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Case Report

Safe Enough to Grow Old: ReAttach as a Transdiagnostic, Salutogenic Intervention in Psychogeriatric Care

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Abstract

Background: Mental health problems in later life rarely fit into clean diagnostic categories. Depression, anxiety, cognitive decline, loneliness, functional symptoms, and the late effects of early adversity often occur together, while pharmacological options are limited by the vulnerability of older adults to adverse effects. Many established psychotherapies assume intact reflective capacity, working memory, and cognitive flexibility, which are often compromised in this population.

Objective: To develop a theoretical framework for ReAttach approach, a brief, multisensory, bottom-up intervention, as a transdiagnostic and salutogenic approach in psychogeriatric care, including the application of the Safety Override Technique (SOT) in dementia care.

Method: Narrative theoretical synthesis integrating literature on late-life mental health, cognitive aging and cognitive flexibility, cognitive dissonance, attachment in dementia, autonomic regulation, and recent practice-based ReAttach research.

Conclusion: ReAttach may address late-life dysregulation at three levels: physiological (lowering arousal to protect the frontal resources the aging brain relies on for compensation), sensory-integrative (offering multiple sensory routes and building cognitive reserve), and social-cognitive (restoring flexible self–other switching and strengthening adaptive schemas anchored in secure experience). In dementia, SOT delivered face-to-face by trained nurses and care assistants may offer a structured, relational way of meeting the basic need for safety. Empirical testing in psychogeriatric settings is needed.

Keywords: ReAttach, Psychogeriatrics, Older Adults, Dementia, Cognitive Flexibility, Salutogenesis, Co-regulation, Safety Override Technique

Introduction

Later life is often described as a period of decline. However, clinical practice reveals a more varied picture: older adults bring decades of adaptive capacity, but they may also carry unresolved emotional wounds, accumulated losses, and nervous systems that have remained in a state of alarm for prolonged periods. Mental health care for older people lies at the intersection of these experiences. Psychiatric presentations in later life rarely fit neatly into diagnostic categories. Depression may coexist with cognitive decline, anxiety with somatic complaints, and loneliness with grief. Childhood adversity that has never been adequately processed may resurface as functional symptoms or suicidal thoughts. These complexities call for interventions that work across diagnostic boundaries and focus on what remains intact, rather than exclusively on what has gone wrong (Oude Voshaar et al., 2018) .

The need for effective interventions is urgent. Adults aged 75 and older have one of the highest suicide rates of any age group, with older men experiencing the highest rates overall (Kiosses, 2024). Projections suggest that future cohorts of older adults may experience even higher rates, while clearly evidence-based interventions for suicide prevention in later life remain limited (Van Orden, 2024). Pharmacological options are also constrained. Older adults are more vulnerable to the adverse effects of psychotropic medications, particularly antipsychotics. In the United States, no medication is specifically approved for psychosis associated with dementia,

underscoring the importance of considering non-pharmacological approaches (Devanand et al., 2023). Social factors are equally significant. Loneliness and social isolation affect mental health throughout the life course; nevertheless, older adults demonstrated relative resilience during the COVID-19 pandemic, suggesting that aging may bring regulatory resources as well as vulnerabilities (Ayalon & Segel-Karpas, 2024).

This observation is particularly important. Research on late-life suicide is increasingly shifting from an exclusive focus on risk factors towards a broader consideration of protective factors. In a systematic review discussed by Van Orden (2024), purpose in life, resilience, and positive relationships were the protective factors most consistently associated with lower levels of suicidal ideation. Van Orden further argues that protective factors can be understood functionally as conditions that interrupt the progression towards suicide once they are established. This perspective aligns closely with the *salutogenic* approach, which examines the factors that support health rather than focusing exclusively on those that contribute to illness. It also raises a practical question: how can these protective resources be made accessible to older adults whose emotional and physiological states are too dysregulated for reflective, talk-based therapy?

Many established psychotherapies rely primarily on top-down processes. They assume that individuals can reflect on their experiences, articulate their feelings, and retain and process information in working memory. When autonomic arousal exceeds a certain threshold, individuals may cross what Zeestraten-Bartholomeus and Mehrad (2026) describe as a *mentalization threshold*: reflective capacity diminishes, rumination places excessive demands on working memory, and talk-based treatment may become less effective. In older adults, this threshold may be reached more readily because of cognitive vulnerability, sensory decline, chronic stress, or long-unprocessed trauma. A bottom-up approach that initially targets bodily regulation and sensory processing may therefore help establish the conditions necessary for subsequent reflective work.

ReAttach is one such approach. Developed by Zeestraten-Bartholomeus in 2010 on the basis of clinical practice, it is a brief, transdiagnostic, multisensory intervention that combines a regulated relational setting with tactile stimulation, associative processing, and cognitive bias modification (Zeestraten-Bartholomeus, 2021; Zeestraten-Bartholomeus et al., 2026a). The ReAttach practitioner facilitates and regulates the process without directing its content, allowing the participant's own associations and meanings to remain central. Over time, Zeestraten-Bartholomeus developed a comprehensive ReAttach methodological framework comprising bottom-up techniques and tools designed to address complex clinical presentations. These include Wiring Affect with ReAttach (W.A.R.A.), which targets the regulation of negative affect; the Forgive and Forget Hood (FFH), which helps reposition persistent mental and sensory material; ReAttach New Mind Creation (NMC), which supports secure exploration and the development of new possibilities; and the Mapping the Individual State of Mind questionnaire (M.I.S.T.), which helps tailor interventions to the individual's current autonomic state and inform a strategic plan for systemic ReAttach sessions that takes co-regulation dynamics into account (Zeestraten-Bartholomeus et al., 2026a; Zeestraten-Bartholomeus & Mehrad, 2026).

