In nature we can see and hear the ocean waves as they swell, crest, and crash, rushing forward and then receding backward. An experienced surfer rides the waves and gracefully balances while rising with the swell and crest, and then just as gracefully lands with the wave’s denouement. Similarly, we can see and hear trees as they sway back and forth with the wind, and we can feel the wind blowing us this way and that. A hang-glider rides the wind currents, gracefully balancing with and against the forces moving upward and downward.

The ocean waves and blowing wind can be compared to arousal, a force of nature that rises and fades, that pushes us forward or holds us back, or that knocks us over and causes us to lose our balance. As with the surfer and the hang-glider, our ability to manage these forces gracefully and in a balanced manner can make the difference between pleasure and misery. Depending on our ability to regulate arousal, we either joyfully and effortlessly master the forces of arousal, or fly out of control until we crash.

_Arousal_ refers to specific brain–mind–body states that are products of various systems and processes. The _sympathetic_ branch of the autonomic nervous system (ANS) influences emotions, produces vitality states, and generates action-readiness; it does so in tandem with the neuroendocrine system, in particular, the hypothalamic–pituitary–adrenal (HPA) axis, which churns out adrenaline. The _parasympathetic_ branch influences emotions, produces relaxation states, and
generates a recovering counterresponse to sympathetic activation; it
does so in tandem with the vagal motor complex and the HPA axis,
which manufactures corticosteroids (cortisol). (For further details,
see Part V.)

When the ANS is functioning optimally, we are able to remain
both alert and relaxed at the same time, without creating too much
action readiness and subsequent recovery readiness. In other words,
a well-running system is economical: It never expends too much
unnecessary energy, and so saves us from too much unwanted
downtime. A state of optimal arousal in the ANS modulates the neu-
roendocrine production of adrenaline and corticosteroids, keeping
us from spending too much of either substance. Optimal ANS arousal
also affects the amount of available oxygen and glucose metabolism
in the brain, which in turn determines our availability to process
and respond to experience (Beneli, 1997; Burleson et al., 2003;
Eagle et al., 2007; Iacoboni et al., 2001).

THE NUTS AND BOLTS OF
AROUSAL REGULATION

Arousal regulation is the process of managing our arousal states and
the transitions between them. Arousal can be regulated both inter-
ally, by automatic (nonconscious) and voluntary (conscious) means,
and externally through the intervention of significant others in our
environment. All automatic internal regulatory functions are performed
by subcortical areas. These are the lower limbic structures (e.g., the
amygdala, hippocampus, and hypothalamus) as well as the mid-
brain, brainstem, spinal cord, and dorsal vagal motor pathway. The
ANS is responsible for nonconscious arousal regulation (e.g., faint-
ing, falling asleep, waking up; perhaps even turning away from a
disturbing person, scene, or sound). Voluntary internal regulatory func-
tions are performed by higher cortical areas. These include the fron-
tolimbic structures—the ventromedial prefrontal cortex, orbitofrontal
cortex, anterior cingulate, insula, and ventral vagal motor pathway.
Without a functioning prefrontal cortex, one would have to rely ei-
ther on automatic internal controls or on external controls such as
another person or medication. Children and adults with attention-
deficit problems often depend on psychostimulants such as meth-
ylphenidate (Ritalin) or dextroamphetamine (Dexedrine) to activate the frontal lobes, which restore self-regulatory capacities.

Many voluntary regulatory strategies are available to us. We can, for instance, take a deep breath when we get too excited, sending a parasympathetic volley to the heart that helps us calm down by reducing our heart rate and increasing oxygen to the brain. We can use distraction or other refocusing methods to adjust our state either upward or downward. We also have higher-level adaptive strategies at our disposal, such as meditation, exercise, going to a movie, reading a book, or calling a friend; we can talk to someone when we are hurt, angry, sad, or fearful, aiming to down-regulate our arousal through self-expression. Alternatively, we can employ lower-level adaptive strategies, such as the use of alcohol, drugs, sex, violence, or any number of other behaviors, to adjust our state of arousal.

External regulatory functions are first performed by our earliest attachment figures, through skin-to-skin, face-to-face, vestibular, and prosodic interactions. Later on, friends, teachers, lovers, doctors, and others may fulfill external regulatory functions. Pharmaceuticals and street drugs provide external regulation, too, in the sense that they at least begin as external agents of state change. The psychobiological approach to couple therapy is particularly concerned with the external regulatory role of the adult primary attachment partner.

