A Synopsis of This Approach

by

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This is a principle-driven therapeutic approach to couples psychotherapy that is informed by current neuroscience and mother-infant attachment research.

Arousal Regulation - Attachment - Developmental Neuroscience - Therapeutic Enactment

The four domains of arousal regulation, attachment, developmental neuroscience, and therapeutic enactment are puzzle pieces that integrate various forms and disciplines of psychotherapy, human development, and scientific investigation. It is difficult to adequately represent this treatment approach by discussing it in summary form. Nevertheless, in the interest of brevity, the main bullet points of this approach will be divided among these domains.
THE ADULT PRIMARY ATTACHMENT RELATIONSHIP HAS A PURPOSE

This approach is largely built around the premise that marriage, or committed romantic partnership, has a purpose. Couples in distress ordinarily come into therapy without a life supporting or marital sustaining theory. It is for this reason that the psychobiologically attuned therapist must provide meaningful organization as to how a primary attachment relationship functions that both explains the couple's distress and points to a way out of that distress.

As partners progress in their relationship they become affectively bound together, as if sharing a common, connecting bundle of nerves. The therapist can take advantage of moments that produce evidence of this fact as a way to convince both partners that it is in each person’s best interest to ensure the other’s comfort, safety and security at all times. This includes building in many more moments of turning toward one another, particularly when in public or when separated (Gottman, 1999; Schachner, Shaver, & Mikulincer, 2005). The couple is encouraged to think of itself in a "them" and "us" manner, as a sealed off entity that can interact with the external world as easily as it can shut it out. Home is understood, not as a physical place, but as the couple system itself. Partners can turn to one another for comfort and relaxation but also for stimulation and excitement. They willingly and knowingly provide one another a steady diet of admiration and appreciation as this positive affection is essential to the safety and security system within which both partners reside (Carrere, Buehlman, Gottman, Coan, & Ruckstuhl, 2000). This practice is consistent with the notion that our sense of self as "good enough" does in fact come from another person with whom we are intimately involved and upon whom we are dependent (Winnicott, Winnicott, Shepherd, & Davis, 1990).

The therapist must have a clear vision as to how a mutually dependent, primary attachment relationship should operate at its most optimum (Beebe & Lachmann, 1998; Cole, Martin, & Dennis, 2004; Feldman, 2003). The therapist must also convey a belief that the couple can not only achieve this new ideal, but that they are already on their way toward achieving it. This is no simple feat for the beginning therapist because it requires a certain confidence, even a
Arousal Regulation

Couples are psychobiologically hardwired for interactive regulation (Beebe & Lachmann, 2003; A. Schore, 2001; A. N. Schore, 1994, , 1997, , 2002a, , 2002b; Siegel, 1999). The synchrony of interactive regulation not only describes a psychobiological function but it is also part and parcel of an intersubjective experience and process. This intersubjectivity incorporates what Sander calls moments of meeting, periods of resonance most often experienced while in a relatively relaxed and alert state (Sander, 1995). These synchronous moments give rise to mutually amplified positive affects or attenuation of negative affects, both of which provide incentive for remaining within the intersubjective orbit.

Interactive regulation operates in two distinct ways: for purposes of threat response (antisocial) and for purposes of mutually regulated stimulation and soothing (prosocial). Most couples come into therapy due to frequent and sustained periods of mutual dysregulation which eventually results in acute and chronic threat response and ultimately avoidance and even violence (Cordova, Jacobson, Gottman, Rushe, & Cox, 1993).

Because partners depend on one another for regulation of their own autonomic nervous system, and because interactive regulation is more efficient than turning to oneself for stimulation and soothing, this therapy approach reorients the couple toward managing one another's state of arousal, especially during conflict (Tatkin, 2003, , 2005).

Psychobiological regulation follows a developmental sequence beginning with external, continuous regulation by a more mature nervous system (e.g. mother). This leads to an integration of self-regulatory operations that set the stage for interactive regulation within a two-person psychobiological system.
Interventions are aimed and sequenced in the following manner: external regulation of the couple (triadic) ➞ external regulation of each partner (triadic) ➞ uninterrupted interactive regulation between partners throughout a full spectrum of positive and negative affective states (dyadic). In order to learn interactive regulation, partners must be face-to-face and attend to moment-by-moment facial and bodily cues involving subtle shifts in arousal and affect. During this period, partners maintain a close physical proximity to one another and must be able to sustain contact during periods of high or low arousal states (A. N. Schore, 1994). Partners must also be able to notice moments of misattunements or injury and be able to quickly make adjustments or repairs as necessary (Gottman, 1994; Tatkin, 2004).