ReAttach is explicitly salutogenic. Whereas traditional trauma treatment often begins with the identification and treatment of pathology, ReAttach focuses on restoring self-regulation, sensory modulation, and adaptive schemas, thereby supporting resilience and positive experiences (Zeestraten-Bartholomeus et al., 2026b). When combined with the Emotional Symptom Regulation Model (ESRM), it links autonomic response patterns, such as shutdown, hypervigilance, and social withdrawal, to targeted interventions rather than relying exclusively on fixed diagnostic labels (Zeestraten-Bartholomeus et al., 2026b). Recent practice-based studies provide preliminary support for this perspective. A qualitative language analysis identified a developmental sequence progressing from bodily sensations to metacognitive reflection and, subsequently, to a sense of agency in both healthy trainees and a patient with Functional Neurological Disorder. These findings support the possibility that the mechanisms of change may be transdiagnostic (Zeestraten-Bartholomeus et al., 2026c). Similarly, an exploratory case series examining remote ReAttach for adults with Functional Neurological Disorder reported reductions in feelings of overwhelm, improvements in emotional regulation and clarity of thought, and an increased sense of control, with co-regulation playing a central role (Call et al., 2026).

To date, these developments have been described primarily in children, younger adults, and specific clinical populations. Older adults remain largely understudied, despite the relevance of many of the difficulties addressed by ReAttach to later life, including emotional dysregulation, rumination, unresolved adverse experiences, loneliness, functional symptoms, and limited capacity for verbal processing. Because ReAttach is brief, does not initially require extensive verbal reflection, and can be adapted to the individual's current state, it may offer a potentially suitable approach for older adults with cognitive vulnerabilities who may face barriers to accessing many evidence-based psychotherapies. Its emphasis on co-regulation and secure relational experiences also aligns with protective factors associated with psychological well-being and lower suicide risk in later life (Van Orden, K. A., 2024).

This article explores the potential application of ReAttach as a transdiagnostic, salutogenic intervention in mental health care for older adults. First, it examines how age-related changes in cognitive flexibility may increase vulnerability to cognitive dissonance and emotional dysregulation. Second, it presents a theoretical framework for the Safety Override Technique in dementia care. Third, it integrates these perspectives into a three-level model of ReAttach in psychogeriatrics. Finally, it discusses implications for clinical practice and identifies directions for future research.

The Aging Brain, Cognitive Flexibility, and Dissonance

Cognitive flexibility is reorganized rather than simply lost

Cognitive flexibility is a core executive function that enables individuals to shift between perspectives and adapt to changing internal and external demands. It involves learning through task switching, developing adaptive strategies, and responding flexibly to unexpected changes. In contrast, cognitive rigidity, defined as the difficulty of accommodating new situations or adjusting to changing demands, is associated with maladaptive behaviour (Gharalari et al., 2025). Age-related declines in cognitive flexibility frequently coexist with broader executive dysfunction in older adults (Gharalari et al., 2025).

Neuroimaging evidence suggests, however, that the ageing brain undergoes functional reorganisation rather than simply losing flexibility. An fMRI meta-analysis of 118 experiments involving 2,246 participants found that older adults recruited fewer brain regions during cognitive flexibility tasks, with activity shifting from posterior perceptual regions towards frontal regions, a pattern known as the *posterior–anterior shift in ageing*. The analysis also identified a shift from bilateral to more left-lateralised activity (Chuikova et al., 2025). Switching between familiar rules relied on a comparable left frontoparietal network across age groups, whereas discovering new rules under conditions of uncertainty showed more pronounced age-related differences. Nevertheless, a core network comprising the bilateral medial frontal gyri, the right anterior insula, and the left inferior parietal lobule remained active across the lifespan (Chuikova et al., 2025).

These findings have three implications for intervention design. First, because the aging brain may compensate for age-related changes through increased frontal recruitment, factors that consume cognitive resources, such as heightened arousal, stress, and rumination, may disproportionately impair cognitive flexibility in later life. Reducing arousal before engaging in cognitively demanding therapeutic work may therefore help preserve the cognitive resources on which older adults rely. Second, because switching between familiar rules appears relatively preserved, whereas discovering new rules under uncertainty may be more demanding, therapeutic interventions may benefit from introducing new perspectives in small, supported steps anchored in familiar and secure schemas. Third, the consistent involvement of the anterior insula, a region central to interoception and the integration of bodily and emotional signals, provides a plausible theoretical rationale for exploring body-based, multisensory approaches to supporting cognitive flexibility. However, this proposed mechanism remains to be empirically tested.

Flexibility as a protective factor for emotion regulation

Cognitive flexibility is not merely a cognitive skill; it may also serve as a resource for emotion regulation. In a study of young adults, higher trait cognitive flexibility and greater flexibility in switching between self-focused and other-focused perspectives were associated with lower affective empathy. The authors interpreted these findings as suggesting that cognitive flexibility may help protect individuals from the emotional costs of empathy (Cai & Qi, 2022). Individuals who can flexibly shift between their own and others' perspectives may be less likely to become overwhelmed by other people's emotions.

