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"I remember checking on my mother to see if she was still breathing." How a relationship maintains, regulates, and helps resolve traumatic experiences: relational family integration

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Abstract: Traumatic experience is one of the most devastating experiences the family can endure. In order to understand why an experience maintains its traumatic nature we must take into account that trauma could be used as a powerful regulative mechanism in the family system precisely because of its organic component. For the first time in the history of psychology, this enables us to connect interpersonal relations with a person's organic nature and to establish that this nature is subordinated to the relationship or space between "I" and "you," which opens an extensive area and continually makes new discoveries possible. In the following vignette we will see that family systems, marked by trauma, develop very specific affective dynamics for affect regulation, which maintains the trauma. Trauma is transferred into interpersonal relations through basic affect and through the development of attachment; traumatic experiences remain present and powerful through multiple generations. The discovery of a new perspective on trauma lies in the fact that a trauma, for which no one takes responsibility, remains unmanageable.

Key words: emotional trauma, families, affect regulation, secondary traumatization, attachment behavior

"Spominjam se, kako sem preverjal, ali mama še diha. " Kako družinski odnosi ohranjajo, regulirajo in razrešujejo travmatične izkušnje: relacijsko družinska integracija

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Povzetek: Travmatična izkušnja je ena najbolj uničujočih izkušenj, ki lahko zadenejo družinski sistem. Če hočemo razumeti, zakaj določena izkušnja ohranja travmatične razsežnosti, moramo vedeti, da je travma lahko zelo učinkovit mehanizem regulacije afekta v družinskem sistemu prav zaradi svoje organske narave. In prav to spoznanje nam odpira vpogled v organsko naravo medosebnih odnosov in prostora, ki se ustvari med »jaz« in »ti«. Na primeru terapije bomo pokazali, kako dinamika regulacije afekta ohranja travmo znotraj sistema skozi več generacij. Odkritje novega pogleda na travmo je namreč, da travma, ki je nihče ne vzame nase, torej zanjo ne prevzame odgovornosti, ohranja svojo neobvladljivost in se z nezmanjšano močjo preko okrnjenega sočutja in neobvladljive tesnobe do otrok prenaša iz

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generacije v generacijo ter preko sekundarne travmatizacije od partnerja k partnerju. Šele odnos, ki bo omogočil sprejemanje odgovornosti za travmo, bo tako ustvaril zdrave razmejitve ter zaustavil prenašanje travmatičnih afektov.

Ključne besede: čustvena travma, družine, nadzor čustev, sekundarna travmatizacija, navezanost

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Systemic level: mutual affect and the trauma family system

Family systems that are marked by trauma develop very specific affective dynamics for regulating this trauma. This paper examines how trauma is transferred into interpersonal relations through basic affect and how, through the development of attachment, traumatic experiences remain present and powerful through multiple generations. The power and intensity of affect is preserved, and only its manifestation changes. Every level of the system and every relationship reflect affect in a different manner or regulate affect through different mechanisms. The discovery of a new perspective on trauma lies in the fact that a trauma that no one takes upon himself, and thus does not take responsibility for, remains unmanageable. This trauma passes with undiminished strength from generation to generation through impaired empathy toward children and, through secondary traumatization, from partner to partner. Only a relationship that makes it possible to accept responsibility for a trauma can create healthy boundaries and halt the transfer of traumatic affects.

In the relational family paradigm (Gostečnik, 2004), affect is understood as a basic mutuality, atmosphere, feeling, or the organic foundation of every interpersonal contact that allows a person to maintain connectedness with others. It is unconsciously and deeply ingrained in the organic structure of our brains. This fundamental mutual affect thus supports the entire psychic structure of thought, feelings, and behavior and is expressed in even the slightest elements of interpersonal dynamics. Through affective psychological constructs, we can therefore recognize basic affect in individuals' thought, behavior, and feelings – and especially from the atmosphere created by a particular relationship. Affect is therefore always systemic as well, which means that it pervades the entire family without the family being aware of this (Gostečnik, 2004).

