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The Re-Attachment Edition

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The plight

of the avoidantly attached partner in couples therapy

By Stan Tatkin

"I want you in the house, just not in my room... unless I ask you"

The avoidantly attached baby quietly suffers from pervasive attachment insecurity, rooted in interpersonal neglect, and adapts by creating a quasi-independent internal working model. The greater the adaptation, the more the adult avoidant appears to the outside world as a person who does not need others and who functions autonomously. In fact, the undefended avoidant feels desperately alone, isolated, and unable to depend fully on a primary attachment figure. The individual or couples therapist must quickly connect with the avoidant's implicit fears and convert his or her ego-syntonic adaptation into therapeutic doubt and curiosity.

The purpose of this article is to help the therapist understand the avoidant adult's dilemma in primary attachment relationships and point toward effective interventions that might facilitate the therapeutic process. The ideas in this article do not necessary apply equally to all avoidant subtypes. For instance, the somewhat rare Ds1, as classified in Main's Adult Attachment Interview (2000), completely minimize attachment, even to the extent of denying any attachment at all. The Ds2, the most devaluing subtype, and the Ds3 both entertain their attachment, albeit minimally. Although I address the avoidant proper, it should be noted the characterizations here also apply to the more avoidant subtypes within the secure classification.

In a World of Their Own

Similar to people suffering from narcissistic or schizoid personality disorders, the avoidant is caught between interpersonal and intrapersonal worlds, between fear of isolation and fear of neglect or maltreatment. From an attachment perspective, the internal working model of the avoidant infant (A1 or A2 subtype) develops in response to its dismissive caregiver (Ds2 or Ds3 subtype). These infant-caregiver pairs typically show low levels of proximity seeking and contact maintenance while together, during separation, and during reunion. Avoidant children display more low-keyed Behaviour, more gaze aversion, and more pulling away than do secure and angry/resistant children. They may show directed Behaviour, such as proximity seeking toward strangers, but drop these Behaviours with their primary caregivers. Avoidant children often go unnoticed because they are considered "good" and "well-behaved" and "never a bother." By all appearances, the avoidant child seems independent; however, this appearance of autonomy is the child's adaption to his or her caregiver's low valuation of attachment Behaviours. One can argue that independence cannot be achieved by way of neglect.

From a psychobiological perspective, the avoidant child lacks continual interaction with caregivers, and so settles into a form of self-stimulation and self-soothing called autoregulation. This turning to the self for all things foreshadows future relationship troubles on a variety of levels, most of which involve approach by a primary attachment figure. The following sections focus on the problem of approach, as experienced by the adult avoidant individual.

> "The undefended avoidant feels desperately alone, isolated, and unable to depend fully on a primary attachment figure."

Intrusiveness

Autoregulation tends to be a dissociative state, requiring little interaction and therefore causing little interpersonal stress. The autoregulatory play state, which involves positive affects, operates on a timeless, spaceless continuum undisturbed by time-bounded, space-bounded reality. In adults, this presents a problem of intrusiveness whenever the autoregulatory state is interrupted by a primary attachment figure (i.e., lover or spouse). The approach of a primary figure disrupts the autoregulatory state, causing a fundamental adaptation much like that experienced during childhood. The avoidant's rejection of the partner's approach is not so much antisocial as it is energy conserving because the avoidant is simply trying to maintain psychobiological homeostasis.

The couples therapist can capture autoregulatory issues by observing couples work, uninterrupted, on a conflict toward a satisfying solution, even if it is temporary. Instead of tracking the content of their conflict, the therapist tracks moment-by-moment psychobiological shifts and changes within and between partners. These changes are observed in the partners' faces, bodies, movements, vocal intensity, and prosody. The therapist also tracks the wave-like variations of each partner's arousal, which either increase or decrease as each is stimulated and calmed.

The autoregulating partner (the avoidant) will appear less expressive, less verbal, more emotionally restricted, and less able to co-regulate than the partner, who will provide calmness or stimulation, as needed by the partner. The avoidant's memory of events may differ greatly from that of the partner; the events the avoidant remembers may be devoid of emotional value or importance, at least in comparison with what the partner recalls. The avoidant's gaze often is averted away from the partner's eyes and may appear low key and under-responsive (withdrawal) or explosive and over-reactive (attack). It is common to observe the avoidant drifting off when his or her partner takes centre stage for longer than brief moments. This can be due to early experiences of feeling "talked at" by primary caregivers or invisible in the presence of caregivers who took centre stage.