Although these findings are based on a cross-sectional student sample and cannot be directly generalised to older adults, they suggest a hypothesis relevant to psychogeriatric care: as cognitive flexibility declines, older adults may become more susceptible to emotional contagion, absorbing the distress of partners, fellow residents, or their care environment without being able to establish sufficient psychological distance. A similar mechanism may operate among professional and informal caregivers, for whom cognitive flexibility may help mitigate emotional exhaustion and compassion fatigue.

Cognitive dissonance and the stability of the self

Tretter and Löffler-Stastka (2024) conceptualise cognitive dissonance as an affective–cognitive imbalance that arises when cognitions and their associated emotional valence are incongruent. This imbalance generates negative emotionality and increases the need for orientation, particularly under conditions of information overload. When the environment fails to meet this need, psychological balance may be restored primarily through unconscious defensive mechanisms. Central to their model is the proposition that new information is processed against an implicit frame of reference concerning the self and the world, which develops through relationships with significant others. A stable sense of self enables individuals to tolerate inconsistent information more effectively, whereas a fragmented internal model may destabilise information processing. Under conditions of overload, individuals may revert to earlier defensive mechanisms, while sublimation may become less effective when the body itself becomes a source of suffering (Tretter & Löffler-Stastka, 2024).

The authors also associate the frustration of basic psychological needs with specific emotional states. The suppression of safety needs is linked to anxiety and a loss of orientation; the frustration of self-determination is associated with aggression; the absence of positive relationships is linked to depression; and restrictions on autonomy in regulating closeness and distance are associated with physical discomfort (Tretter & Löffler-Stastka, 2024). Although their model was developed in the context of the COVID-19 pandemic rather than ageing, it offers a potentially relevant framework for understanding later life, particularly within residential care settings. In these environments, inconsistencies may accumulate across bodily experiences, social roles, relationships, and physical surroundings, while opportunities for safety, autonomy, social connection, and freedom of movement may be simultaneously restricted.

Building on these theoretical perspectives, The researchers propose that age-related reductions in cognitive flexibility, particularly when accompanied by cognitive impairment, frailty, or dementia, may diminish the capacity to process inconsistencies, thereby increasing the likelihood that cognitive dissonance will lead to emotional dysregulation. The researchers of the study conceptualise this vulnerability as more closely associated with cognitive decline than with chronological age itself, recognising that healthy older adults may retain, or in some circumstances demonstrate improvements in, aspects of emotion regulation. From this perspective, the likelihood that inconsistency results in emotional dysregulation may depend not only on the extent of the inconsistency but also on the stability of the individual's internal frame of reference and the degree to which basic psychological needs are met. These considerations provide a theoretical link to ReAttach, which aims to support self-regulation, adaptive processing, and secure relational experiences. Whether and to what extent ReAttach can influence these processes in older adults remains an important question for empirical investigation.

Age-Related Neurodegeneration and the Unmasking of Autistic Traits: a Collapsing Façade

For many older autistic adults, sometimes described as a "lost generation," a lifetime of camouflaging has been a strategy for navigating a predominantly neurotypical world (Lai & Baron-Cohen, 2015). Camouflaging can require sustained cognitive effort, including the suppression of visible autistic traits, the use of learned social scripts, and the management of sensory and emotional distress (Hull et al., 2017). In later life, the development of conditions such as Alzheimer's disease or vascular dementia may compromise the executive functions that support these compensatory strategies (Stern, 2012). As a result, this perpetual front of masking may become increasingly difficult to maintain , potentially leading to the emergence of behaviours that had long remained concealed.

Behaviors that were previously suppressed or concealed, such as stimming, a strong preference for predictable routines, and heightened sensory sensitivities, may become more visible, reflecting traits that persist into older age (Hickey et al., 2018). In traditional psychogeriatric care, however, these changes may be misinterpreted because of diagnostic overshadowing. For example, an autistic meltdown or autistic burnout may be incorrectly attributed to the behavioural and psychological symptoms of dementia (BPSD) or late-onset psychosis (Cerejeira et al., 2012). Such misinterpretations may lead to inappropriate treatment decisions, including the unnecessary use of sedating psychotropic medication, which can carry substantial risks for older adults.

ReAttach has been proposed as a transdiagnostic approach that may offer a complementary framework for addressing such complex clinical presentations (Zeestraten-Bartholomeus et al., 2026a). By emphasising relational co-regulation, voice modulation, and multisensory processing, the approach aims to support regulation without relying exclusively on effortful verbal reflection and executive control (Zeestraten-Bartholomeus et al., 2026a). Rather than treating the re-emergence of autistic characteristics as inherently pathological or attempting to restore camouflaging, this perspective prioritises the individual's regulatory needs and sensory experiences. Its salutogenic orientation focuses on supporting self-regulation, reducing autonomic arousal, and promoting a greater

sense of internal coherence (Weerkamp-Bartholomeus, 2019; Zeestraten-Bartholomeus et al., 2026b). Within this framework, ReAttach may offer a non-verbal or minimally verbal means of supporting emotional stabilisation while encouraging a broader shift in care away from reliance on pharmacological containment and towards neurodiversity-affirming, sensory-informed, and co-regulatory practices. However, its effectiveness and safety for older autistic adults experiencing cognitive decline require direct empirical investigation.

The Safety Override Technique in Dementia Care

For many people living with dementia, the world may gradually become less predictable and more difficult to understand. Familiar faces may become difficult to recognise, previously known environments may feel unfamiliar, and the perception of time may become increasingly disoriented. In these circumstances, a sense of threat or distress may persist even when the individual cannot clearly identify or communicate its source. Restlessness, wandering, calling out, suspiciousness, and resistance to care are commonly interpreted as behavioural and psychological symptoms of dementia. However, these behaviours may also be understood, in some circumstances, as expressions of distress and a diminished sense of safety.