From a self-management perspective, we move from an automatic, inflexible, nonconscious level to a purposeful, flexible, conscious system of self-regulation, the latter being better suited to creating and maintaining social contracts based on fairness and mutuality. We begin to incorporate rudimentary self-regulatory functions at around 10–12 months of age, when our orbitofrontal cortex comes online (Schore, 1994, 2002c); the process continues throughout childhood. Impulse control and frustration tolerance are orbitofrontal, self-regulatory functions that are not fully completed until frontal lobe development reaches its pinnacle in early adulthood. As noted, we learn to self-regulate with the help of our first external regulators, our primary caregivers. Our young self-regulatory system is a fractal representation, or duplicate, of theirs. So, constitution and genetics aside, we are only as good at arousal regulation as were our earliest external regulators. Thus, if our primary caregiver was an effective modulator of his or her own feelings of anxiety, fear, anger, and excitement, we tend to become effective in turn.
An infant or child may be either wholly or partially neglected or otherwise deprived of good external regulation by a caregiver. In many such cases, certain mental, emotional, or bodily states are dismissed, discouraged, or devalued. When both parents consistently avoid a particular arousal or affective state, children must avoid or regulate these states on their own. The result is a poorly managed internal experience that can later produce negative social consequences.

For example, a young man comes from a family that has always favored the lower ranges of arousal, preferring quiet, low expectations and no drama from its members. Excitement of any kind was discouraged by both parents. Sympathetic arousal or intensity, positive or negative, was not a part of the family culture. Growing up, the young man stayed away from high-intensity friends but briefly dated a rather animated girl during senior year of high school. He found her liveliness attractive but intimidating; much to his dismay he could not tolerate her passion, especially when directed at him. He withdrew from any interactions that could have resulted in elation, joy, or desire, and instead swiftly shut down. For this young man, excitement or anything nearing excitement represented an unregulated and therefore unmanageable, state.

In adulthood his bride-to-be is similar to his high school girlfriend, and in fact struggles with the same problem but on the opposite end of the arousal spectrum. She’s a master of high vitality states but avoids the lower range: repose, satiation, sadness, and depression. Together they form a biphasic couple—that is, one partner prefers higher sympathetic states and the other prefers lower parasympathetic states. In couple therapy, the task is to help him regulate (or tolerate) higher states and her the lower ones. As primary partners, each is in the best possible position to help the other, at least potentially. Each is also in the best possible position to hinder the other, and that is often the most likely outcome without the help of a psychobiologically oriented couple therapist.

From a developmental perspective, each individual should be moving toward complexity—from self play to interactive play, from autoregulation toward interactive/mutual regulation. In couple therapy, we are concerned with the developmental state of each partner’s prosocial capacities, which affect his or her ability to function at the highest levels of self-management within a relationship.
AUTOREGULATION

Autoregulation is the earliest and simplest level of arousal regulation. It is an insular, automatic process that requires little internal resource because it is non-interactive on an interpersonal level. For example, gaze-aversion is an infant’s autoregulatory strategy for gating stimulation and calming down. The infant will make eye contact with its caregiver but will eventually avert its gaze because eye contact is highly stimulating. If the caregiver becomes intrusive after the baby averts his or her eyes and tries to “chase” the gaze, the baby will feel defenseless against the overstimulation and turn to other, more drastic autoregulatory strategies (ducking away, arching its back) or resort to dissociation.

Autoregulation, in terms of a psychobiological approach to couple therapy, is a do-it-yourself management strategy for calming and stimulating oneself. Initially, it is internal, primitive, and non-relational: the infant sucks its thumb to pacify itself, the toddler carries a blankie or other transitional object for self-comfort, the young child self-entertains with toys, the teenager gets excited by romantic fantasies. But autoregulation also entails more conscious, non-reflexive activities—watching TV, reading, eating, drinking, or drugging, spacing out, obsessing, meditating, surfing the Internet, playing video games, and so on. On the creative side, autoregulatory behaviors can include dancing, singing, playing an instrument, writing, and painting, as long as they are non-relational in the sense that another person is not required. They allow us to regulate our degree of stimulation without the element of interpersonal stress.

How we experience autoregulation is influenced by our attachment orientation. Interaction with another person generally requires more internal neurobiological resources, so for avoidant individuals, autoregulation is predominantly energy-conserving; reliance upon it over time consolidates a one-person psychological system of non-mutuality. The pleasantly dissociative state it confers allows for a blissful, focused unawareness of space and time, reminiscent of infant play states in which self-stimulation and self-soothing are unencumbered or interrupted by anxiety or insecurity. In the case of angry-resistant persons, however, the opposite prevails: For them, extended periods of noninteraction with primary figures leads to intensely dysregulated states; autoregulation for them demands high
energy-expenditure, particularly when making the shift away from interaction.