Arousal regulation is of primary concern to the couples' therapist as most couples come in with some measure of dysregulation due to repeated interactions that lead to prolonged, intense states of hyperarousal or hypoarousal resulting in distancing, avoiding, and sometimes violence. This leads to a psychobiological threat response wherein both partners are in danger of being viewed as dangerous by the other. To a great degree, the couples therapist must address and contain issues concerning mutual dysregulation at the beginning of therapy and at various times throughout the entire therapeutic process.

Similar to Bowen’s approach to family therapy, the therapist acts as an external regulator for the couple, at least in the beginning (Bowen, 1978). He or she must remain present and relaxed enough to modulate tension and relief and not flood or neglect either partner. The autonomic nervous systems of each partner can pose a challenge to the therapist's equanimity. Very low, parasympathetic states (conservation withdrawal/dissociation/anaclytic depression/shame) can be as difficult to tolerate as can very high sympathetic arousal states (fight/flight/freeze). Being in the presence of a hyperaroused partner and hypoaroused partner, both in a threat response, may be even more challenging. It could be argued that the therapist's own ability to self-regulate while in the presence of intensely dysregulated states is the single most common determinate of therapeutic success or failure, more so than any other factor (skill,
experience, theoretical orientation). This raises another issue for another paper, and that is our training of therapists.

Initial sessions can be anywhere from two to four hours long, with multiple sessions throughout the week. If nothing else, time spent with the therapist acting as an external regulator can be enormously containing for the couple.

On the level of arousal regulation, the goal of treatment is for the couple to achieve an increased ability to interactively regulate across a full spectrum of potential arousal and affective states. More importantly, each partner should become an expert on the other. This means that each partner knows exactly how to calm and soothe the other in the quickest way possible and also be able to (appropriately) stimulate the other when necessary. Additionally, each partner should be able to notice and respond to injury whenever it arises and as quickly as possible. These increased skills in interactive regulation countervail fears of mutual dysregulation, leading to either hyperarousal or hypoarousal, threat responding, and avoidance.

**Attachment**

General attachment patterns are used as models for both understanding approach and avoidance behaviors as well as guidance toward interventions. An early attachment inventory is taken from each partner while in the room together. This serves two useful purposes: as an intervention in itself and as an informational tool for use at various times throughout the course of treatment.

This attachment interview, which should be conducted sooner rather than later, works best when starting with the most avoidant of the two partners. The interview often has a powerful (and softening) effect on both partners, sometimes even moving the most dismissive partners to tears. This entire process is case-building, or leading the patient to his or her injury. Some very important assumptions can then be made about that partner without appearing intrusive by making big leaps. These assumptions are focused in a particular way to bypass
defense and go right for the pain. In structure, this is very similar to a mirroring interpretation except not of narcissistic vulnerability, but rather of a condition of neglect and frightening aloneness. (As a side note, it is extremely helpful to view many hours of standardized Strange Situations covering a full range of attachment scenarios. Another but somewhat less useful viewing are the unedited Mahler tapes.)

The Strange Situation is a useful model for understanding various degrees of adult contact maintenance and proximity seeking problems under certain conditions of insecure or disorganized attachment. This model also leads to several interventions that point to repair and resolution of insecure attachment via the adult primary attachment relationship.

The attachment puzzle piece is extremely important as it focuses the work in two major ways (both informed by mother-infant attachment studies):

1) It provides a guiding principle that directs the couple to protect and preserve its safety and security system at all times from external, and especially internal threat.

2) It provides the therapist, and eventually the couple, with a tactical understanding of each partner’s specific internal working model which directs approach and avoidance behaviors, and more importantly, provides more specific clues about injury and repair.

We know the childhood experience of the dismissive/derogating/avoidant partner involves some measure of neglect; whether outright neglect, a continual dismissal of attachment needs, or rejection/devaluation of various emotional/arousal states (for example, some dismissing parents are intolerant of lower arousal states that include depression and shame). Regardless the type of neglect suffered, these children are invariably forced to rely on autoregulation for both stimulation and soothing. They lack the continuity of interactive regulation

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1 Alan Sroufe’s program is a good place to start. (Contact the Minnesota Longitudinal Study of Parents and Children research lab)
2 Contact the Mahler Research Foundation for these tapes.
enjoyed with an autonomous (adult) attachment figure and instead turn to
themselves too often and for too long a duration. Bouyed by a false sense of
autonomy, his or her dependency needs are denied; “no one can give me
anything that I can’t give myself” is the credo.