Affects always have a physical root, which means that they are always linked to bodily sensations and illnesses, and they create the basic dynamics of an attachment mechanism, and thus unconscious mechanisms for preserving a feeling of belonging, security, or fixedness in a network of interpersonal relations (Siegel, 1999). This interpersonal quality itself, or the ability to be connected, is the foundation of humanity and is the most powerful survival impulse that a person knows (Bowlby, 1982). Based on this, it is easy to understand the persistence of the most painful

forms of relations, abuse, and neglect, which are destructive, dangerous, and sometimes terrifying by nature. Mutual affect makes it possible for an individual to continually reestablish relationships that are indissoluble because they include and are based on attachment mechanisms. Relational trauma or attachment injury is thus the most powerful attractor in family systems (Bradeley, 2000). At the systemic level, attachment injury or trauma manifests itself as a blockage in the system or an inability to develop basic compassion and an effective parental relation towards children at a particular developmental level.

In the following vignette we will see how parents find themselves frustrated and unable to respond to the minor trouble with their son.

H (husband): We're still worried. Our child has been ill for so long and he's still running a temperature. We're really worried and we just don't know what to do.
W (wife): We were at the doctor's and she said they did all that could be done. They said that he's all right, physically. All the tests showed that there's nothing wrong with him.
H: And the thing that worries us the most...
W: Yes.
H: ...is that there might be something serious behind all this. That they won't be able to figure out what's wrong with him. There might be something seriously wrong and we won't even know about it. The doctor said that there's nothing physically wrong with him, but I'm still worried that there could be something serious, maybe even life-threatening. (They express a feeling of concern and they also act as if they feel guilty. The therapist will contain the underlying affect of fear by addressing guilt and concern.)
T (therapist): There's a deep concern here. It seems like it's a connection between the two of you.
W: Because it's a big problem that we would like to resolve. So we know where we stand.
T: (to the wife) How are you feeling?
W: I'm very scared and concerned. It's the uncertainty that's the worst. The feeling of not knowing. If I knew that he was physically 100% all right, that he was healthy, it would be easier because then I would at least know that it could be psychological. Now I'm not really convinced. What if it's a disease that they just don't know about and they'll say in a year's time that now it's just too late?
T: It would be easier for you to understand if it were a disease that could be cured at the physical level...
W: Yes, I would at least know how to fight it.
T: Because these psychological things...
W: Even if it were psychological, it would be easier because I would at least know.
T: How do you feel? Guilty? There's a lot of guilt here. (By addressing guilt the

therapist allows them to reach the fear)
W: No, I'm more or less scared.
T: Scared. And you, sir?
H: I don't know. I'm thinking of what the doctor said that it might be psychological. I really don't know... is it something that's between the two of us that's not being addressed and so our child then needs to..., are we pushing our child into an illness?
T: So the guilt has its home here.
H: I guess a little. I'm asking myself... Maybe I wasn't home enough or didn't spend enough time with him.
T: It's just not fair to the two of you. This is not something you could have caused. This child should have gotten better. Jernej should be healthy. We talked about this a lot in the last session. Where did you feel like this? (When affect undergoes the situation the therapist will try to find its real origin)
H: I guess I felt like this at home when I ... my parents were often ill.
T: Your parents?
H: Yes.
T: And what's it like being the child of parents like that?
H: I always... there was always something you needed to worry about. If it'd be okay or not, would they... The worst part was thinking that they'd just die. There were heart failures and my mother had some kind of seizures, we didn't know if she would survive or not. I remember checking on her to see if she was still breathing.

We have seen that the family system is blocked at this point. The husband is scared and not able to connect with the child because at this point he became connected with his family of origin, namely with his own family system. In the family, mutual affect may thus appear as a block to the system. When this blockage is manifested, the interpersonal level of the traumatic system opens up, which is made possible by the valence of the partners toward the affect of the trauma. We are talking here about the traumatic experience (as is for example an accident) that happened long ago in the primary family system of one of the parents of the family presented here. And we are considering the prerequisite that allows that an annoying experience retains its traumatic effect through the generations. At the interpersonal level, the trauma can be recognized according to the typical pattern of secondary traumatization or unusual relational stress between the partners accompanying children's minor problems.

