

Adoption Advocate



Prenatal Stress, Preverbal Trauma, and Developmental Trajectories: The Importance of the Attachment Relationship

BY DIANA OSIPSOV, LMSW

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The impact of prenatal stress and preverbal trauma on developmental trajectories is both a topic of education and area of treatment focus in my clinical practice. As a specialist in infant and early childhood development, as well as trauma and attachment disorders, I often work with children who present with a variety of surface-level symptoms that are, at their core, the effects of prenatal, preverbal, or developmental trauma. I often discuss with parents the potential long-term ramifications, and the hope and healing that early intervention can bring.

When discussing the relationship between trauma and attachment, there are a variety of factors to consider. The attachment relationship, prenatal stress, preverbal and developmental trauma, and intergenerational trauma are interrelated concepts that are

often misunderstood, and their impact on a person's developmental trajectory is often underappreciated. If we as families, caregivers, professionals, providers, and educators wish to see true change in our children and communities, we must learn to recognize the importance of the attachment relationship, the role of emotional safety and security in brain development and secure attachment, and the detrimental impact of trauma in this process.

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Attachment: Nourishing the Roots

The level of safety and security experienced in early childhood is the biggest indicator and predictor of a person's ability to cope with adverse experiences in adulthood. More than social supports, access to resources, education, socioeconomic status, or healthy lifestyle, the level of security experienced within the attachment relationship in

the first few years of life outweighs all other factors when determining a person's ability to cope with challenges, stressors, and even traumas in adulthood.^{1,2} If we use a tree as an example, we can see the vast difference in a bottom-up versus top-down approach to understanding development, the importance of the attachment relationship, and the impact of prenatal stress and preverbal trauma.

The attachment relationship and all that it encompasses represents the roots of a tree. As an infant experiences safety, bonding, emotional engagement, and co-regulation within the attachment relationship, their tree "roots" are nourished. When the infant cries, the parent tunes in to the infant's experience, mimics the facial expressions of the infant, verbally empathizes with the infant, (e.g., "Does your tummy hurt?", "Are you hungry?", "Are you tired?"), holds the infant close, and meets the physical need of the infant in that moment. These experiences of attunement, joint attention, synchrony, engagement, and co-regulation begin to strengthen neural pathways in the brain and begin teaching the infant, "I am safe. I have a voice. When I am upset, my needs are met. I can express my distress and it is relieved. I'm not in this alone." The infant's brain begins to learn that even when they experience distress, the attachment figure is there with them in their experience, will meet their needs, and will help them return to a state of emotional regulation. This process is crucial to the development of self-identity and self-regulation capacities.

As these roots are nourished, the trunk begins to grow. The infant grows into a toddler and

begins to explore their environment. In this stage, there are more opportunities for both adventure and distress. For example, the toddler might get hurt while playing outside but may choose not to run to the attachment figure immediately. A small bump on the knee with minimal pain may not warrant immediately seeking the safe haven of the attachment figure. The toddler's brain begins to remember, "I know what this is like. Sometimes hard or painful things happen, but eventually it always gets better." This process of remembering distress relief and returning to a state of emotional regulation may allow the brain to activate the "calming down" process on its own, without the support of the attachment figure. As these experiences happen, the trunk of the tree, whose roots have been well-nourished, begins to grow bigger and stronger. The trunk represents growth and development of the sense of self: self-awareness, self-regulation, self-monitoring, and self-control.

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As the young child continues to grow and develop, leaves and blossoms naturally bloom, representing executive functioning skills housed in the frontal lobe of the brain. These skills include relating to others, problem-solving, critical-thinking, perspective-

¹ McLewin, L. A., & Muller, R. T. (2006). Attachment and social support in the prediction of psychopathology among young adults with and without a history of physical maltreatment. *Child Abuse & Neglect*, 30(2), 171-191.