The Safety Override Technique (SOT) is a bottom-up ReAttach technique designed to facilitate a state of perceived safety, contentment, and acceptance, with the aim of reducing threat-related responses such as fear, shame, and hypervigilance. In dementia care, SOT is proposed as an approach that does not depend exclusively on the individual's capacity for independent self-regulation. Instead, a trained professional, such as a nurse or care assistant, may facilitate the process through face-to-face interaction and relational co-regulation. In this framework, the practitioner provides a regulated and supportive relational presence that may help the individual experience greater safety when independent regulation is difficult. Five theoretical perspectives provide a basis for exploring this potential application.

The loss of the social baseline

Social Baseline Theory proposes that the human brain treats the presence of safe, familiar social relationships as a baseline condition, allowing individuals to share the demands of vigilance and emotion regulation with others (Beckes & Coan, 2011). When access to trusted social support is reduced, individuals may need to expend greater effort to monitor their environment and regulate their emotional responses, increasing the demands placed on their regulatory systems. Dementia may gradually disrupt this social baseline by impairing the recognition of familiar people and weakening the individual's sense of trust and security, even when supportive caregivers are physically present. Within this theoretical framework, a trained caregiver delivering the Safety Override Technique (SOT) may help re-establish a temporary sense of relational safety through regulated interpersonal contact. This supportive presence may communicate, implicitly, that the individual is not alone in managing the demands of the environment and may therefore reduce the perceived need for constant vigilance.

The return of attachment

Miesen (1992, 1999,2016) observed that people with dementia often exhibit heightened attachment behaviors, such as calling for their parents or expressing a desire to go home. He interpreted these behaviors not simply as manifestations of confusion, but as meaningful responses to persistent feelings of insecurity. From this perspective, dementia may resemble an ongoing *strange situation* in which the attachment system is repeatedly activated but cannot readily be deactivated. Individuals with a history of insecure attachment or parentification may have fewer internalized resources of safety and security to draw upon. As dementia progressively compromises compensatory cognitive strategies, earlier patterns of hypervigilance and feelings of shame may become more pronounced. Rather than attempting to correct the person or reorient them to their immediate circumstances, the Safety Override Technique (SOT) aims, within this theoretical framework, to respond to the underlying need for attachment by fostering a subjective sense of being held, supported, and protected.

Feelings outlast memories

Emotions persist after memories fade. People with Alzheimer's disease who watched emotional film clips quickly forgot their content, yet the evoked sadness or happiness lasted well beyond the memory (Guzmán-Vélez et al., 2014). This works in two directions: rushed, corrective or shaming interactions may leave an emotional residue without a story attached, whereas an experience of deep safety may continue to have an effect even when the moment itself is forgotten. SOT therefore does not depend on memory, insight or verbal processing, and repeated sessions may gradually lower baseline arousal.

Behavior as a signal of an overloaded nervous system

The Progressively Lowered Stress Threshold model proposes that the threshold at which stimuli become stressful drops as dementia progresses, with agitation appearing when it is crossed (Hall & Buckwalter, 1987), closely resembling the mentalization threshold described in ReAttach work (Zeestraten-Bartholomeus & Mehrad, 2026). The unmet needs model views challenging behavior as the expression of an unmet need, with safety and connection among the most fundamental (Cohen-Mansfield, 2000), and person-centered care identifies comfort and attachment as core psychological needs throughout dementia (Kitwood, 1997). From this perspective, SOT is not an additional therapy on top of care but a structured way of meeting a basic need, an important consideration given the risks of antipsychotic use in this population (Devanand et al., 2023).

The mechanism: safety dampens threat

Polyvagal theory describes neuroception, the unconscious evaluation of safety and danger based on cues such as voice, facial expression, rhythm, and touch (Porges, 2009). In addition, Gilbert's (2010) three-systems model proposes that the affiliative soothing system helps regulate the threat system in which fear and shame are rooted. In dementia, the channels through which safety is conveyed remain accessible longer than language and narrative memory, as implicit, procedural and sensory memory are relatively preserved. SOT can therefore be framed as a structured, relational way to evoke a bodily state of safety in which threat, shame, and hypervigilance are temporarily dampened. The researchers of the study present this as a hypothesis: these models offer a plausible mechanism, but direct evidence that SOT suppresses shame or threat responses is not yet available.

The caregiver as carrier of safety

Because SOT can be delivered by trained nurses and care assistants, the caregiver becomes the instrument of the intervention, which has several consequences:

- Caregiver regulation matters. A nervous system can only transmit safety it actually has. Training should therefore address the caregiver's own regulation, protecting both intervention quality and staff well-being.
- SOT can be woven into daily care, for example during personal care, transitions, evening restlessness, or after upsetting events.
- Application differs by stage. In early dementia, elements of SOT may be learned as a self-regulation skill; in moderate and advanced

stages, SOT becomes mainly a co-regulatory intervention.

- Consent and autonomy are essential. Any approach involving closeness or touch requires continuous attention to consent, non-verbal signals, and resistance. Consistent with the importance of autonomy over closeness and distance (Tretter & Löffler-Stastka, 2024), the person should retain control over proximity, particularly with a trauma history.