Interpersonal level: secondary traumatization and dissociation

Reshaping the trauma at the interpersonal level requires first recognizing the source of the traumatization – that is, who has the trauma, who the source of the

trauma is, whose trauma it is (i.e., returning the trauma to the original families), and seeking mutual affect on the basis of which the link of non-secure attachment between the partners can then be broken. As long as the basic affect is unconscious and unrecognized, it is frightening and does not allow the relationship to grow. When this occurs through the continual repetition of one and the same pattern of relationships, something actually unites two individuals – that is, mutual affect – the relationship relaxes and each of the partners in it can begin to seek new hitherto inconceivable responses to the situations encountered in the relationship. Flexibility in feelings, thoughts, and behaviour are the main sign of secure attachment, while the criterion is the genuineness of emotional responses (Kompan Erzar, in press). The following shows what happened between the man and woman in the previous example and how the trauma took root between them. When the husband and wife could not work through their anxiety about children, this means that they are trapped into some affective loop, maintaining the same affect:

H: Well, the situation is a little more complicated. Time-wise, if I want to do all these things then it's normal that I have to finish up some things at home. I can't always fit everything in even though I would sacrifice everything for my child. To think that there would be something wrong with my child. I'm willing to sacrifice everything for my child. Even work, but at the same time it seems a little unfair that I should have to choose between all these things.
T: Hmmm.
H: I don't know how to manage all of this.
T: We'll come back to this later. There's a different atmosphere here that was just created. (to the wife) What are you feeling now? There's something new here.
W: How can you say sacrifice! You can't say that you sacrifice things for your child. You have to want these things. Isn't it human nature to want to spend time with your son and with me?
T: Just a minute. We'll go ahead with this in a minute. You have a situation here from home that is repeating itself. You took care of your parents. It was terrible for you, totally unpredictable, and you couldn't even count on anyone else. They would die and leave you. Constant fear...
H: This fear...
T: ...and now you have a child that is continuously ill and he doesn't know whether his father will come for him or not. I don't know why there's so much of this here. We'll see. Your wife is telling another story that is filled with emotions and horror. You have to want it. You're actually telling his story. These parents should have wanted to be there for the child, but the child had to keep checking up on them to see if they were still alive. They didn't give you any safety and security. This child is now obviously forcing something that you never had – security. There isn't any here. (to the wife) What do you think? There's your child and there's you on the other hand.
W: Yes, he really tries too hard and he tries to do everything.

T: He's very hardworking, your husband.
W: But he's never really there.
T: How much do you miss him?
W: A lot.
T: We're doing this dance between parenthood and your partnership. There's your marriage on the one hand and your parenthood on the other. I don't know where the answer lies. It's probably complex. How do you feel when he's not there?
W: I feel... it's so humiliating how you have to try so hard and sacrifice everything.
T: Who had to try this hard?
W: Probably someone at home, my parents, who...
T: You had the feeling that they tried so hard to be there for you.
W: They did everything for me. They just didn't do anything for themselves.
T: They didn't want to do anything for themselves. And you felt this? Was being ill allowed?
W: No, not really.

We can easily see that they could not connect easily to each other. That means that they are reaching mutual attachment injury. Research on the structure of attachment and its development (Solomon, 1994) has revealed seven levels at which the emergence of pathological attachment occurs – which has also been called secondary, and only seems to be a secure attachment – that can be traced in the partners' relations. These layers extend from the core part of personality, shaped by the more-or-less secure attachment to parents, to concrete forms of interpersonal relations, in which false attachment predominates. In the most difficult cases, seemingly secure attachment is rooted in the core part of personality. From the perspective of attachment, such a disorder is not difficult to explain, because only attachment to the parents gives a child security, but if that attachment is non-secure it demands that the child gradually adapts to the distorted and abusive bond with his or her parents. We must acknowledge that there is no direct casual relationship between trauma, abuse and insecure attachment, but that an individual with insecure attachment bond is more prone to the traumatic experience and more vulnerable to become the victim of the abuse, while in cases of severe abusive parenthood it is common to find insecure attachment as well. Of course the traumatic or abusive experience is much more likely and easily to be resolved if the person is securely attached. Every "secure attachment" disturbance caused by an unsuitable relationship with the parents, unresolved trauma, abuse, or triangulation threatens secure attachment and causes the emergence of "primitive aggressive ego organizations". As Fonagy (2001) points out, "The early environment is crucial not because it shapes the quality of subsequent relationships (for which the evidence is lacking, as we have seen) but because it serves to equip the individual with a mental processing system that will subsequently