The therapist can help both the avoidant and his or her partner understand that true mutuality and inclusion are foreign to the avoidant, who believes he or she is only needed and never really wanted. Feeling needed but not wanted is a central attachment injury for the avoidant, who had to adapt to a non-reciprocal, dismissive, or derogating caregiver. Psychoanalytic literature has long described the exploitation of the narcissistic child and the master/slave relationship with the schizoid child (Freud, Sandler, Person, & Fonagy, 1991; Guntrip, 1969; Klein & Masterson, 1989; Kohut, 1977; Masterson, 1981).

Startle/Attack

Another problem closely related to intrusiveness is the avoidant's experience of startle and attack with the sound and sight of an approaching primary figure. The autoregulatory state is dissociative, energy conserving, and non-interactive. On a neurological level, brain metabolism is low, as is demand for the brain's resources. Interaction requires greater central and peripheral nervous system activation, and therefore can be experienced by the avoidant as having to "wake up," as if from a deep sleep. The avoidant may feel startled or attacked in response to the sound of an approaching voice or the visual of an approaching person, or for that matter, the experience of an approaching interpretation by a therapist. The avoidant's reflex may be anger; dismissal; withdrawal; and of course, avoidance.

The couples therapist can use any number of physical exercises that move partners together and apart so that the couple can experience and the therapist can view their immediate bodily reactions to approach and withdrawal. In my practice, I use a formalized, structured exercise wherein I have partners stand and move toward and away from one another (Figure 1). I also use video recording and playback so couples can see immediate reactions in the face, eyes, posture, and skin color, and see other physiological cues of stress and anxiety. I find these exercises go a long way toward helping convince partners of their psychobiological reactions to one another and toward understanding that these reactions are immediate, predictable, and reproducible. I also find it important to tie these psychobiological reflexes to their attachment history (see attachment interview) and to current issues with approach, physical proximity, and distance.

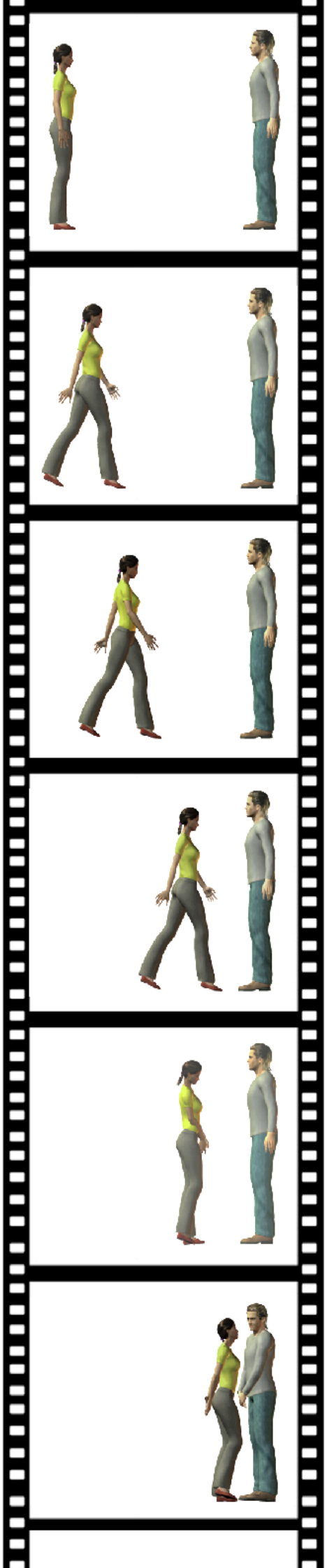


Figure 1

Switching States

One problem that pertains to both intrusiveness and startle/attack is the avoidant's difficulty with switching states. Secure individuals can switch easily between autoregulation and interactive regulation with another person. Interactive regulation is characterized by focused and sustained interactive play that involves face-to-face, eye-to-eye, and perhaps skin-to-skin contact with at least one other person. Secures are accustomed to moving between these two states without anxiety or depression because both states are pleasurable and because the transitions between them are pain free. However, avoidants are rooted in an autoregulatory strategy and are unaccustomed to switching between self-play and interactive-play. For them, the ball naturally rolls in the direction of self-play as a default, and does so without any awareness of it on their part.