An Integrative Model: ReAttach at Three Levels

Integrating these perspectives, the researchers propose that ReAttach may support older adults by moving them from cognitive and emotional rigidity toward flexibility at three interacting levels.

- **Physiological level.** By lowering arousal before any reflective work, ReAttach may protect the frontal resources that the aging brain relies on for compensatory flexibility (Chuikova et al., 2025) and keep the person below the mentalization threshold (Zeestraten-Bartholomeus & Mehrad, 2026). In dementia, SOT delivered by trained caregivers extends this level through co-regulation.
- **Sensory-integrative level.** As posterior perceptual processing declines, combined tactile, auditory, and visual stimulation may offer the brain multiple input routes. This parallels the emphasis on immersion and embodied interaction in technology-based interventions shown to improve flexibility in older adults with mild cognitive impairment (Gharalari et al., 2025), while adding a regulated relational context. Training multiple sensory routes and adaptive schemas may also build cognitive reserves.
- **Social-cognitive level.** ReAttach aims to restore flexible movement between self and other, which may protect against empathic overload (Cai & Qi, 2022), and to strengthen the internal reference structure of self and world through associative processing, cognitive bias modification and New Mind Creation (Tretter & Löffler-Stastka, 2024). New adaptive schemas are best anchored in familiar, secure experiences rather than introduced as open-ended discovery under uncertainty.

A coherent care environment supports all three levels. Tretter and Löffler-Stastka (2024) argue that consistent narratives calm emotions; in psychogeriatric care, consistent routines, consistent caregivers, and consistent messages may reduce the dissonance load on a vulnerable brain.

Clinical Applications

- Late-life depression and suicidality: strengthening protective factors such as purpose in life, resilience and positive relationships (Van Orden, 2024).
- Unprocessed early adversity resurfacing in later life (Zeestraten-Bartholomeus et al., 2026b).
- Loneliness and social withdrawal (Ayalon & Segel-Karpas, 2024).
- Behavioral and psychological symptoms of dementia, including late-onset psychotic symptoms where non-pharmacological approaches are indicated (Devanand et al., 2023).
- Functional and somatic symptoms (Call et al., 2026).

Contextual and Disability-Inclusive Safety: From Felt Safety to Lived Safety

Later-life safety is not reducible to symptom relief or transient reassurance. For older adults living with disability, frailty or isolation, safety is also environmental and relational: the ability to communicate needs, exercise choice, navigate services and rely on consistent support. The researchers propose distinguishing perceived emotional safety (felt safety) from the conditions enabling participation and dignity over time (lived safety). Future ReAttach-informed research could therefore document feasibility, accessibility, caregiver readiness, safeguarding and continuity of support within person-centred care, while testing rather than presuming the manuscript's proposed mechanisms. Figure 1 presents the conceptual framework, and Table 1 sets out illustrative feasibility questions and safeguards.

The relationship between social experience and symptom burden also warrants consideration. Daily diary research in midlife adults has associated greater daily loneliness with more numerous and more severe physical symptoms (Witzel et al., 2024). A preliminary, unpublished retrospective analysis of naturalistic, longitudinal, patient-generated NeuroLog records provides a related observation in an FND tracking context (NeuroLog, 2026). Within accounts that recorded days both with and without each selection, choosing "lonely" or "social isolation" was associated with greater same-day emotional intensity and broader symptom reporting. After adjustment for calendar month and follow-up, the estimated symptom-breadth difference was 4.00 additional selected labels for loneliness (95% CI 3.14–4.86; 5,025 account-days from 215 accounts) and 3.30 for perceived isolation (95% CI 2.11–4.50; 4,152 account-days from 180 accounts). These counts span physical, cognitive and psychological experiences and do not represent independently confirmed physical symptoms. The observations suggest that social circumstances deserve explicit consideration alongside biological and psychological factors when examining reported burden. In psychogeriatric care, this raises a question for prospective investigation: how do perceived connection and dependable everyday support relate to changes in distress and symptom reporting? The NeuroLog findings do not establish a causal mechanism, applicability to dementia, or benefit from ReAttach.

Felt safety, agency and identity, and lived safety are considered within four contextual domains. Dotted links organise the concepts and do not represent demonstrated causal pathways. No intervention effect or validation is claimed. Case examples from clinical practice

Case 1: Alzheimer's Disease, Nightmares, and Self-Injurious Behavior

An 80-year-old woman with Alzheimer's disease was living in a residential care facility when nursing staff sought support because she had suddenly begun banging her head forcefully against the wall during the night. This was entirely new behavior and had emerged only in the preceding weeks.

Further exploration revealed that she was experiencing recurring nightmares linked to childhood memories of December months marked by conflict, fear, and violence. These memories appeared to be reactivated during the holiday season. In addition, she rarely participated in social or festive activities within the care facility because celebrations and festivities had not been permitted during her childhood.