generate mental representations, including relationship representations. The creation of this representational system is arguably the most important evolutionary function of attachment to a caregiver" (p. 31). This is, of course, multi-layered because it arises gradually, through recurrent behaviour at various levels of development. These degrees or layers are the following:

1. *Secure* (also primary or prenatal) *attachment* is the foundation of personality; on top of this there emerges:
2. *The pain of trauma* (separation from parents, loss, absence of contact), producing
3. *Sadness, regret, and despair*, which leads to:
4. *An unconscious rage* toward people that the child is attached to; however, because the expression of rage and aggression toward loved ones threatens contact with such persons, during such rage the child is also overcome by
5. *Anxiety*, which always accompanies aggressive reactions; both are covered and masked by
6. *A feeling of shame and guilt* and *perception of oneself as bad*, which is one of the main signs of primitive aggressive ego organization. Because this rage is repressed and they remain alone in their emotional rage, anxiety, and shame, such children now try to seek contact that lays blame on them and they hate themselves. This hatred and recourse to guilt is expressed outwardly as
7. *An inability to maintain emotional closeness and a freezing of all initiative in intimate relationships or extreme fear of intimacy* (Solomon, 1992).

In the words of Donald Winnicott, this involves the development of a false ego, or an extreme form of avoiding attachment, through which the trauma is preserved (Winnicott, 1990).

Dissociation at the moment when it is necessary to establish contact is the main sign of traumatization at the interpersonal level. Breaking off contact through dissociation is the most painful attachment injury. One of the most powerful interpersonal responses to trauma is dissociation. We could see many kinds of dissociative responses to highly emotionally laden triggers. We are talking here about dissociative stance that the husband is not able to respond when the basic attachment is addressed. It ponders him with so much stress, that he doesn't react. He freezes. We will see that he doesn't enter into the conversation, doesn't interrupt his wife or the therapist when they are talking about him.

W: It showed that we're not really that close.
T: And that hurts.
W: Yes.
T: He doesn't want to be there when you're experiencing this?
W: Not that he doesn't want to, it...

T: He needs to try.
W: That you have to try so hard. It's actually not that hard. You come home and you're there. He can finish the article any other time. And at home you can ask questions like "How are you? Anything new?" Just basic everyday questions. You're relaxed and not occupied with planning and thinking about other things. You're just there (at home).
T: You're feeling hurt? Confused?
W: Yes, if it's lacking, it's hard.
T: It's difficult to trust... Sir...
H: There's always something that comes up. I wish there were someone that would tell me what to do so I would know, and then have the information. I want someone to say "Do that. Go home. This will take this much time to do...", and then it'd be ok.
W: It doesn't matter how it's done, just do it and get it done.
T: Sir, we'll talk more about what your wife is saying later. This child never got instructions how to do things. He was just scared. And he probably didn't have the courage to say anything because if he were to do something... What would happen?
H: You don't know. You don't have enough information.
T: Because this child lost his spontaneity, his playfulness. He just has to be careful not to do anything wrong. You're a grown man and you can't do anything the way you'd like to, only listen. And it's never all right, it's never enough. You're always guilty of something. Yes?
H: I always expect some sort of catastrophe to happen. I can't do this anymore.

The intrapsychic level: Relational trauma as attachment injury and its neurobiological aspects

Let us now turn to the consequences of trauma for organic development and the development of attachment, which sheds light on the origins of the persistence and indestructibility of relationships marked by attachment injury. Trauma that is not acknowledged is transferred into the system as a constant source of relational stress. A child that is included in a system of trauma, or even becomes the bearer of a traumatic experience, will build the trauma into his nervous system because there will not be anyone to aid him in processing the stress of the trauma and to prevent the secondary traumatization experiences by those closest to the traumatized individual (Van der Kolk, 1996). External trauma (e.g., an accident) is thus transformed into relational trauma, because this is the only way of regulating stress that a traumatized individual is capable of. For children that grow up with traumatized parents, this means that they will grow up with permanent attachment stress, because parents that regulate traumatic stress through parenthood are unable to regulate their children's affect

or stressful emotional states. The child is thus permanently traumatized.

