first case to my preceptor who was Al Stanton, one of the original class of 12 of Harry Stack Sullivan, the interpersonal psychiatrist and he asked me what I remembered about the hour. I said, "I didn't remember much because the woman was talking mostly word salad, they couldn't follow it at all." He said, "Why didn't you tell her to stop and work in collaborative behavior? She needs to learn to work in an interpersonal world and if you just let her go on like that, you're not doing any favors. She needs to learn to talk in a way that makes sense." It had never occurred to me before and it made a lot of sense when he said it.

So, that's what we're trying to do now we're trying to take patients who are not collaborative, verbally and non-verbally. An example of non-verbal collaboration would be dismissing a patient who never makes eye contact or never looks at you and turns the head towards you when they talk. If we let that go on, we're not doing the patient any favors so we teach the patient how to correct all of that so they live in a divers-able world.

What Liotti taught me also was the Collaborative System is different from the Attachment system, he called them Behavioral Systems using Bowlby's term. So, when a therapist gets into therapeutic breach, if you try to be empathic with the patient it gets worse, they get more disorganized. He said "You have to step out of the Attachment System and shift to the Collaborative System and then you repair the breach much quicker.

If you have a patient that you've committed some empathic rupture with and you say "I'm really sorry or I really see how that hurts you" that's going to make it worse. But if you say "Let's talk about this and let's work together as a team here and let's look together what exactly happened? What were you triggered by in terms of what I said? Let's work on this together and see if we can explain it." They get out of the break in the attachment system, the collaboration begins to work, the therapeutic breach is repaired and then you can go back to the empathy; it's remarkable.

Scott Hoye

This is a really unified way of looking at the treatment and putting a lot of diverse information together that looks at—I would almost venture right object for the ideal parent figure, right mind for the mentalizing capacities.

Dan Brown

Or observation of mind.

Scott Hoye

Like right mentalizing or right observation?

Dan Brown

Mentalizing, yeah.

Scott Hoye

Right social construct or social contracting.

Dan Brown

Yes, it's a good way of describing it.

Scott Hoye

Not right in a judgmental way but one that's going to work the best, trying to find the best fit model for treatment with a template that's generalized, but then takes into account the specifics of the individual who is in front of you whom you're helping.

Dan Brown

Yes, and what the specific developmental deficits and repairing them. We're just working on an outcome study on this, the first major outcome study on this and we have tentative results that we analyzed last week. We had about 20 subjects so far in Three Pillars treatment for one to three years once a week and once every other week and then we have a control group.

The control group is interesting, the control group of people who took a class for a number of weeks in psycho-education about Attachment, so they know all about Attachment, but they never took treatment of Attachment, just like educational attachment. Most of them have also one to three years of Mindfulness Training and some of that is DBT-based Core Mindfulness where they not only just being mindful of the state of mind, they're mindful of feeling states and regulating feeling states; all that kind of stuff.

We found that the control group and the treatment group are not totally comparable and they weren't uniform in the sense that the people who had never been in treatment before had no Meta Cognitive skills. So, they started with a low-level of Meta Cognitive awareness but the people in the control group, because they had years of Mindfulness Mediation, and Core Mindfulness training had a much more variable range of distribution of cohesion of mind and Reflective Capacity. We had to use non-parametric statistics and what we found were there were three outcomes that we measured.

1) Change in Attachment status in the 20 subjects in the treatment who, all of them went from mostly disorganized, sometimes anxious pre-occupied sometimes dismissing attachment, but mostly disorganized attachment. All went to secure Attachment within three years.
2) We found that none of the people in the control group reached secure Attachment. A lot of the people in the control group had increased Reflective Capacity and some had partial organization of mind. Some were in the mid-range of their organization of mind but not in the high range we see with secure Attachment. So, they showed some improvements but not the kinds of improvements we expected in the attachment status.

So, what it seems to suggest is the ideal parent figures are a necessary component to treatment to positively remap the Attachment System and make a new map that they operate on. Shifting to a larger list of a complete Meta Cognitive skills, particularly those that involved in perspective taking in, something beyond relativity where they get an overall view of the universe here, then everything is interconnected within that and they're part of that. That makes the difference in terms of organization of mind.