The avoidant, for example, may show initial resistance when a partner makes a bid for interaction. However, after becoming acclimated to interactive regulation, the avoidant may show no signs of discomfort or interest in returning to autoregulation. Not surprisingly, though, if the avoidant is left alone for several minutes, the ball rolls back into autoregulation and the resistance to interact on can quickly reappear, leading to a renewed period of acclimation. Again, the avoidant is unaware of the immediate drift back into autoregulation, but is aware of the intrusion by the partner, who stands mystified and even miffed by the rapid, inexplicable shift away from interaction.

Therapists can look for instances in the couple's narrative that point to this kind of problem and help educate them and normalize this issue for them. Chances are very good neither partner will have focused on this issue in this particular way.

Non-Mutuality

The other problem with approach for the avoidant refers back to the attachment injury with the early primary attachment figure. Because the avoidant is born out of a dismissive/derogating parenting style, the basic experience of relationships as non-mutual becomes concretized in early childhood. The dismissive parenting style values things and self over relationship and attachment. Although secures do not always value attachment and relationship, mostly they do. In all relationships, what is ultimately important is the degree and frequency to which a partner makes relational versus non-relational choices on a day-to-day basis.

A one-person psychological system can be defined as one in which little or no true mutuality exists. Personality disorders are one-person psychological systems because true mutuality is a non-existent feature of that internal object relational world. For a variety of reasons, constitutional and/or relational, personality-disordered individuals suffer pre-oedipal wounds that sometimes permanently delay the formation of whole object relations. Attachment injuries derived from constitutional and/or relational etiologies also involve childhood organizational adaptations to either insensitive or frightening caregivers. The experience of true mutuality is replaced by basic insecurity about the self and other; the attachment relationship is not safe or secure and it is not held together as much by attraction as by fear, either of loss of self or loss of other.

The avoidant bristles in response to an approaching primary attachment figure because he or she does not believe in mutuality. The approaching figure wants something from him or her, and reciprocity is not possible. This leaves the avoidant in a dilemma that can only be resolved with compliance, withdrawal, anger, or avoidance. The avoidant experiences shame and fear with the emergence of aversion toward the primary attachment figure. He or she fears the other will recognize this aversive reaction, and because the cause of this reaction is a mystery even to the avoidant, the experience is one of shame: "There is something wrong with me."

Insight for the avoidant is notoriously poor, and problems with autobiographical memory and somatoaffective awareness are noted (Fukunishi, Sei, Morita, & Rahe, 1999; Guttman & Laporte, 2002; Larsen, Brand, Bermond, & Hijman, 2003; Main, 2000). The avoidant's declarative memory is filled with ideas about parents and childhood, but lack autobiographical memories filled with the experience of parents and childhood. Most often, the avoidant's report is idealized, lacking in detail, and superficial. For this reason, the avoidant is largely unaware of his or her attachment dilemma, and because adaptation has been so complete, he or she does not appear distressed and tends to see nothing wrong with his or her avoidant strategies.

"I Want You in the House, Just Not in My Room... Unless I Ask You"

The avoidant wants to feel securely attached, but tends to form attachments that are pseudosecure. The avoidant wants to know a primary attachment figure is around, but does not want to be approached unless invited. This is because approach by the other is experienced as a threat, something that does not occur when the avoidant makes the approach himself or herself. It is as though the avoidant is saying, "I want you in the house, just not in my room. And you can only come into my room when I extend the invitation." This particular feature generally does not appear during the courtship phase of romantic relationships. However, as the relationship begins to appear more permanent and settled, approach issues become evident in areas concerning time (interaction), space (proximity), and sex (libido).

The avoidant's pseudosecurity is rooted in a fantasy of omnipresence and permanence. This fantasy allows the avoidant to spend extended time away from the primary figure, without awareness of separation or loss. In the avoidant's mind, the other partner is always there, is always around, and will never leave them. This notion of omnipresence, while comforting in one sense, is smothering and intrusive in another, which then leads to more avoidant Behaviour and devaluation of the partner.