Allan Schore in his revolutionary work discovered, that in conditions of continual traumatic assaults, more than dendritic fields may be lost, rather the neuronal components of one or both of the limbic circuits may undergo extensive programmed cell death (Schore, 2001).

When acute attacks occur in turn, the neurons loose their movement towards the neurons that are connected with them in synapses. This intersynaptic advancement of neural death is strongly reminiscent of degenerative neural diseases in which "systematic degeneration" includes the expansion of cell loss to neurons that are connected in the same functional circuit (Schore, 2003).

The limbic system is the area where psychology and neurology meet. In the most recent psychiatric discussions, the seriousness of the trauma is no longer a decisive cause of posttraumatic stress disturbances, but is dependent on the characteristics of the individual, especially his or her reaction to trauma (Schore, 2003).

A pathological response to stress reveals an excessively sensitive, excessively responsive amygdale and the memory processes in the amygdale are also strengthened (Schore, 2003). In such a case, subliminally processed weak interpersonal stressors will also trigger unmodulated threatening and painful emotional experiences from an individual's early past that are recorded in the amygdale-hypothalamic circuit. These fear-torpidity responses will be intense because they are mostly unregulated by the orbitofrontal areas, which is inaccessible for the correction and fine-tuning of emotional responses.

In ideal circumstances, the amygdale and the orbitofrontal cortex are connected through the hypothalamus, the area that is responsible for activation of the parasympathetic nervous system. This is the area that makes it possible to play dead or invisible when confronted with danger. That is, to dislocate oneself and therefore flee from a situation that has no exit, to disconnect oneself from an unbearable situation and, in Bowlby's terms, to fall into a state of deep unconsciousness (Schore, 2003).

The amygdale defines the emotional meaning of a threatening stimulus; the ventromedial prefrontal cortex uses this information to examine and provide feedback on the organism's internal state, and to adjust the response to the stimulus with regard to the internal state. Without this feedback on the internal state as well as the danger level of the stimulus, for survival reasons the organism could remain in defense mode for longer than is necessary (Schore, 2003).

We have already ascertained that a traumatic painful event, in contrast to non-traumatic pain, triggers an intense emotional reaction with an accompanying autonomic and somatic cycle, and creates increased sympathetic activity and noticeable responses in the limbic system – that is, in the hypothalamus, the gray areas of the brain, and the prefrontal cortex. Positron emission tomography (PET) shows that the right interior cingulate gyrus plays a central role in the sensorial affective aspects of pain, while the orbitofrontal area modulates the indirect processing of pain – thus

facing pain and not the pain itself.

What is therefore very interesting is that direct pain is not connected with its emotional affective sense; that these two processes are anatomically separate!

The orbitofrontal system is sufficiently developed as to be able to regulate both sympathetic-adrenomedullary catecholamine and the corticosteroid level – that is, both hypo- and hyper-excitation (Schore, 2003). This means that an insufficient frontolimbic system will not process pain signals that come from the body itself. The non-activation of the orbitofrontal cortex creates an analgesic effect, and its disappearance then causes the suppression of behaviour associated with pain and the increased threshold for pain associated with affect (Schore, 2003).

It has been argued that the theory of attachment is a theory of the regulation of affect. "What cannot be regulated within the relationship, for example the emotional pain of abandonment and shame the child experiences with the parents, is regulated through the relationship, which means that the pain is transmitted via fantasy bonding to the next generation. There is no middle ground, so to say, between sufficient and insufficient regulation of those two core affects, since they are both included in the way mutuality is established in the relationship. The paradox of bonding lies in the fact that the bonding relationship is guaranteed by the very affects, whose differentiation and regulation the relationship promises to achieve. On the one side, this partial solution prevents the total breakdown of the network of intimate relationships, but on the other, opens the door to repeating of traumatic affects in future relationships.« (Erzar & Kompan Erzar, in press)

Attachment can therefore be understood as interactive regulation between psycho-biologically regulated organisms. In this manner the unconscious dynamics of attachment is the basis for a dyadic regulation of affect. Emotions are therefore the highest direct expression of the bioregulation of complex organisms.