² Tyano, S., Keren, M., Herrman, H., & Cox, J. (Eds.) (2010). *Parenthood and mental health: A bridge between infant and adult psychiatry*. Wiley-Blackwell: Chichester, West Sussex, UK.

taking, empathy, planning, organizing, sequencing, and logical reasoning skills.³ The everyday skills that individuals display and utilize regularly as they interact with the people, environment, and world around them develop in the context of the attachment relationship.^{4,5} Research has shown that when a parent or primary caregiver uses their frontal lobe while interacting with their baby, mirror neurons in both the parent's brain and the infant's brain "turn on" and begin to mimic one another.⁶ This means that when the parent uses their executive functioning skills while interacting with the infant, the same part of the infant's brain grows and develops.^{7,8} For most parent-infant dyads, this process happens naturally. We do not manually "turn on" our frontal lobes; rather, the more developed our executive functioning skills become, the more automated the process becomes. We learn to problem-solve more easily, plan, organize, empathize, and observe and care about the experiences of others. Then, as we have children, we continue to use our frontal lobes, including when we interact with our infants, and the attachment "dance" naturally ensues.

The Detrimental Impact of Trauma

Let's further explore the impact of trauma on the brain. Trauma is another concept that is often misunderstood. Many people believe

trauma can only be categorized as experiences such as physical abuse, sexual assault, war and violence, or other horrific events and experiences. And while these experiences certainly fall into the category of traumatic, they are not the only experiences that can be categorized as traumas. Trauma is, in fact, any experience that overwhelms a person's ability to cope?

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It is common to assume that if a person does not develop a conscious memory of something challenging, painful, or traumatic, it will not impact them, when in fact nothing could be further from the truth. Thus, preverbal trauma is often unintentionally disregarded. A child's brain doubles in size in the first year of life. By the age of 3, a child's brain reaches 80% of its adult volume, and by age 6, the brain is at 95% of its adult weight and at the peak of energy consumption.¹⁰ And all of this development takes place in the context of the attachment relationship. Unfortunately, there are many ways in which this process can be disrupted (e.g., parents being emotionally

³ Regueiro, S., Matte-Gagné, C., & Bernier, A. (2020). Patterns of growth in executive functioning during school years: Contributions of early mother-child attachment security and maternal autonomy support. *Journal of Experimental Child Psychology*, 200, 104934.

⁴ Ibid.

⁵ Bernier, A., Beauchamp, M. H., Carlson, S. M., & Lalonde, G. (2015). A secure base from which to regulate: Attachment security in toddlerhood as a predictor of executive functioning at school entry. *Developmental psychology*, 51(9), 1177.

⁶ Šešo-Šimić, Đ., Sedmak, G., Hof, P., & Šimić, G. (2010). Recent advances in the neurobiology of attachment behavior. *Translational Neuroscience*, 1(2), 148-159.

⁷ Botbol, M. (2010). Towards an integrative neuroscientific and psychodynamic approach to the transmission of attachment. *Journal of Physiology-Paris*, 104(5), 263-271.

⁸ Farmer, R. L. (2014). Mirror neurons. *Neuroscience for social work: Current research and practice*, 37-55.

⁹ Giller, E. (1999). What is psychological trauma? Sidran Institute: Traumatic Stress Education & Advocacy. <https://www.sidran.org/wp-content/uploads/2019/04/What-Is-Psychological-Trauma.pdf>

¹⁰ Gilmore, J. H., Knickmeyer, R. C., & Gao, W. (2018). Imaging structural and functional brain development in early childhood. *Nature reviews. Neuroscience*, 19(3), 123-137. <https://doi.org/10.1038/nrn.2018.1>

disengaged from their infants, children being separated from their parents at birth, and children who are unable to form a lasting attachment relationship as they move from foster home to foster home). Sadly, when this window of attachment formation and crucial brain development is missed, the resulting trauma acts as a disruption to the typical process of development, health, and functioning. If we continue our tree root analogy, infants with emotionally distant or disengaged parents are like trees whose roots are malnourished—the relationship may be there, but it is significantly lacking what it needs to grow and thrive. Infants moved from home to home may never have the opportunity for their roots to be firmly planted in a deep and nourishing soil. Their roots, when finally planted somewhere, will likely be weak and easily influenced by harsh climates and challenging environments, poorly equipped to withstand the adverse experiences that will inevitably be faced in life. Infants separated from birth parents are like trees whose roots have been ripped up and re-planted. While the environment and soil they are replanted in may be more nourishing, the experience of being uprooted and transplanted will still leave its mark. This highlights the impact of attachment trauma.