Treatment Focus

ReAttach treatment focused on:

- Reducing the emotional intensity associated with distressing childhood memories
- Addressing trauma-related nightmares
- Decreasing self-injurious behavior
- Supporting participation in social and recreational activities

Outcome

Following a single ReAttach session:

- The head-banging behavior stopped completely
- The nightmares disappeared
- Sleep quality improved
- She began participating in activities again

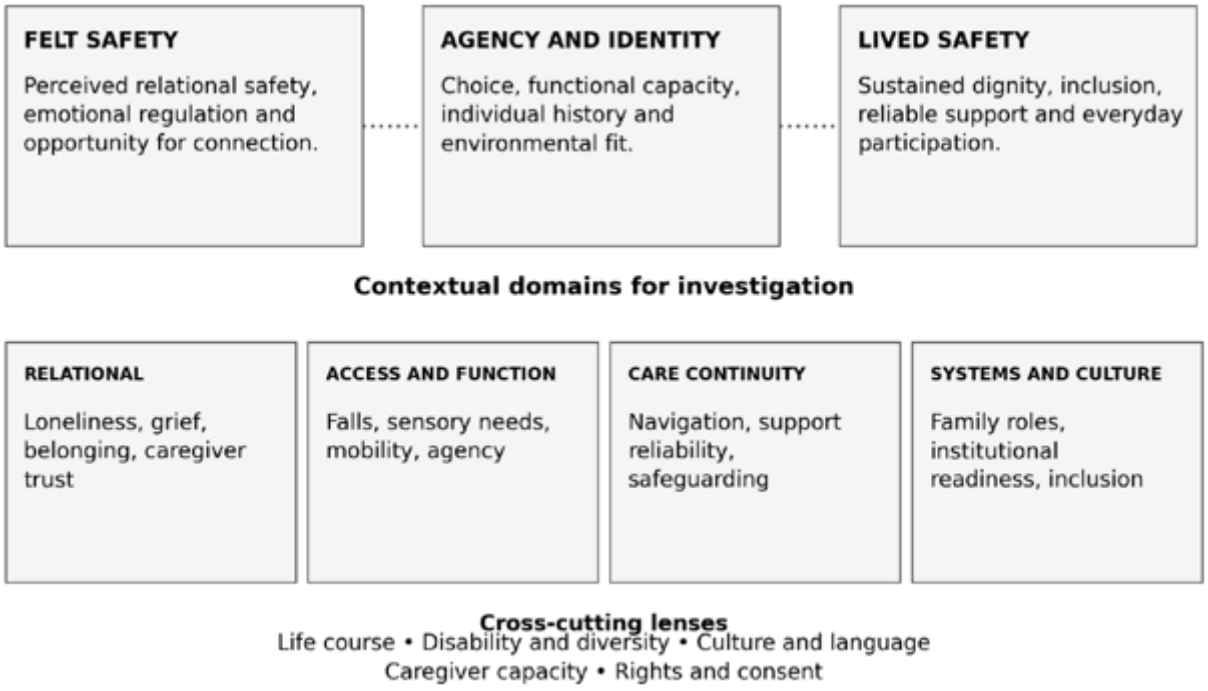


Figure 1: From felt safety to lived safety

Domain	Implementation question	Illustrative indicator	Research boundary
Relational safety	Can people communicate distress, needs and preferences?	Participant feedback on perceived safety; an appropriate measure of participation	Do not infer efficacy from satisfaction.
Accessibility	Can people with hearing, vision, mobility or cognitive needs participate?	Accessibility adaptations; refusal and dropout reasons	Document accessibility barriers and reasons for exclusion.
Consent and agency	Are autonomy, assent, resistance and proximity preferences respected?	Consent records; escalation and withdrawal pathway	Separate care consent and research consent.
Caregiver capacity	Are caregivers trained, supported and competent for the task?	Training completion; supervision; self-reported burden	Maintain appropriate clinical oversight and referral pathways.
Care continuity	Are support pathways reliable across home, community and residential settings?	Follow-up feasibility; referral completeness	Treat service context as a potential confounder.
Cultural fit	Do language, family roles and local resources affect acceptability?	Interview themes; contextual adaptation logs	Assess variation within and across cultural groups.
Research integrity	Are eligibility, safety, fidelity and limitations documented?	Protocol adherence; adverse event reporting	Independent ethics and evidence review needed.

Table 1: Feasibility Matrix

These illustrative indicators concern feasibility and acceptability. They are not surrogate evidence of improved cognition, mood or dementia-related symptoms. Outcome selection and validation belong to the final research protocol.

A particularly remarkable aspect of this case was observed one week later. Although the woman recognized the therapist, she had no recollection of the treatment itself due to her severe memory impairment. Nevertheless, the therapeutic effects remained evident. When asked about the nightmares, she simply replied that she slept well and no longer experienced them. When asked about participating in activities, she responded, "Why shouldn't I participate?"

Despite significant cognitive impairment resulting from Alzheimer's disease, the intervention appeared to substantially reduce the emotional burden of painful childhood experiences. The case illustrates how meaningful emotional and behavioral improvements can occur even when explicit memory for the treatment is absent.

Case 2: Parkinson's Disease, Stress, and Freezing Responses

A 71 year old man who has Parkinson's disease, for 5 years, experienced severe stress and frequent "freezing" responses, particularly in demanding or emotionally challenging situations. In addition to managing Parkinson's disease, he and his wife cared for their adult son with autism, which created substantial and ongoing stress. He also struggled to remember to take his own medication, despite using reminders.

Treatment Focus

Treatment focused on:

- Reducing chronic tension and stress
- Lowering hypervigilance and increasing relaxation

- Addressing freezing responses in stressful situations
- Improving medication-taking behavior and independence

Outcome

Three weeks after treatment, he reported significant improvements:

- Medication adherence had improved completely
- Stress levels had decreased substantially
- He felt more confident and capable in daily life
- He was better able to respond in situations that had previously caused him to freeze
- His wife no longer needed to monitor his medication schedule

For him, one of the most meaningful changes was regaining a sense of independence. Successfully managing his medication routine without relying on his wife provided a tangible sign of progress and increased his confidence in coping with both the challenges of Parkinson's disease and the ongoing demands within his family life.