It should also be noted that autoregulation can be employed in pseudo-relational interactions with other individuals, as occurs in some psychiatric and personality disorders. For instance, relationships of narcissistic personalities involve using others as mere extensions of the self, not as separate real persons (Kohut, 1977; Lichtenberg, 1991; Winnicott, 1969). In this sense, narcissistic-disordered individuals appear to be regulating interactively with others, but are in fact autoregulating—using others as objects of self-stimulating and self-soothing.

INTERACTIVE REGULATION

Interactive regulation is the process whereby at least two individuals comanage and dynamically balance ANS arousal in real time. Developmentally, interactive play by infants with their primary caregivers forms the foundation for mutuality and reciprocity. When interactive play does not take place, infants turn instead toward autoregulation as an adaptation to interpersonal neglect. They do so at great cost, remaining in exile from the interactive world as they grow older.

Whereas autoregulation is fundamentally self-absorbed, internally focused, and pro-self, interactive regulation is fundamentally interpersonal, externally focused, and pro-relational. An individual’s reliance on autoregulation (one way, do it myself) or external regulation (one way, do it for me) is a sign of a one-person psychological orientation that is rooted in nonmutuality. Reliance on interactive regulation (two way, we do it for each other), on the other hand, points to a two-person psychological orientation that is rooted in true mutuality.

Attunement is the feeling of being on the same page, in alignment, or in synchrony—the feeling that launches primary attachment relationships. Attunement produces a sense of safety and security as well as attraction and is sustained by a couple’s capacity to remain predictable and friendly on a micromoment basis. (Micromoment refers to the subcortical speed at which people appraise and respond to social situations; that speed is roughly between 30 and 300 millise
Moments of misattunement between otherwise attuned partners are quite unpleasant. Reactions are reflexive and instantaneous and therefore cannot be fully controlled; once expressed, they cannot be taken back but should be repaired posthaste. Although skillful couples will quickly reattune without much awareness of what they are doing (awareness of misattunement lags behind the primitive operations already in motion to protect the couple from danger), discomfort will increase if partners take longer than usual to error-correct. Misattuned moments can spike partners’ arousal in either the hypo or hyper direction, and too many such moments, without repair or error-correction, lead to an amplification of negative experience and a sense of threat. So in the region between misattunement and reattunement, time is not on the couple’s side. In fact, when it comes to regulating rapidly increasing or decreasing arousal, time is of the essence.
Extended periods of misattunement between two people increase the likelihood of extreme arousal states, which in turn increase the likelihood of the internal and mutual mismanagement of those states. In other words, as arousal gets out of hand, couples move from love to war. The term dysregulation describes the somatoaffective, neurobiological condition that involves extreme negative alterations of the brain, the mind, and the body. In layperson’s terms, dysregulation is equivalent to “freaking out.”

CAUSES OF DYSREGULATION

Infants depend on their caregivers for help in regulating their internal states. The process is an exquisitely delicate and finely tuned collaborative dance. When the caregiver is too intrusive, too unresponsive, too reactive, or too preoccupied to maintain relational equilibrium with an over- or understimulated infant, however, errors or missteps occur. Normally, they are met with the caregiver’s corrections and adjustments. However, when a caregiver cannot or does not correct or adjust, producing extended misattunement that goes unrepaired, the result is dysregulation of the infant’s internal state.
This isn’t to say that dysregulation is always caused by a caregiver. On the contrary, similar problems can occur when the internal world of an infant or young child is one of constant physical agony (e.g., in the case of colic, acid reflux, or other constitutional issues). The child’s intense and continuous distress signals pave the way for mutual dysregulation due to the caregiver’s inability to adequately soothe or comfort the distressed child. A child who is experiencing acute or chronic pain could present a regulatory challenge for any caregiver.

On an affective level, a parent’s anger can become dysregulating when it becomes too intense and lasts too long. Frequent, extended outbursts of rage on the part of the father, for example, can negatively affect every nervous system in the family such that everyone becomes dysregulated along with him: A son rages in response, a daughter leaves the house, the mother cries and begs the others to stop; the younger girl keeps to her room and destroys her dolls and grows up to be fearful, disorganized, disoriented, and hyperaroused whenever she feels or encounters anger. Indeed, repeated frightening parental behavior is known to cause disorganization and disorientation in children (Cassidy & Mohr, 2001; Holmes, 2004; Lyons-Ruth & Spielman, 2004; Main & Hesse, 1990; Main & Solomon, 1990).