The avoidant's fantasy of omnipresence is yet another challenge to the couples therapist because the avoidant partner is unaware of his or her extreme dependence on the other. The therapist may not see the extent of this dependency until after the avoidant has been left, unequivocally, by the partner. When this occurs, the avoidant may collapse in an anaclitic depression unlike any he or she ever experienced before. This is because, in childhood as in adulthood, neglect

does not equal abandonment for the avoidant. Although the avoidant's early caregiver may have been neglectful, insensitive, or disappointing, the caregiver was always there. The same is true for the adult relationship: no matter how disappointing the partner may be, he or she is experienced as always there. This is why the incontestable departure of a partner can come as an unexpected blow to the avoidant.

Therapeutic interventions should be aimed at penetrating the fantasy of omnipresence and permanence. Only through the dissolution of this defense can the avoidant truly appreciate, value, and move toward his or her primary attachment figure. In this case, healthy fear of realistic loss helps counteract the avoidant's pseudosecure strategies. I have used death and dying suggestions and exercises to facilitate the awareness of impending loss through illness, death, or other unexpected conditions that would result in the loss of the other. Still, the reader should be aware that, in severe cases of avoidance, even the most potent attempts to interrupt the avoidant's fantasy of omnipresence and permanence will be thwarted by the avoidant's denial of loss.

Brief Separations Without Distress

All couples go through periods of brief or extended separations in the course of their relationship. Separations can result simply from going to work or school daily or can be associated with trips, either personal or business. It may seem contradictory to say the avoidant is highly distressed in anticipation of and upon separation from his or her primary attachment figure, especially because I just described how the avoidant avoids loss by using pseudosecure strategies (e.g., a fantasy of omnipresence). However, the avoidant's defense is so rapid and effective that he or she is unaware of distress when he or she must physically separate for a day, several days, or a week. The shift to autoregulation is immediate, and so the partner's exit allows the avoidant to make an easy transition. The avoidant may claim to feel relieved or excited by brief or even extended separations.

If the therapist queries how well the avoidant fares in the partner's absence, such as by asking about sleep and eating and other self-care habits, the difference between self-regulatory efficacy with and without the partner can be surprising. For instance, one partner admitted he did not get himself to bed regularly when his partner was not there. His eating habits worsened, as did his time management. This came as a surprise to both partners, who always assumed he did quite well alone. In general, therapeutic progress for the avoidant is evident through increased awareness of somatosensory, somatoaffective cues of distress upon separation from his or her primary attachment figure.

Treatment Approach

The Psychobiological Approach to Couples Therapy™ (PACT) focuses on early attachment and its effect on brain and nervous system development, as well as on specific neuroendocrine issues related to interpersonal stress. Four primary domains drive the approach: attachment, arousal, developmental neuroscience, and therapeutic enactment. What follows is a brief set of interventions and goals to use for avoidant partners in each domain.

Attachment

The couples therapist should use some formal variation of an attachment interview, with both partners present in one session. A well-designed, disciplined interview, such as the one I use in my practice, can help the therapist expose the avoidant's early neglect history and lifelong struggle with attachment relationships (Tatkin, 2007). I use an abbreviated version of Main's Adult Attachment Interview (Hesse, 1999), which was originally developed as a research or assessment tool, as an intake device that serves as an intervention contrivance.

The therapist must create enough therapeutic doubt and curiosity early in treatment to get the avoidant partner invested in therapy. The avoidant always requires proof, and a competent attachment interview can provide the emotional experience necessary to convince the avoidant (and partner) that things are not what they seem. A proper attachment interview is extraordinarily stressful and often quite depressing for the avoidant. For this reason, it is important to allow enough time to fully carry out and interpret the procedure for both partners, and to deal with any fallout.

In this domain, the therapist should expect the following treatment goals with the avoidant partner:

- He or she will able to convert maladaptive avoidant defenses from ego-syntonic to ego-dystonic.
- He or she will become aware of his or her own internal working model (avoidant organization).
- He or she will cease all explicit and implicit threats to the couple's safety and security system (this system scaffolds both partners and makes possible personal growth and development).
- He or she will accept and be willing to make some counterintuitive Behavioural changes (e.g., make approaches when preferring to withdraw; make proactive elective bids for connection with the partner; set pro-relationship boundaries and limits; and make quick and effective repairs to the relationship when a breach occurs, especially when the breach is due to avoidant strategies).