Experiences and memories are tied to the sensory system.¹¹ When you experience a particular smell, for example, it immediately brings to mind memories that are connected to that sensation. That is how our sensory memory system works, and with trauma it is no different. Through the sensory memory system, the body stores sensations that are tied to particular trauma experiences. Thus, even after a trauma experience is

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over, when a person encounters the smells, sounds, sights, or other sensations that were tied to that trauma, the sensory memory system triggers an emergency response. The amygdala is the part of the brain responsible for emergency control responses.¹² When danger is sensed, the amygdala activates an emergency response, the brain and body go into defense, and the frontal lobe shuts down. This is a necessary function for survival but can become maladaptive when there is no longer any actual danger. Therefore, when a person's past trauma is triggered—e.g., a person might smell or hear something that is tied to trauma (this can include preverbal trauma experienced before conscious memory can be formed), the amygdala will initiate the same emergency response, even when there is no actual danger or threat. Once this process is initiated, a person no longer has access to the executive functioning skills housed in their frontal lobe, and the body begins to respond by activating hormonal systems within the body to prepare for action. Thus, when a person experiences trauma triggers repeatedly, they have reduced access to their frontal lobe, their hormonal system secretes increased levels of stress hormones, and this entire process causes significant wear and tear on both the brain and body.

¹¹ Van der Kolk, B. A. (1998). Trauma and memory. *Psychiatry and Clinical Neurosciences*, 52(S1), S52-S64.

¹² Guy-Evans, O. (2021, November 5). Amygdala Hijack and the Fight or Flight Response. *Simply Psychology*. <https://www.simplypsychology.org/what-happens-during-an-amygdala-hijack.html>

Before a person can develop their own ability and capacity for tolerating challenge, distress, and discomfort, they must have another person who can regulate these experiences for them. This person is their attachment figure, and this buffering experience is called co-regulation. Infants do not have the brain capacity to cope with distress themselves. Therefore, if an infant does not have a consistent person to buffer distressing experiences for them and help them return to a state of calm, the distress, corresponding hormones, stress responses, and activation of the sympathetic nervous system will continue to sit in the infant's body and nervous system, building up over time. This type of repeated exposure to stress—without the support of an attachment figure to bring relief—will register as trauma for the infant.

A child's brain must experience safety within the context of relationship with another person in order for the rest of development (social, emotional, intellectual, relational) to take shape.¹³ Without these early experiences of safety and emotional rest, the part of the brain responsible for navigating and coping with difficult experiences has fewer opportunities to develop, thereby decreasing the person's capacity to cope with adverse experiences. Additionally, since identity develops in the context of attachment, disruptions to this process can disrupt a person's entire sense of being. Through the continued disrupted cycle of attachment, a child frequently receives messages of distress and lack of safety, and begins to believe they are not heard, are not safe, do not matter—and their self-image is formed around that. When emotional distress is not buffered by an attachment figure, a child

will learn that they are on their own, they can only rely on themselves for survival, the world is a confusing and scary place, and they do not have the capacity to regulate emotional distress. Such is the potential impact of prenatal, preverbal, and attachment trauma.

If we return to our tree analogy, prenatal trauma, toxic stress in-utero, and genetic predispositions impact the soil that the tree is planted in—filling it with toxins, rocks, and sand rather than nutrients, minerals, and a rich foundation for the tree to be planted in. Preverbal trauma and attachment trauma harm the roots themselves, and other developmental traumas cut into the trunk of the tree. Intergenerational trauma can be described as the seeds of this tree, carrying with it the remnant characteristics of the trees from which it came. And so, with intergenerational trauma, we see the effects of adoption trauma—a ripping away from an original environment (the good with the bad), and a transplant into a new tree grove. Though the new grove may be lush and healthier and inviting, this experience of transplanting is still painful and challenging, regardless of when in life it took place.