Scott Hoye

Just to kind of circle back to hypnosis, which I know you are well trained in here having worked with Erica and other people.

Dan Brown

I should add for those listening, I'm a Chicago boy. I went to the *University Chicago* for graduate school. I studied with Erica myself and Steve Khan were her main students over the years. I worked with her for 35 years and when she was in her late eighties and we were still teaching around the world together I used to tease her. I was in my twenties at the time and I would say "I'm getting too old to keep up with you."

Scott Hoye

I've never met her personally but I know she was a force of nature and a very big influence on the hypnosis and the world and the world of psychotherapy.

Dan Brown

Certainly, in Chicago.

Scott Hoye

I think that her effects have reached a lot of other people elsewhere also. Just kind of circling back to the 'Ideal Parent Figure' it really dawned on me that it sounds a lot like reattaching hypnotic work. I'll put this out here, my own knowledge base is very Ericksonian. Erickson had a case called the 'February Man' where he himself became an Attachment figure for a person he was working with.

Dan Brown

That was where it all started before Bowlby even with that case, right?

Scott Hoye

Possibly, yeah, I don't know how famous the case was before it was published by Ernest Rossi and Erickson in the '70s and I don't think he was necessarily intentionally coming out of Attachment Theory although, my understanding is he knew that to a certain degree having been trained analytically, but not accepting it per-say being Erickson.

Certainly, I think he was becoming an attachment object, it's certainly a way to work and look at that case. How did you develop this Ideal Attachment Model? I know it comes out of Attachment Theory but how did you come about this idea?

Dan Brown

Well, some years ago I taught a course on Attachment Repair with Elgan Baker, he was the one that started this idea. He came up with this idea of 'The good enough therapist' and having the patient imagine and interacting with the 'good enough therapist' in positive ways to develop a new positive map for attachment.

He was the first person to think about changing the representation, being important as a primary focus of the treatment rather than just being a therapist as a parenting model. It spoke more clearly to the issue of what Bowlby was talking about of the importance of developing a positive internal working model in treatment. I picked up on Elgan's idea and just took it from there.

Scott Hoye

I've heard him speak and I can definitely vouch for his brilliance as a clinician and trainer. But you've done a lot work with this by integrating so much more information I think based on European and other journal work. The work in Attachments has been out there so it seems like you've had a lot of contemplation of how to construct this with your team.

Dan Brown

Yes, I would say in the early days we used hypnosis in induction ceremony. For years we didn't have a good definition of hypnosis for years, but I think that's revolved around looking at hypnosis in terms of a heightened state of focus beyond ordinary focus.

The neuro-science of that is the activation of the (ACC) Anterior Singular Cortex which is the attention center of the brain. When you effortlessly on something and tune everything out you activate the ACC. In a Stroop Test, if I showed you an index card and it's printed and the print says the word 'RED' but the text is green and color, it would double-take you to focus on the text you'd focus on the color. In that kind of task, it activates the ACC. Whenever we have a competing detention demand we activate the ACC to put effort to focus on this and tune the other thing out.

The ACC is underactive in children/adults who have Attention Deficient Disorder. The ACC is active in concentration, but not mindfulness meditation. The ACC is active in hypnotic induction, and thirdly the ACC David Spiegel found was active when athletes who spontaneously go into peak performance; their zone and so all of those require a heightened state of focus.

John Gruzelier did some work in London showing that, if you put controls to this and you ask people to focus in a heightened way, if you have a control state where they just sit and let the mind wonder that's not the activation of the ACC. If they try to mathematics in their head that's not an activation of the ACC, it's a cut above, it revolves in intense, heightened attentiveness to activate the ACC, but that is what is required in hypnosis. That is why people who are highly hypnotizable have the skill that they can activate an extraordinary focus of attention at certain times when they intend to do that.

Why we introduced that in treatment is because it's easier to learn to develop a new internal working model for relationships if you're practicing that in a non-distracted state, a heightened state of focus. There isn't a lot of extraneous thought activity going on in your mind so it just happens quicker, that's why we choose hypnosis.