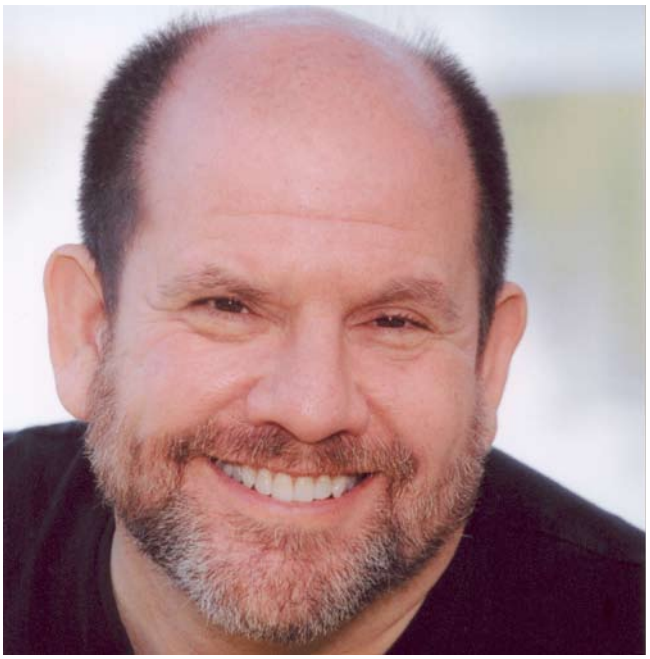
Arousal

This domain pertains to the autonomic nervous system (ANS) and its entrenchment in the internal working model. Because the ANS is intricately associated with emotional experience and expression, arousal and affect regulation are considered here as interchangeable. The therapist collects a history on each partner's capacity to self-regulate and interactively regulate with the other. Self-regulation pertains to a partner's ability to manage his or her own arousal (level of stimulation) in such a way that he or she maintains a pro-relationship mental/emotional condition adequate for relating to the other partner. Self-regulation skill is assessed by observing each partner's ability to manage fear and threat without going into hyperarousal (fight/flight/freeze) or hypoarousal (energy conservation withdrawal), two extreme arousal states that lead to anti-relationship Behaviour. Interactive regulation is the couple's capacity to co-manage positive and negative arousal states, acting as stewards of the intensity and duration

of their positive and negative emotional states.

The therapist observes the couple in real time as the partners work any conflict toward a solution. The therapist tracks the couple as a regulatory team, moving in and out of various mental and emotional states, and notices if or when partners become overwhelmed by either too much positive or too much negative experience, and notices if they do anything about it, what they do, when they do it, and how effective they are at restoring emotional equilibrium. Poor self-regulation makes more difficult the prospect of effective interactive regulation. One partner is often better at interactive regulation, and sometimes is much better than the other partner. One partner's skillfulness can sometimes but not always compensate for the other's deficits in self-regulation.

As mentioned earlier, the avoidant gravitates toward autoregulation, an inherently non-relational practice. This often leads to problems with the couple's interactive regulatory practices. The couples therapist must pay special attention to the avoidant's nonverbal arousal cues that suggest either hyperarousal or hypoarousal and intervene in ways that increase the couple's skill at co-regulation. This often is best achieved through increasing each partner's moment-to-moment awareness of nonverbal cues, especially concerning distress or injury, and improving their ability to quickly administer relief to one another. As with distress cues, partners must learn how to recognize relief in one another to gauge the success of their attempts to soothe, console, and repair.



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In this domain, the therapist should expect the following treatment goals with the avoidant partner:

- He or she will become aware of interoceptive (body) cues that alert him or her to his or her own ANS state.
- He or she will be better able to tolerate and manage negative states without going into either hyperarousal or hypoarousal.
- He or she will no longer freeze, still, or under-respond while interacting with his or her partner; under-responding is gauged by nonverbal Behaviours (e.g., a lack of vocalizations, facial motility, eye contact, movements, or gestures).
- He or she will become a better co-regulatory partner.