Case 3: Dementia, Hallucinations, and Chronic Feelings of Unsafety

A 84-year-old woman, had a complex clinical profile characterized by illiteracy, a mild intellectual disability, recurrent depressive episodes, and longstanding personality difficulties with traits associated with Cluster B and Cluster C personality disorders. In addition, she showed signs of moderately advanced dementia.

Throughout her childhood, conflict and arguments were common within the family environment, contributing to a communication style in which confrontation and mistrust became familiar patterns. She had also experienced repeated exploitation and mistreatment by others, resulting in chronic feelings of vulnerability and suspiciousness.

During the last several years, she increasingly experienced hallucinations. Initially, these appeared to be misinterpretations of her surroundings, but over time they became more intense and distressing. She reported seeing and hearing people who were not present, often arguing with one another. She also heard music that others could not hear. These experiences became increasingly disruptive and caused significant distress.

She regularly experienced conflicts with care staff, particularly when agreements were not kept, when explanations for mistakes felt dismissive, when she felt misunderstood or not taken seriously, or when staff members responded inconsistently. Such situations reinforced her feelings of unsafety, exclusion, and mistrust.

Treatment Focus

ReAttach treatment focused on:

- Reducing chronic tension and stress
- Increasing feelings of safety, calmness, and trust
- Improving emotional regulation
- Reducing sensitivity to environmental and interpersonal triggers
- Supporting resilience in coping with hallucinations and daily challenges

Outcome

She reported experiencing an immediate sense of calmness and relaxation following treatment. She described feeling better able to cope with everyday life and less overwhelmed by the many stressors she encountered.

Because numerous triggers continued to be present in her environment, treatment was repeated regularly over the course of a year, initially on a weekly basis and later every two weeks. These sessions helped maintain emotional stability and provided ongoing support in managing stress and feelings of unsafety.

An important change occurred when she moved to a care unit where she felt safer, more understood, and more consistently supported by staff. As her sense of security increased, the need for frequent ReAttach sessions diminished.

A memorable aspect of this case was her nickname for the therapist: **"Handje" ("Little Hand")**. Because of her memory difficulties, she gave nicknames to many people rather than remembering their names. She referred to the therapist as "Handje" because of the hand-tapping element of the ReAttach sessions. The nickname became a warm and familiar way for her to refer to the therapist and reflected both her cognitive limitations and the trust she developed during treatment.

This case illustrates how improving feelings of safety and reducing chronic stress can positively affect quality of life, even in individuals with a complex combination of dementia, intellectual disability, personality-related vulnerabilities, depression, and hallucinations. For her, the combination of a supportive environment and repeated ReAttach sessions contributed to greater calmness, stability, and resilience in daily life.

Case 4: Alzheimer's Disease, Bereavement, and Traumatic Memories

A 79-year-old woman with Alzheimer's disease, had spent many years avoiding formal care services. Eventually, she and her husband moved together into a residential care facility. On the very first night after their move, she experienced a profoundly distressing event. She awoke to find her husband lying lifeless on the floor.

She recalls being terrified and calling for help, repeatedly telling staff that her husband had died. When assistance arrived, she was helped back into bed. She experienced the situation as confusing and overwhelming and felt that no one adequately answered her questions about what had happened. According to her, she was simply told to return to bed while staff attended to her husband. The memory of finding him dead on the floor remained vividly present and repeatedly intruded into her thoughts.

Although she was deeply saddened by the loss of her husband, she also expressed relief that his suffering had ended. He had been seriously ill for a long time, living with advanced COPD and experiencing frequent severe breathlessness. He had never wanted to move into a care facility, and She found some comfort in knowing that he no longer had to endure his illness.

A notable aspect of her presentation was that she was aware of her significant memory problems. Because of her Alzheimer's disease, she could remember very little from day to day and often struggled to recall recent events.

Treatment Focus

ReAttach treatment focused on:

- Reducing tension and emotional distress
- Increasing relaxation and a sense of safety
- Reducing the emotional charge associated with the image of finding her husband on the floor
- Decreasing intrusive recollections of that moment
- Supporting adjustment to bereavement and life in the care facility

Outcome

Immediately following the session, she reported feeling noticeably calmer and more relaxed.

During the following week, despite her limited memory for events and conversations, she spontaneously told staff and relatives that she felt much better after "the physiotherapist tapped on my hands."

In reality, she was referring to the psychologist who had provided the ReAttach intervention. Although she could not remember the treatment itself in detail, she clearly remembered the positive effect it had on her.

One week later, she reported that she felt calm and relaxed. The distressing image of her husband lying on the floor no longer dominated her thoughts. Instead, she found herself thinking more often about positive memories of their life together. She continued to grieve his loss and remained sad about his death, but these emotions were appropriate to the situation and no longer accompanied by the overwhelming distress caused by the traumatic image.

She also reported feeling comfortable in the residential care facility. She described the staff as kind and supportive and appreciated their efforts to help her. With the intrusive image no longer causing constant distress, she felt able to focus on settling into her new home. She increasingly participated in group activities and reported enjoying them very much.

This case illustrates that even in the presence of significant memory impairment due to Alzheimer's disease, ReAttach may help reduce the emotional impact of a traumatic experience. Although she retained little explicit memory of the intervention itself, the reduction in tension, the disappearance of the intrusive image, and her improved adjustment to both bereavement and residential care remained clearly evident.