Remember, traumas that occur early in life corrode a person's development at the root level. Developmental studies have found that the amygdala is increasingly sensitive to stress in the early years of life, and trauma experienced early in life can produce both structural and functional changes to the amygdala itself.^{14,15} Just as an injury to the trunk or roots of a tree will have a far more detrimental effect than an injury to a leaf or branch, trauma or toxic stress experienced in-

¹³ Music, G. (2016). *Nurturing natures: Attachment and children's emotional, sociocultural and brain development*. Routledge.

¹⁴ Yan, X. (2012). Amygdala, childhood adversity and psychiatric disorders. In *The amygdala: A discrete multitasking manager*. IntechOpen.

¹⁵ Guy-Evans, O. (2021). *Amygdala Hijack and the Fight or Flight Response*. Simply Psychology.

uterus, in the first few years of life, or especially within the attachment relationship will carry the potential for significant and severe ramifications later in life if left untreated.

The Importance of Early Intervention

Many adoptive families start treatment feeling confused or surprised about why their child is displaying symptoms of emotional and behavioral dysregulation, attention and concentration deficits, struggles to form healthy friendships, is very bright and intelligent but struggles to perform well academically, or struggles to relate well to other people. We often hear, “We adopted them at birth, so why are we seeing these issues?” and we spend a lot of time educating families on the impact of maternal stress and cortisol levels during pregnancy, genetic predispositions and epigenetics, prenatal stress, and preverbal trauma. Remember, adoption trauma is like a tree being transplanted into a new grove. The transplanted tree will bring with it the genetic qualities and characteristics from its original environment (the soil it was planted into, the environment it was first exposed to). It will respond to its new environment, and over time its own genetic makeup will become more similar to that of the grove in which it finds itself, as roots take in the same nutrients, minerals, and soil, receive the same sun and rain exposure, and interact with the same climate. Future generations will likely see this intermixing, but the transplanted tree will always remain that—a transplanted tree in a new grove that experienced exposure to multiple environments and shows the effects of such.

Another common misconception is that a child must be a certain age before they can begin treatment, when nothing could be further from the truth! Early intervention,

infant mental health, attachment-based therapy, and parent-infant mental health programs set the stage to break patterns of intergenerational trauma, to treat core issues, and to nourish a child’s brain development at the foundational level. Many providers in this field specialize in working with pregnant mothers, parent-infant dyads, toddlers, and young children to address developmental trauma and attachment needs, strengthen neural pathways, and fill in foundational gaps to alleviate the effects of trauma before they turn into more set patterns of psychological disorders.

Preventative and early intervention approaches are the best way to equip providers to support the health of individuals and families.

Preventative and early intervention approaches are the best way to equip providers to support the health of individuals and families. The impact of untreated prenatal and preverbal trauma can be compared to building a house with no foundation. As the person continues to age chronologically, the house continues to be built even though the foundation is lacking a solid base. The cement may have cracks (not enough experiences of safety or bonding in the attachment relationship), perhaps the foundation was not formed with adequate material (genetic predispositions to stress, mental illness, or high cortisol levels and heightened stress responses formed in-uterus), or the builders had a poor blueprint of the formation and

structure of the house (underdeveloped frontal lobe). As a result, receiving early and specialized treatment is key in this process.

People at any age or stage of development can work toward healthier functioning and a more secure attachment, but early intervention is preferable whenever possible.