The avoidant's nervous system reacts to forward or approaching cues by
tensing, pushing away, or repudiating attempts at influencing them. These are
reflexes that, in large part, react to perceived intrusions upon their reliance on
autoregulation. The therapist must connect early (and accurately) with the
suffering that plagues the avoidant adult. This is the only way to deal with the
ego-syntony of the avoidant’s defensive structure.

Most often the dissatisfied partner is the more angry/resistant of the two. The
avoidant scenario is a more total denial of dependency so that individual is less
likely to complain about failures of interactive regulation because they really do
not want any part of it anyway. Their reliance on autoregulation (a one-person
psychological system) circumvents any distress he or she would feel if aware of
his or her dependency needs. On the other hand, the angry/resistant scenario
more resembles a two-person psychological system, so there is more acceptance
of dependency but also increased frustration resulting from frequent failures at
interactive regulation (interactive dysregulation) which result in breaches of the
attachment system.

If the avoidant relies on autoregulation which, by definition is a turning away
from the primary attachment object, the ambivalent/angry/resistant relies on
interactive regulation but it is one way and not truly interactive. For instance, the
angry/resistant child is allowed to interact with the primary attachment figure but
the interactions all too often result in frustration and punishment with little or no
repair. Quite differently, the avoidant child may not be invited or even allowed to
interact with his or her attachment figures. The angry/resistant’s attachment
history often involved frequent breaches in the attachment system resulting in
relational trauma. In the adult attachment relationship, interactive regulation
during periods of distress often trigger a threat response with the anticipation of
an empathic failure, frustration, criticism, punishment, and/or withdrawal.

Because interactive regulation results in interactive dysregulation, the belief often
held by the angry/resistant individual is that the only way out of the dilemma is to separate (cut-off) and simply not depend on anyone (Titelman, 2003).

Partners of a secure primary attachment relationship maintain and protect the safety/security system that allows them to exist within the dyadic orbit. A primary goal in the attachment puzzle piece is to eliminate all threats to the couple's safety and security system which includes the use of threatening words and phrases, the use of threatening facial expressions, vocalizations and sounds, and the use of threatening physical behavior. Additionally, a sufficient capacity must be developed that will enable each partner to detect injury as it emerges in the other partner and be able to make quick and effective repair.

On the level of attachment security, the goal of treatment is to create an awareness of each partner’s early attachment patterns and the reflexive, psychobiologically driven defenses unique to those patterns.

As we move onto other puzzle pieces, it becomes clear that discussion of the attachment piece cannot be isolated from the arousal regulation piece. The two areas fundamentally overlap, implicate, and influence one another.

Developmental Neuroscience

Awareness of the developmental neuroscience puzzle piece is central to understanding the other pieces. It is an area that underlies and bridges attachment and arousal regulation. A psychobiological approach to couples therapy deemphasizes the role of verbal content and emphasizes somatosensory experience of implicit systems. Development of social-emotional faculties has been repeatedly associated with right hemispheric specialization and limbic integration with the ventromedial prefrontal cortex (Adolphs, 2001; Damasio, 2000; A. N. Schore, 1994, , 1997, , 2002a, , 2002b, , 2002c). The therapist focuses upon right brain functional integration of moment-to-moment experience.
Far less emphasis is placed on left brain verbal integration and expression or on callosal crossings between right and left hemispheres.

Because this model focuses away from conflict and onto deficit, or from left brain to right brain processes, it is important for the therapist to understand the neurobiological deficits that underlie a couple’s ability or disability with regard to interactive regulation.

For instance, an alexithymic partner, that is, one who does not know what he or she is feeling, will obviously have a difficult time reading and responding to his or her partner’s affective state, and state shifts. Organic causes aside, alexithymia has been described as a functional (and sometimes structural) deficit in right brain, frontolimbic circuits (Larsen, Brand, Bermond, & Hijman, 2003). In other words, the alexithymic partner’s ability to read somatoaffective, interoceptive cues is significantly impaired and as such is affectively blind. This understanding may lead the therapist to work with this partner on a somatosensory level and in a more elementary manner. At the same time, the therapist may need to bolster the other partner’s self regulatory capacity while literally in the face of an under-responsive mate.