Discussion

Limitations

The framework presented here is theoretical. None of the reviewed studies examined ReAttach in older adults, and several sources have limited generalizability: the link between flexibility and empathy derives from a student sample (Cai & Qi, 2022), the dissonance model is a theoretical essay developed in the context of the pandemic (Tretter & Löffler-Stastka, 2024), and some neuromodulation findings rest on small case series (Gharalari et al., 2025). The proposed links between ReAttach mechanisms, insular function, and cognitive reserve require empirical testing. Existing ReAttach research is practice-based and largely conducted by the method's developers, underscoring the need for independent evaluation. Furthermore, the distinction between clinical concepts, contextual hypotheses, and implementation indicators needs to be carefully maintained, ensuring that perceived safety or satisfaction is not conflated with clinical efficacy. The clinical examples reported here are descriptive practice observations, not controlled evidence of efficacy; concurrent care and environmental changes limit causal interpretation. The NeuroLog observations are exploratory, unpublished associations based on self-reported records from a self-selected FND tracking cohort; the cited analyses did not establish an older-adult subgroup. Shared reporting methods, uneven engagement, confounding and reverse causality limit interpretation, and estimates varied across sensitivity analyses. The findings cannot demonstrate autonomic dysregulation, establish temporal direction, or support claims of ReAttach efficacy in psychogeriatric care.

While the immediate improvement observed in the case examples, such as the cessation of self-injurious behavior after a single session is promising, these results should be interpreted with caution. Single-case observations cannot account for non-specific contextual factors, therapist presence, or placebo-like effects. Future research must track these outcomes over longer periods to determine whether a single or short series of SOT interventions produces lasting neurobiological and behavioral changes

Directions for research

Putting this approach into daily clinical practice also comes with practical challenges. First, relying on nurses and care staff as 'carriers of safety' requires that staff members themselves feel regulated and supported. In busy, understaffed psychogeriatric wards where burnout is high, achieving calm co-regulation can be difficult. Training must therefore focus not only on the technique itself, but also on supporting caregiver well-being. Second, because ReAttach uses light touch and sensory prompts, practitioners must remain sensitive to non-verbal signals of consent and comfort, especially when working with non-verbal patients or those with unknown trauma histories, where touch could inadvertently trigger distress or sensory overload.

To address these implementation challenges and build a robust evidence base, future research should focus on the following directions:

- **Feasibility and acceptability studies:** Conducting exploratory case series and feasibility studies of ReAttach in psychogeriatric settings, following established ReAttach research protocols.
- **Evaluating Lived Safety indicators:** Assessing relational safety (the ability to communicate needs), accessibility (ensuring full participation for individuals with hearing, vision, or cognitive impairments), and consent and agency (respecting patient autonomy and non-verbal resistance).
- **Social and emotional well-being:** Assessing loneliness, perceived social support, and the frequency of social contact separately, alongside repeated measures of emotional distress and symptom burden. Measurement tools should match participants' cognitive and communication abilities, clearly distinguishing self-reports from caregiver observations. Prospective studies should also control for disability, bereavement, and environmental changes when evaluating temporal relationships.
- **Clinical and behavioral outcomes:** Evaluating the direct impact on agitation (e.g., using the Cohen-Mansfield Agitation Inventory), mood, anxiety, and overall quality of life.
- **Neurobiological and cognitive mechanisms:** Measuring potential changes in cognitive flexibility alongside physiological markers such as heart rate variability (HRV), quantitative EEG (Q-EEG) and neuropsychological tests.
- **Systemic and care-level impact:** Monitoring changes in the use of psychotropic medication and restrictive measures (e.g., physical or environmental restraints).
- **Caregiver well-being:** Investigating the experiences of nurses, care assistants, and family caregivers, including measuring changes in their own stress levels, emotional regulation, and sense of relational connection.
- **Continuity of care and cultural sensitivity:** Assessing care continuity across home, community, and residential settings to control for service context as a potential confounder, while mapping cultural fit to avoid assuming one care model fits all cultural backgrounds.
- **Methodological rigor and ethics:** Ensuring independent ethical oversight and rigorous evidence review to thoroughly document participant eligibility, intervention fidelity, safety, and potential limitations.

Conclusion

Later life places growing demands on the capacity to adapt, while cognitive decline, sensory loss, and accumulated adversity can reduce the flexibility needed to meet them. ReAttach offers a brief, bottom-up, and salutogenic approach that does not require intact reflective capacity to begin working. By regulating arousal first, engaging multiple sensory routes, strengthening flexible, secure schemas within a co-regulating relationship, and extending safety into daily dementia care through the Safety Override Technique delivered by trained caregivers, ReAttach may help make protective resources reachable for older adults who are hard to reach with

conventional psychotherapy. Integrating the transition from felt safety to lived safety ensures that interventions are firmly embedded within supportive, accessible, and continuous care systems.

While the framework presented here provides a promising theoretical foundation supported by initial clinical observations, rigorous empirical research and controlled trials are the essential next step to establish a stronger evidence base. Ultimately, this approach invites a broader shift in psychogeriatric care: moving away from reactive symptom management and toward creating sensory-safe, relationally rich environments where older adults, and caregivers, feel safe enough to grow old.

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Disclosure

Dr. Paula Zeestraten-Bartholomeus is the developer of ReAttach. Steven Painter is the developer of Neurolog and the Symptom Amplification Model (SAM). Gaurav Duggal has a paid independent consultancy engagement with ReAttach Academy. The other authors declare no conflicts of interest with respect to the research, authorship, and/or publication of this article.

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