I have always used hypnosis, but then more than once I was influenced by Jeff Young's work who works on Schema Therapy in New York. I brought him up to Boston a couple of times, and he doesn't use hypnosis, he doesn't know anything about hypnosis. When he works on his Schema he says "close your eyes, focus and relax" and he goes right into it. We found that for [for half the patients we didn't need a formal induction ceremony they just went right into the state anyway.

We were wasting time on the hypnotic induction ceremony [chuckles], when you could just go into it easily. What you have to focus on are the people who are more distractible and giving them some way of becoming less distractible so they can do the visualization, and tolerate it best. So, sometimes we use hypnosis and sometimes we don't.

Scott Hoye

Have you ever considered using more of an alert state or eyes-open version of hypnosis at all?

Dan Brown

If that's indicated, I'll do that yes.

Scott Hoye

Since we're talking about hypnosis maybe we can touch on how you might use it and how the protocol was born out of Elgan Baker's work and your work with this as well along side of him, in developing that for the Ideal Attachment Figure.

Maybe talking towards dissociation and hypnosis correlates, what makes them kind of connected, and maybe parsing out the dissociation aspect or element of hypnosis. I know there has been some talk about what that is and some of the theories around them.

Dan Brown

Well, the thing we know about is that kids who have disorganization, if you give them the Frank Putnam Scale on child dissociation, if you have mothers, parents, or teachers rate the child on dissociation, the kids who have Disorganized Attachment score high marks on dissociation throughout childhood into adolescence. That's not a good thing, dissociation works and it doesn't work, it allows them to stay more connected to the world but they pay the price of that by sealing off major aspects of their experience and they can't process then.

We see dissociation as a coping style as problematic and eventually you want to develop a cohesion of mind and healthy attachment representation. Once they get organized then you can then process the trauma in a way that they no longer need to dissociate from it. The trouble with people who are HIGH dissociative and they have Dissociative Predominate PTSD, if you process the trauma alone, they get worse.

I did over a hundred law suits of people who sued in the 1990s and 2000 by the False Memory people for allegedly implanting false memories of treatment. Sometimes we'd have to read hundreds of crates of records.

We found that both sides were wrong, the False Memory people were accusing therapists of creating false memories in the treatment with most of the patients that came to treatment. The facts said "Most patients came to treatment already spilling old memories" they'd already recovered the memories, and the therapist was simply processing what was presented to them.

But not necessarily uncovering them, accept in a small number of cases. The therapist was using phase-oriented trauma treatment, they were processing trauma treatment and the patients were getting more disorganized rather than less disorganized. They had lower coherence of mind as a result of the processing. What we found is that with traditional phase-oriented trauma treatment doesn't work well for people who have low coherence of mind, they get more disorganized.

Scott Hoye

Hence, in the disorganization parts might show up as defense mechanisms or various things like that?

Dan Brown

Exactly, so it goes endless, it doesn't go anywhere. So, at some point you have to treat the disorganized attachment and the result of that is they develop a new positive representation that's stable, and they have high coherence of mind.

On a 1-9 scale the coherence of mine were somewhere between seven and nine, which is in the secure attachment range. Then once they get organized then you can go back and revisit the trauma with short-term treatment models, positive cognitive processing models. So, you don't have to do all this work calling for all the parts, that doesn't usually work.

Scott Hoye

It might not be the affective aspect of that kind of DID treatment something else might be happening relationally that's under the threshold of the therapist. If someone does get better in that kind of model it's over time and it's because of the relationship. Maybe all these Meta cognitive and ideal parental objects internalize, kind of unconsciously or beyond the range of both the therapists.

Dan Brown

We can make those models more explicit as treatment focused and they can accomplish more in terms of Meta Cognitive skills, a range of Meta Cognitive skills. They can accomplish more in terms of being collaborative and it works better that way if you target them as a treatment focus.

Scott Hoye

Well, I'm curious does the therapy rollout, does it look more like a CBT therapy? Does it look more like a relational therapy or psycho-dynamic therapy the way it's structured? How does it look in action with your team and with PTSD?