The Couples Therapist Must Understand That There Are Structural and Functional Neural Correlates of Behavior

Amygdala activation is complicit in all forms of dysregulation. However in cases of early relational trauma, amygdala hyper-reactivity is implicated along with hypo-reactivity of the ventromedial and orbitofrontal cortices (Donegan et al., 2003; Driessen et al., 2004). The psychobiologically informed therapist must be concerned about each partner’s ability to \(^3\) wait, watch, and wonder about the mind of the other. This capacity points to an orbitofrontal function which may be more or less developed in various partners, especially in cases where there has been early neglect and/or abuse. The therapist must build this function in couples where there is a deficit in orbitofrontal functioning. This will be observable in partners who cannot wait, who interrupt, who lack empathy or a moral sense of

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\(^{3}\) This refers to the wonderful program implemented by the Muir’s at the Hincks Institute in Canada.
Another concern is the capacity of the orbitofrontal cortex to regulate the amygdala rather than be regulated by it (a major cause of misappraisals). In cases of borderline psychopathology, the latter is often a problem (Henry, 1997; Meyer, Pilkonis, & Beever, 2004; Wagner & Linehan, 1999). Yet another concern is the capability of each partner to recover from hyper- or hypo-aroused states. This capacity rests upon the employment of either the dorsal or ventral vagal system as well as the orbitofrontal and ventromedial prefrontal cortices. The difference between good and poor functioning of these systems will dictate each partner's ability to recover quickly from dysregulated states and determine whether or not that partner can calm down or be stimulated upward and out of a deep conservation withdrawal state. The therapist must track each partner's ability to self regulate and look carefully for problems involving recovery and overreliance on autoregulation. Since this therapeutic approach is primarily a right brain process, interventions will necessarily be focused on somatoaffective experience. This is in part accomplished through therapeutic manipulation of somatosensory experience through the use of body movement, body placement and physical proximity in order to trigger psychobiological reactions to visual, auditory, olfactory, tactile, and maybe even gustatory experience (Ogden & Minton, 2000). Because the visual stream provides vital co-regulatory information, partners are often directed to maintain eye contact while in conflict with the other.

The clinician should take into consideration attachment stress and the psychobiological difficulties in adapting to that stress, a process known as allostasis (Schulkin, 2004). Early chronic attachment stress has been linked to relational trauma, sometimes referred to as ambient trauma, and as such has been considered a form of PTSD that appears in adult attachment relationships (McEwen, 2004; van der Kolk, McFarlane, & Weisæth, 1996). Symptoms include dissociation, acute/chronic affect dysregulation, biphasic cycling of the arousal system, and poor recovery from sympathetic and parasympathetic states. If untreated, a kindling effect accelerates the pathogenesis of axis I disorders and a
whole host of autoimmune diseases, the latter of which may be due to allostatic load which is considered to be the sum total price of adaptation (hormonal burden) over the years (Bracha, 2004; Panksepp, 2001; Scaer, 2001). In theory, the therapist may actually help couples increase allostatic support within the couple system, which may in turn increase the couple's resilience to external stresses such as children, other family members, finances, and employment issues.

In summary, there is a direct link between developmental neuroscience, affect and arousal regulation, and attachment formation. The therapist must integrate these three areas when assessing couples, planning treatment, and constructing interventions. The treatment goal in this puzzle piece is to shore up neurobiological deficits, often but not always due to early neglect and/or abuse by primary attachment figures. By working with individual partners on self regulation and eventually on the couple's ability to interactively regulate, the therapist works to reduce allostatic load and increase allostatic support for each partner.

### Therapeutic Enactment

Therapeutic enactment is the important fourth puzzle piece of this approach to couples therapy. Attachment systems and psychobiological right brain processes of autonomic nervous system regulation are experienced-dependent, thus the work must necessarily focus on real-time enactment of dysregulated, state-dependent interaction. This includes manipulation of proximity and contact between partners as well as a distinct focus on somatosensory, somatoaffective moment-by-moment experience. The therapist directs the couple to discuss "areas of importance" or conflict in order to enact dysregulated states brought about by poor interactive regulation. This becomes the essential area of therapeutic play within the treatment landscape.