Treatment approaches that are recommended for this type of work can include a variety of interventions. For children with prenatal, preverbal, or developmental trauma, it is essential that their provider specializes in developmental psychology, infant and early childhood development, and/or infant mental health. Providers with these types of specialized training can adequately assess the presentation and needs of the child and will likely utilize interventions or treatment approaches such as attachment-based therapy, play therapy, Traumaplay, EMDR, Theraplay, and other similar interventions. Treatment approaches for parents might include neurofeedback, EMDR, cognitive behavioral therapy, sensorimotor psychotherapy, or other similar approaches. Treatment approaches for the parent-child dyad and the family may include dyadic developmental psychotherapy or family therapy. Within this context, it is important to recognize the value of an interdisciplinary approach. Given all that we discussed about the impact of trauma not only on the brain but on the body and the person as a whole, complementary treatments such as MNRI

(typically implemented and provided by trained occupational therapists) and sensory integration therapy are recommended in order to see best results. Clinics, providers, and systems that recognize the needs of entire family units, and a person's whole being, recognize the importance of interdisciplinary treatment in working through the effects of early childhood trauma and attachment disruptions in order to achieve optimal healing and success. Though it is important to recognize the gravity of attachment trauma, preverbal trauma, and developmental trauma, it is also highly important to recognize that individuals can always work toward a more secure attachment. People at any age or stage of development can work toward healthier functioning and a more secure attachment, but early intervention is preferable whenever possible. If we use the house analogy once again, consider which is easier — filling in gaps in the cement foundation before building the rest of the house, or trying to fill in gaps after most of the house is built. No matter the stage of the build, it will benefit the house to fill in those gaps, as the house will become stronger and more stable. But a house with a shaky foundation is much more difficult to work on than a house in the early stages of being built, when the foundation is still easily accessible. Likewise, early intervention is key in addressing attachment disruptions and insecurities, and helping the brain develop neural pathways wired for safety and connection rather than survival.

Case Studies/Patient Stories

Some of these concepts are best illustrated through stories. In clinic, I previously worked with a family whose daughter was adopted at birth. The family was so eager to have her join their family, and she and her parents bonded well with one another. They began forming a

secure and healthy attachment relationship with one another in their daughter's first few years of life. They described her demeanor as happy, content, and emotionally engaged. Sadly, their daughter experienced a sexual assault at age three. The family took legal action and addressed the situation accordingly but failed to seek trauma treatment for their daughter. In the years following, she began to exhibit concerning behaviors such as lying, stealing, and hoarding. The parents attempted to curb these behaviors but they only escalated as time went on. By early adolescence, these concerning behaviors escalated to unsafe sexual interactions, ongoing and increased severity of stealing and lying, and resulting legal issues. By that point, their daughter met criteria for Borderline Personality Disorder—a direct result of the attachment disruption that occurred when she experienced a severe trauma as a toddler and was left emotionally struggling. The big question the parents had was: “Why do other people who experience trauma in early childhood, even similar traumas like sexual assault, not develop attachment disruptions or personality disorders?” While the answers are complicated, clear patterns can be seen related to genetic predispositions, early childhood trauma, and attachment disruptions.

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The attachment relationship being formed between this girl and her parents in infancy and early childhood was disrupted by the trauma she experienced at age three. A lack of early intervention, a lack of intentional provision of emotional safety and connection following the trauma, and ultimately a lack of repair in the attachment disruption turned on a light switch in this daughter's physiology. This means she had a genetic predisposition for emotional instability, and by experiencing a trauma during the attachment-building window without repair this genetic “light switch” was turned on, resulting in the young girl experiencing emotional instability. There is always hope that these disruptions can be healed, but the journey will likely be long and hard, just as fixing cracks in the foundation of a house is much harder when the house is already built and occupied.

In contrast, another family adopted their son in infancy as well. His biological mother used substances and experienced significantly high levels of stress during her pregnancy. This baby boy was difficult to soothe, a poor sleeper, and generally fussy as an infant. As he grew older, he presented as hyperactive, aggressive, continued to struggle with sleep, experienced ear and sinus infections, significantly struggled with emotional regulation, and demonstrated challenges in healthy social engagement and interaction. He fought, sometimes physically, the safety and security his parents offered—and attempted to survive on his own. But his parents were determined to help him build the secure attachment relationship that he so desperately needed. His adoptive mother would cry in sessions as he would physically push and fight against the safety and structure she offered. She never left his side as his brain struggled to accept experiences of safety and rest. As I facilitated this process, I narrated for the child

what he needed, what he was experiencing, and what his mom would always offer and provide (structure, safety, routine, boundaries, love, and emotional engagement). My job was to co-regulate with the mother—to be her emotional safety net in a sense—as she provided co-regulation to her son.