From this perspective, the stress of separation can be understood as the loss of the maternal regulation of the child's immature behavioural and physiological systems, which then expresses itself as an attachment pattern of protest, despair, and detachment. The period of synchrony that follows the period of stress makes the reestablishment of equilibrium or the healing of the wounded relationship possible. The child learns to handle stress through this pattern.

Flexibility and plasticity in facing traumatic stress is the last and final sign of secure attachment, which is expressed as flexibility in regulating emotional stress through self-regulation and regulation during interaction with others.

It may be said that unsuitable regulation of affect means the inability to integrate various neurobiological systems. Each of these then operates on its own and creates confusion in the individual, a feeling of total loss of control over life, dread, and fear. The individual feels normal, understands things normally, and reacts normally, but all of these systems are completely disconnected and it is therefore impossible to arrive at the true meaning of specific events, feelings, and affects (Siegel, 1999).

Moreover, the maternal style of caring for the child becomes a process for the direct transfer of individual differences in facing stress, which are stronger because of genetic predispositions. “In the child, maternal care therefore serves as a program for children’s behavioral response to stress” (Schore, 2003, p. 179).

The most significant discovery of attachment theory and the neuropsychology of regulating emotions is that these processes are always unconscious and that they represent an ingrained and built-in foundation for later behaviour, experiences, feelings, and activity (Schore, 2003).

Just as the mother is decisive in the early maturation of the ability to handle stress, after the third year, when the development of the right hemisphere is complete, the role of the father is of key significance for expansion of and greater flexibility in children’s ability to deal with stress.

In the case of a trauma (after the third year of childhood), a child with secure attachment that does not have this flexibility therefore also develops dissociation and other pathological mechanisms for the preservation of a traumatic experience.

The orbitofrontal region of the brain retains its plasticity throughout a person’s life and is therefore the basis for all emotional learning. Non-secure attachment can therefore change or be built into secure attachment through this learning and psychobiological regulation in later relationships. This means that flexibility and connection between individual brain systems is increased, and the individual thus obtains control over external and internal experience and is capable of making a suitable response to external and internal stimuli. The first such relationship is an adult intimate relationship (Siegel, 1999).

The relationship of psychobiological regulation from attachment between the child and the mother has now become the foundation for every empathic relationship, including the therapeutic one, because it clarifies and addresses the deepest affective mechanisms for the development of secure attachment in therapy (Schore, 2003).

Trauma that is not acknowledged, or the transfer of trauma to children, is therefore manifested in a greatly curtailed ability to regulate emotions, which at a moment of stress created by a trauma operates similarly to a disorganized form of attachment. There are two circuits for regulating emotion: the parasympathetic and the sympathetic – one driving activation, and the other blocking it. In this type of attachment – that is, the disorganized, chaotic type – both are impaired or function incorrectly and therefore both poles for regulating affect are nonfunctional or overloaded. Simultaneous overloading of activation and non-activation results in the release of calcium in cells, which kills them. Neuropsychologists call this mechanism apoptosis or “programmed cell death” (Schore, 2003). The conditions of this stress are analogous to being in a car and pressing hard on the accelerator and the brakes at the same time. Brains to which this regularly happens gradually lose their flexibility. When these two mechanisms operate at the same time, especially independently of each other, this creates dissociation.

We can conclude that the more we know about how the relationship between

children and parents determines how the brain circuits that are responsible for the healthy regulation of emotions will develop, the better we can understand how one mind shapes the development and functioning of another, which is the core of interpersonal connectedness.