Dan Brown

It's all of the above, it's integrative so that some at skill base like practicing over and over again, and the Ideal Parent Figures it would change their content as we go along in the treatment. The book describes how we change the content over time in each of these treatments. Throughout this time we're dispersing that and looking at the state of mind with a variety of Meta Cognitive skills. If we see lack of collaborative behavior and evidence for that we educate the patient on how to do it differently.

Scott Hoye

What has the reaction being from the trauma crowd and the detachment theory crowd towards you're book?

Dan Brown

They've actually been most favorable.

Scott Hoye

I guess maybe to kind of sum up here is there a way for people out there, besides you're book which I'll obviously have a link to in the show notes, but is there a way for people to become trained in this particular model of treatment?

Dan Brown

Yes, we have a website called the 'Attachment Project' so you can Google "attachment project." It has the paper and pencil self-report test for Attachment Diagnosis, but the better one is the AII with those procedures on how to get AII administered on you or inventory interview.

On the website there is a three-day training course in Attachment that professionals can get CEU's for.

Scott Hoye

Oh, okay excellent!

Dan Brown

Then beyond that we have different levels of treatments, beyond the three-day beginning training there is a Master Class that we have in various sites around the world. Then after that the Master class would be supervised by one of the co-authors of the book.

There are nine co-authors of the book, it's not just myself or David Elliot there are nine co-authors, but they couldn't list them all on the cover though. Then after that there is a certification process, but we're still working out the details of that currently because there is a lot of demand for this now.

Scott Hoye

Is there any particular trainings that will be available at any point in time out in the wide world?

Dan Brown

As of now it's online.

Scott Hoye

Okay, so you're talking about the Masters level training, was that in person or was that online?

Dan Brown

We want to try and travel less so that's why we did it online. In terms of hands on what I can do without having to travel so much, because it's too much wear and tear at this age.

Scott Hoye

Is there anything else you would like to add? I think that kind of covers what we had set out to talk about today.

Dan Brown

Thanks to the clarity of your questions, I appreciate that.

Scott Hoye

Well, thank you for been here, I know we had some earlier technical difficulties on my end and we had to reschedule so, appreciate that very much. Thank you for your time. Best of luck with all your endeavors.

Dan Brown

My pleasure!

Scott Hoye

Thank you so much.

Dan Brown

Bye everybody.

Narrator

Well, that's my conversation with Dr. Dan Brown. I can't recommend highly enough the book *Attachment Disturbances in Adults; Treatment for Comprehensive Repair*. For those of you who would like to explore the 'Three Pillars Model of Attachment Treatment' please do pick up that book and also go to the website www.attachmentproject.com. Access for continuing education units can reached on that site.

I mentioned that I had an earlier technical mishap that actually caused me to lose part of Dan Brown's earlier interview. Dan was gracious enough to step and redo the interview almost immediately. In that earlier interview we touched on Dan Brown's 40 plus years of been a meditator in the Tibetan Mahayana tradition.

Much of what is behind Dan Brown's work in philosophy is a deep understanding of that tradition and the role of the subjective experience of human-beings. He is working to roll out translations of Buddhist texts that are more approachable to Western people.

I hope to have Dan Brown back in the future on the show to discuss that work and the confluence of new information about the brain and mind from neuro-imaging, psychiatry's, psychotherapy, and contemplative practices.

This is an exciting time to be alive as a clinician, researcher, and just as a human-being. Just a side note for my colleagues who are also invested in Milton Erickson's process-oriented psychotherapy. I was not arguing that Milton Erickson was a relational or psycho-dynamic therapist but that his training and education, during that time the dominant models available were basically psycho-analytic.

Erikson was obviously conversant in those theoretical models of psychiatry and even worked with some of the prominent psycho-analytics psychiatrist of his day, such as Laurence Kubie.

Since I've invested a great in Erickson's model, I just wanted to append my comment. I also find the correlates between Erickson's February man case, and Elgan Baker and Dan Brown

Brown's work fascinating, and helpful in my own way of conceptualizing hypnotic work and attachment as it plays out in psychotherapy.

[Music Playing]

Scott Hoye

Well, I think that is about it for today. As always, thank you so much for listening. Your presence is appreciated.