With two years of early intervention and intensive treatment, the young boy learned that he could experience safety with his parents, he could trust the safety net they offered, and they would always be there to buffer the hard things for him. His brain learned that his parents were a safe base whenever life got too scary or too hard. He entered school successfully, learned to make friends, strongly deepened his relationship with his parents and family, and his incredible capacity for intelligence, ingenuity, and creativity blossomed. His tree was transplanted into their grove, and with the proper nourishment and tending of the roots, he flourished.

Based on their presentations in infancy, it may have seemed likely that the baby girl would have grown to be a healthy and functional child and adolescent. She was mild in temperament, emotionally engaged, easy to soothe, and seemed to be a happy and cheerful infant. In contrast, it may have seemed likely that the baby boy would grow up struggling with impulsivity, displaying aggressive tendencies, experiencing difficulty paying attention in school, struggling academically, demonstrating poor relational skills, and perhaps even later in life being diagnosed with something like Oppositional Defiant Disorder (a diagnosis labeling surface-level behavioral issues under which almost always exists a trauma history, disrupted attachment, or other emotional needs that were unmet or unaddressed in childhood).

Both children were born to mothers who experienced high levels of toxic stress

during pregnancy. Both children experienced attachment disruptions in being separated from their birth mothers. Both children were placed with loving adoptive parents who desired a relationship with them. But one child experienced trauma while still forming and solidifying her attachment, and this trauma was not emotionally buffered for her by anyone. Her parents did not recognize the potential impact that abuse, at such a crucial developmental period, could have on her sense of safety, and they did not respond to the cues she was providing. As she began demonstrating patterns of self-preservation (lying, stealing, hoarding, and increasing the intensity of concerning behaviors), her parents had the opportunity to recognize these behaviors as signals of crisis and need. Unfortunately, these missed cues further reinforced the survival messages her brain was sending her: “You’re on your own; people aren’t safe; you can’t trust anyone,” which put her on a track for self-preservation. This young girl’s unresolved trauma disrupted the foundation of her house being built; it cracked the foundation and the crack was never mended. Instead, it was allowed to continue to grow deeper and wider and further corrode her house’s foundation. This led to deeper and more severe issues as time went on and sadly, the attachment relationship was never repaired. If there had been early therapeutic intervention to guide the parents in mending this foundational crack, it could have allowed safety to be restored, the attachment disruption to be mended, and the young girl’s house to continue to be built successfully.

The young boy, however, though similarly predisposed to high stress, trauma, and other emotional and physical health risks, was afforded a sound and solid attachment foundation. Though he presented as significantly emotionally dysregulated at a very young age with high indicators of prenatal

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trauma, his brain learned that he was not alone in the world. As he continued to experience safety within the attachment relationship over and over again, his brain learned to calm the emergency signals going off in his brain, his body learned to experience peace and safety, and he began to grow and flourish. His parents worked tremendously hard to be his emotional safety net early on as he struggled to make sense of the world around him. They remained a safe and regulated presence in the midst of his storm of outbursts, chaotic behavior, aggressive tendencies, and attempts to push them away as a toddler. His brain learned, through experiencing safety and co-regulation over and over again with his parents, that they would always be the life preserver out on the water with him. As he continued to grow, swimming further away as he explored more of his world, he began to grow confident that the life preserver would still be there when he needed to swim back to it. When the waters grew choppy and the waves got bigger, he knew to swim back to the life preserver and hold on until the world around him calmed again. With time, his ability to navigate rough waters grew stronger as well, and his eagerness to explore the world continued to grow, as he knew the life preserver would always be there when he needed it.