The awareness that a mind is composed of a flow of information and energy allows one to conceive the complex nervous system that creates it. Just as the brain is composed of parts of neurons, groups of neurons, synaptic connections, individual neurons connected in various circuits, all the way up to large subsystems such as the left and right hemispheres, relationships are also a system composed of individual relationships, subsystems, and internal psychological systems connected in various interpersonal ties, together creating a family system that then has an influence on every minute part of the system (Siegel, 1999). Contact between two minds takes place directly through physical proximity as hidden regulators (e.g., through warmth and touch) and, in addition, it has been shown that physical proximity directly shapes electrical activity in the brains of both individuals. Even in the case of physical distance one mind can directly influence another through the transfer of energy and information. Contact is established both at the verbal as well as at the prosodic, nonverbal levels. Nonverbal signals such as facial expressions, gestures, tone of voice, and the timeframe of responses have a direct influence on socially responsive parts of the brain – the amygdale and hippocampus, i.e., the structures of the central part of the brain (Siegel, 1999). These signals excite the brain circuits that determine emotional responses – that is, directing attention, seeking meaning, and determining excitement levels. This emotional connection with another person creates an entire group of complete and differentiated processes for receiving stimuli in the brain, and these processes directly orient the flow of energy and information in an individual's brain (Siegel, 1999). The emotional state of the sender thus directly shapes the emotional state of the receiver. In other words, external restraint such as nonverbal signals received from another person has a strong and immediate effect on the flow of one's state of consciousness (Siegel, 1999). Children's patterns of energy and information transfer between two people organize relationship strategies, which are seen as behavioural responses to situations connected with attachment (and therefore also with trauma, which is the greatest injury to these connections). Children's minds adapt to specific emotional communication that they receive from their parents. In the course of development, such patterns of relationships are established as behaviour strategies in the broader context of relations. Certain aspects of children's regulation of emotions (such as adaptation to stress), cognitive processes (memory and attention), and social skills (including relationships with their age-mates) stem from the history of an attachment. Among adults, one can observe basic features of early attachment in the characteristic approach to interpersonal privacy and the shaping of autobiographical narratives that express the entire history of these early experiences, which harden into generalized states of mind through life experiences (Siegel, 1999).

The persistence of a trauma is therefore a sign that a system is not functioning,

that it is based on the dissociation of traumatic feelings and thus does not provide any relational changes, departure, growth, or transformation of relationships, because the system thereby loses the mechanisms of regulating trauma through children. A family that has experienced a trauma and regulated it through children will react in a very traumatic manner to each of the child's developmental steps – starting school, adolescence – and preserve itself through the parenthood of those children.

H: Well, you said that it could be easier to understand for the sake of our child and our relationship because living under such pressure and constant fear... It's not easy.
T: (to the wife) You waited your whole life for your father to do something, right? And he didn't. And your mother went her own way. (to the husband) And you also patiently waited for your father and your mother also had to go her own way.
H: Yes, but emotionally...
T: She fell ill.
H: Yes, they went their separate ways.
T: Who fell ill?
H: Both of them.
T: Did they meet each other in sickness?
H: When there were problems they got along very well. Actually they got along.
T: But some sort of physical pain had to be there. And emotionally, they couldn't...
H: There were some painful things there, at least I think so.
T: Yes.
H: I don't know if they had enough information to be able to resolve their issues. I don't know. When my sister died. I don't know. If they knew how to resolve these emotionally issues.
T: Is it her death that's still in the air? But there is hope here.
H: I'm sure we can do something for our relationship.
T: This issue here is very painful. (to the wife) You would like only one thing and that's for him to be at home because he wants to and also that he would do what he wants because he wants to.
W: Right.
T: And that there would be something there for you two.
W: That it would be spontaneous and that it would feel right, natural.
T: Natural. And you're afraid to be that because you need instructions. You would like someone to tell you what to do.
H: Yes, because what I do is then done right.
T: So it's done correctly. You doubt you can do something spontaneously.
H: If I don't have the adequate information then it's pointless to do anything because you can then worsen the situation.
T: Who should have given you these instructions but didn't?