The therapist should utilize therapeutic enactment only when the couple has stabilized enough to tolerate it. This is another reason to schedule long
sessions. The therapist should provide enough time for the couple to cycle through a variety of arousal states before sending them home. He or she should help put the couple "back together" prior to the end of each session and try to remain thoughtful about the time the couple spends between therapy sessions. Depending upon the amount of dysregulation, the therapist might recommend more frequent sessions.

During therapeutic enactment the therapist asks the couple to address one another for about 10 to 15 minutes about an "area of importance." (See figure 1)

![Figure 1](image)

These are usually resolvable or unresolvable issues around which they disagree. The therapist watches for a number of things, only one of which is the couple's ability to interactively regulate without having to break off early. The therapist will feed back to the couple what he or she has noticed, particularly within the realm of arousal management. Video feedback can be a powerful tool if used properly and at the right time. A DVD recording system works best for several reasons. It allows for immediate playback without having to rewind or fast-forward, it is easily archive-able, and can easily be shredded for confidentiality. In addition, many DVD recording systems will allow the operator to inconspicuously mark or index significant moments for playback.

In the beginning of treatment, the therapist may work with only one partner as an external regulator to bolster that partner's ability to self regulate while in
conflict. The therapist will work with the "listening" partner while the other one complains, and track that partner for shifts in arousal/affect. (See figure 2) The purpose is to help him or her stay present and relaxed (in mindfulness terms, awareness and equanimity) especially when hearing threatening words, phrases, and vocal sounds, or when seeing a threatening face. This process allows the therapist and that partner to work closely with the threat response that becomes activated during conflict.

Figure 2

Dysregulated couples must learn how to tense and relax during conflict. The ability to move in and out of tension is a hallmark of interactive regulation. The couple maintains a parasympathetic tone that provides enough relief to the couple system (initiated by one partner or the other) which enables partners to continue their "fight" without becoming flooded and/or defeated. Regulated interaction becomes a digestive system that allows for the metabolizing of painful experience without triggering a threat response (the fight-flight-freeze response quite literally disables the digestive system). Those familiar with John Gottman's work may think of negative sentiment overrides, accepting influence, and repair as examples of possible relaxation (Gottman, 1999). Ultimately the therapist doesn't care how partners provide relief to one another during periods of tension, just that they do it and do it effectively. When effective one can experience a quick down-regulation of the couple system which can then return to a state of tension. Couples lacking in this ability may benefit from psychodramatic
techniques such as doubling, whereby the therapist speaks for a partner. This can be an effective way to demonstrate different methods of repair utilizing the quickest and most direct path. The therapist must help couples reorient their approach to conflict by convincing each partner that the immediate putting out of emotional fires is an absolute priority if either expects to move forward without turning away.

During therapeutic enactment, the therapist can intervene when noticing contact resistance and proximity avoidance with either partner. The therapist may choose to move one partner or the other forward, return his or her gaze toward his or her partner, or maybe have one partner placed a hand on the other partner's hand during conflict. These are methods that may result in very quick and very dramatic shifts in the arousal system of both partners. Of course, these techniques should be done carefully and cautiously. In keeping with the idea of alternating tension with relaxation, the therapist is attempting to encourage play states even during conflict.

In closing, the adult primary attachment relationship does in fact have a purpose. Like the mother-infant dyad, the adult romantic relationship resides both in a fixed and suspended space-time continuum. As such, repair of attachment insecurities is a responsibility partners must undertake regardless of when and by whom such injuries occurred. The past is inescapable and the future of both partners rests in each other's stewardship of the safety and security system. The couple is a psychobiological system with each partner depending upon one another for regulation of their autonomic nervous system. Their ability to do so may determine the success or failure of their relationship.

The couples therapist must counter some of the myths regarding independence and self-reliance that have become prevalent in American culture, particular those that have affected marriage. Two is better than one, and interactive regulation is the preferred mode of human functioning, just as it has been since the beginning of time.

Around primary attachment relationships do all things revolve, even marital affairs, which may appear as a turning toward the outside when it is in fact a turning away from the frightening, centrifugal force of dependency. Home is not
a physical place. Rather it is an intersubjective space within which partners reside and from which each derives energy, vitality, comfort, relaxation, and valuation.

The primary attachment relationship, even in its worst condition, contains the greatest potential for helping individuals overcome addiction, insecure attachment, relational trauma, and developmental delay. A therapist who believes this to be true can provide powerful guidance and hope to the couple in distress.

Good luck with your couples.
References


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*Psychologist-Psychoanalyst: Division 39 of the American Psychological Association, XXV*(No. 1), 20-22.