One child learned that he had a safe haven to retreat to when life got difficult, while the other learned that she was on her own. This

is why the level of security established in the attachment relationship in the first few years of life is the biggest indicator of a person's capacity to handle adverse experiences later in adulthood.

Takeaways

Though the ramifications of prenatal stress, attachment disruptions, and developmental traumas can be severe, the potential of these critical periods of development can also offer hope.

We learn best through experience:

Learning about safety is not the same as experiencing it. If I've never eaten a strawberry, I could learn all about its texture, taste, smell, color, and properties, and I could perhaps recite many facts about strawberries and where they grow and how, but none of that compares to actually eating a strawberry. Likewise, learning about coping skills, self-regulation, relationships and safety in no way compares to actually experiencing safety in relationship with another person.

Early intervention:

From birth to age 3 is a critical developmental period. Don't wait until there are significant issues before seeking support and treatment services! Early intervention is best thought of in terms of intergenerational trauma and healing; intervention for a young child is fantastic while their brain is still developing, growing, and healing. But this doesn't discredit intervention for adolescents or adults. Intervention for an adolescent or adult can break the cycle of trauma for the next generation. And if the next generation can avoid these struggles altogether, that is early intervention in the best way.

Trained specialists:

Ensure that your provider is not just informed on developmental trauma, attachment, and

prenatal stress, but specializes in these issues and offers specialized intervention. This is crucial in the fields of trauma and attachment work.

Interdisciplinary approach:

We are comprised of our mind, body, heart, and soul. Thus, treatment is most effective when implemented with a holistic approach. Recognizing the effects of developmental trauma on all aspects of development and functioning is crucial in the healing process.

Secure attachment:

Any person can move toward a more secure attachment relationship, whether in childhood or adulthood. There are many factors that come into play (intensity of trauma, resiliency, genetics and epigenetics, and so many others), but there is always hope. The more that a person's brain and body experience safety, the more their wiring and functioning become adaptive and responsive.

When a person experiences safety with another person, their brain, heart, body, and soul begin to heal.

The human brain is wired for connection and relationship. We are meant to develop, grow, and flourish in the context of relationships with other people. Though many things can disrupt this process, healing is found when we circle back to safety and connection. When a person experiences safety with another person, their brain, heart, body, and soul begin to heal. John Bowlby summarizes this perfectly when he says, "Life is best organized as a series of daring adventures from a secure base." The best thing we can offer our children, families, and loved ones is both simple and infinitely complex: a safe haven to launch from, and retreat to, when navigating the ever-changing waters of life!¹⁶

¹⁶ Bowlby, J. (1988). A secure base: Parent-child attachment and healthy human development. Basic Books.



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About the Author

As the founder and owner of Roots Therapeutic Specialty Services, Diana Osipsov, LMSW, is passionate about helping patients find hope and healing by addressing issues related to trauma, anxiety, attachment disorders, emotional and behavioral dysregulation, and other psychological disorders. Diana specializes in pediatric care and early childhood development, and provides treatment services to children and their families; she also provides specialized trauma treatment to individuals of all ages with various trauma and attachment disorders. In addition to her clinical practice, Diana teaches as an adjunct faculty at Grand Valley State University, and travels across the U.S. and internationally to offer crisis response services and trauma training programs to anti-trafficking safehouses and organizations both domestically and abroad.

Diana completed her undergraduate and graduate degrees in clinical social work at Grand Valley State University. She is currently a doctoral candidate at Fielding Graduate University's School of Psychology Infant & Early Childhood Development program



studying the intergenerational effects of human trafficking as a complex trauma experience. Diana has developed her skillset working in a community mental health setting, pediatric residential treatment facility, and neuropsychological treatment clinic before opening her own practice—Roots. Over the past decade, Diana has partnered with school districts, legal systems, community groups, and nonprofit organizations to offer comprehensive support and services to individuals and families, and now offers specialized consultation and training services in ongoing efforts to collaborate and serve families most effectively.

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