H: My parents. But maybe they didn't even know. The doctors. And then they didn't know.
T: There were a lot of people who should have given these instructions but...
H: Those who have certain roles and certain qualifications are there to give you the needed information. I don't want to do something or put myself in a position where I don't have the information to do the right thing.
T: This angers you, doesn't it?
H: Yes because if you're in a certain position you should know things.
T: Did your father know?
H: No. The doctors should have known, in my opinion.
T: And your father?
H: What about him?
T: Because the doctors should have known about your sister and today about your son. Of course, this is its own kind of frustration but you weren't ill there. Your father, did he give you the information?
H: I'm totally lost.

If the children are able to start their own families, the traumatic experience and relational stress will be repeated in every otherwise completely normal stress in their children.

In the way that they perceive basic emotional content, relations, and events from their childhood, the parents (the children of the parents that experienced the trauma) recreate for their children an atmosphere similar to the one that they themselves experienced with their own parents.

For the time being, the best answer to this question is that the function of attachment is always the same – that is, the capacity to regulate emotions with the help of another and with the help of recognizing, understanding, and dealing with the stress caused by emotions. It is in the area of affect regulation that an individual form of attachment is transferred and at the same time created (Shaver & Cassidy, 1999).

Conclusion: When a system speaks from within, relational family integration

Intimate relations – that is, relations based on psychobiological harmony and compassion – are a unique space in which we shape ourselves and develop. The structure of a family's activity or relationship system is directly reflected in and dictates the directions of development of basic organic structures. Not a single process in the human body is immune to contact with others because the system of relations defines their form, direction, and responsiveness. It could even be said that children do not "learn" from their parents, but that they internalize their manner of activity through contact with their parents, adapting this to their bodies and their characteristics. Thus, children that have a very sensitive nervous system will be very responsive

and will imitate many of their parents' emotions in detail, more so than children that are born with a less responsive nervous system. The intenseness of this connection and the colouring of its development will depend on the breadth of responsiveness and capability of the parents or adults that represent the external framework or range within which the child will be able to develop.

The basic affects that we seek in relational family therapy represent the basic dynamics that creates and sustains both functionality and pathology in the most diverse relations. There is always some constitutive affect present, most often preserved deep in an unconscious level of psychological experience, and it is therefore often difficult to perceive, recognize, and reveal this in the multi-layered entanglement of the most various relations that the individual participates in (Gostečnik, 2004). The organic basis that makes it possible to understand the mutuality and affective basis of human activity is the mechanism for regulating affects and the dynamics of attachment, which are the core of the organic formation of the human brain. If we understand mutuality between two persons at such a complex level, we quickly see that it is not only a matter of the transfer of feelings between two people, but the actual organic growth and development of those nerve cells that form the central information system of the human brain (Siegel, 1999). Traumatic experiences enter into the family system at all levels through strong affects and extreme relational stress through interpersonal regulation mechanisms, and these directly shape the development and formation of the brain's operation. From the pattern of relationships between family manners, especially through the regulation of stress and the manner of establishing and breaking off contact between them, we can get a sense of the depth of mutuality and connection. A new professional understanding of a person arises on the basis of this integration, one that is more complete and especially more natural, because it can integrate both intrapsychic dynamics as well as interpersonal and systemic dynamics. This is where the professional search for a response to the following questions begins: What is the basic motive of family systems, Why is trauma preserved in a particular family, When does stress have traumatic extensions, and Why are traumatic experiences transferred from generation to generation? It especially reveals the systemic nature of the inner psychological world, offering the beginning of a response to the question of why an individual and, at the same time, an individual part of every relationship can be a fractal of the entire system. To date, integration between neuropsychology and psychotherapy has not been completely developed, although the relational family paradigm makes this possible. "For the first time in the history of psychology, this enables us to connect interpersonal relations with a person's organic nature and to establish that this nature is subordinated to the relationship or space between "I" and "you," which opens an extensive area and continually makes possible new discoveries – that is, leads to the very core of nonlinear understanding" (Siegel, 1999, p. 13). We may conclude that: "Based on the model of relational family therapy, the affective space between 'I' and 'you' or other, between a father and mother, and between a father or mother and child, represents one of the

subsystems or psychic structures in an entire system that is located in a broader system – that is, in the entire family affect that leads and guides the entire family atmosphere (Gostečnik, 2004, p. 25), which in a very strong manner marks the entire family and also has an influence on individual relationships within it.

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