Developmental Neuroscience

This domain is interrelated to attachment and arousal because early attachment affects and is affected by the early development of basic regulatory functions and of critical brain structures and neuropathways, the maturation of which are experience dependent. Avoidant's social-emotional deficits, which can be observed in the areas of empathy, accurate reading and responding to social-emotional cues, alexithymia, theory of mind, and attachment formation, point to neurological deficits in the right hemisphere and frontolimbic circuits. A psychobiologically oriented therapist must consider social-emotional deficits and explore whether or not these deficits are specific and limited to partner interaction and interpersonal stress, or possibly indicate neurological issues of an organic or developmental nature.

In this domain, the therapist should expect the following treatment goals with the avoidant partner:

He or she will cease to make misappraisals of the partner's mal-intent, in light of any uncovered of deficits, and will adjust his or her expectations accordingly.

He or she will develop neurologically with the help of partner interactions, partner support, and the reduction of interpersonal pressure to perform beyond his or her capacity in identified areas.

Therapeutic Enactment

Finally, this domain is the therapeutic component that ties it all together. A successful psychobiological approach to couples therapy must ultimately focus on partner experience, not ideas. Psychobiological systems are generally implicit in nature; that is, nonverbal and often non-conscious. Psychobiological processes are reflexive, automatic, and extremely fast. A couple's narrative, or the cognitive content of their distress, is only the tip of the iceberg. What lies below is the often incoherent, implicit account of their real distress—the things they cannot name or describe, but that they experience and act upon, often inexplicably. For this reason, the couples therapist must set the stage to observe and work with interpersonal stress, attachment insecurity, arousal dysregulation, and social-emotional disability.

To accomplish this task, the therapist and couple must have enough time. Therapy sessions cannot be only one hour, but may require two, three, or even four hours to accommodate the various emotional states through which the couple will pass, aided at times by therapeutic provocation.

The therapist needs to enact dysregulating events in real time for the couple to help them while in various mental and emotional states. Simply talking about what happens will be of little use to the couple after they leave the session. Couples in distress frequently move into emotional/mental states they cannot manage without employing defensive, pro-self, anti-relationship strategies, often with devastating results. The therapist will err if he or she follows a cognitive or problem-solving approach because this is not a problem of ideas, values, and principles, but a crisis of two brains and two nervous systems unable to mollify threat.

In this domain, the therapist should expect the following treatment goals with the avoidant partner, all of which will be demonstrated during therapeutic enactments:

- He or she will be able to enter any couple-focused conflict without fear of becoming overwhelmed or defeated.
- He or she will know the three or four things that can quickly and effectively calm and relieve his or her partner most of the time.
- He or she will know the three or four things that will quickly and effectively excite or please his or her partner most of the time.
- He or she will be able to do what is necessary to quickly and effectively short-circuit any mounting threat to the couple's safety and security system.

Conclusions

The avoidantly attached romantic partner can be characterized as someone who adapted in childhood to neglectful, insensitive parenting by turning inward and away from sustained, mutually rewarding interactions with primary others. Part of this turning away came from psychobiological adaptations to caregiver disregard of attachment values and true mutuality, and another part came from spending too much time alone. Despite these adaptations, the avoidant craves relationship and interaction (as do secures), but suffers from issues surrounding approach by a primary attachment figure, such as sensitivity to intrusion, feeling startled and attacked, having difficulty switching between states of aloneness and interaction, and feeling used. Contradictory desires for connectedness and freedom from engulfment are held together by a pseudosecure fantasy of partner omnipresence and permanence. This fantasy allows the avoidant to separate from his or her partner without awareness of loss because the partner's permanent presence is taken for granted. However, it also exposes the avoidant to unwanted advances and intrusions by his or her partner, whose intent is to make one-sided, non-reciprocal demands. The avoidant is largely unaware of the price of his or her adaptation and generally remains in denial of his or her inability to reconcile contradictory dependency needs and fears.

The couples therapist must gain a therapeutic alliance from the onset of therapy by penetrating the avoidant's defensive system. This is most effectively accomplished by administering an abbreviated, clinically-oriented Adult Attachment Interview (Tatkin, 2007) as an intake device, with both partners present and within the span of one session. This abbreviated interview is intended to serve as an intervention, rather than an assessment. The PACT approach (Tatkin & Solomon, in preparation) is particularly useful in treating avoidant partners and couples, and employs experience-based tools and techniques to effect and alter implicit, nonverbal intersubjective systems. Moreover, this approach helps the couples therapist understand the developmental vicissitudes of the avoidant partner, which helps point treatment interventions in the right direction.

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