Attachment insecurity and dysregulation go together. The more insecure a partner, the more likely psychobiological dysregulation will appear as a regular feature in the couple system. This is ever so much more the case when both partners are further along the insecure attachment spectrum. Many insecure partners come with a history of unresolved trauma or loss: Their pockets of unmetabolized, painful experience can emerge under stress and increase instances of dysregulation. Because relational experience is interwoven with anticipatory systems such as the ANS and HPA, it not only profoundly affects one’s attitude but also configures one’s biology on a structural and functional level. Primary attachment relationships, whether characterized by sensitivity, insensitivity, or frightening unpredictability, powerfully alter the brain, mind, and body on the cellular level, even affecting DNA and gene expression (Schore, 2002a, 2002b; Cappas, 2005).

Individuals with unresolved early relational trauma, PTSD, or a chronic neuroendocrine response to threat are vulnerable to amyg-
Dysregulation

dala hypertrophication and hippocampal atrophy (McEwan, 2003; Vyas, 2003, 2002, 2006; Tebarz, 2000). Individuals such as these become organized around trauma, fear, and aggression. There is some evidence to suggest that mothers under high stress affect the prenatal neurobiological development of their infant, which is preparing for a stressful environment (Davidson, 2008; Cottrell, 2009; Pardon, 2008; Oitzl, 2009).

Individuals with overgrown amygdalae and shrinking hippocampi may be prone to paranoia or an overly pronounced perception of threat and seem somewhat disoriented and unable to properly sequence events in time and space (a function requiring the hippocampus). High chronic stress, also a result of insecure attachment, leads to an overproduction of adrenal products, causing overpruning of cells during childhood and adolescence and neurotoxicity in adulthood (Schore, 2005; Teicher, 2002; McEwen, 2003, 2001, 2000).

In early development, attachment security also affects parasympathetic tone, which reflects the body’s ability to relax and recover. Directed by the vagus nerve, parasympathetic tone is responsible for cardiovascular down-regulation and modulation of sympathetic arousal states. Insecurely attached children and adults may experience lifelong problems with impulse control and sympathetic acceleration (disinhibition) tendencies and poor vagal brake (inhibition) function.

Dysregulation between partners occurs in response to an intense and/or lengthy breakdown of interactive regulation. Intensity and duration are two dimensions of arousal involving negative emotion, and they correlate with dysregulation. Intense negative experiences of short duration are of little consequence, as are mildly or moderately negative experiences of longer duration. However, intensely negative interpersonal experiences of long duration lead to overwhelming interpersonal stress, resulting in relational trauma and a breach of the safety and security system. This breach leads to a threat response, a drive to get away from the object “causing” the stress.

Dysregulated couples’ reactions can occur anywhere along the insecure spectrum and may include features of uncontrollable arousal, intense affect, poor recovery, dissociation, and significantly compromised information processing. Partners lack either skill or capacity to self- or mutually regulate along the middle ranges of the arousal spectrum. Collectively, they are unable to maintain prosocial
LOVE AND WAR IN INTIMATE RELATIONSHIPS

levels of arousal (i.e., those in which higher cortical areas are oxygenated and available for contingent responsiveness) and avoid re-active extremes—either fight/flight/freeze (sympathetic, associated with hyperarousal) or energy conservation/withdrawal (parasympathetic, associated with hypoarousal). In extreme states of arousal, the brain and neuroendocrine system undergo changes that support self-survival away from prosocial values and behaviors. In other words, during hyperarousal or hypoarousal, brain activity is limited to more primitive, subcortical processes dedicated to survival of the organism, first and foremost.

A couple becomes dysregulated when either or both partners fall outside of the social range of arousal (Porges, 2001) and are unable to reregulate downward or upward. Negative emotions become amplified. Behaviors related to hyperarousal tend to be overly expansive (e.g., mania, rage, terror, aggressiveness, grandiosity), and behaviors related to hypoarousal tend to be overly constrictive (e.g., dissociation, anaclitic depression, incapacitating shame, deadness).

HIGH-AROUSAL COUPLES

In high-arousal couples, both partners have biases in the high sympathetic range of the autonomic nervous system. Their arousal profile, which is remarkably stable and predictable, shows an excess of shared high positives and high negatives. The high positives can be attributed to their mutual preference for sympathetic states that include vitality affects such as excitement and mania, but also rage and terror. Their high negatives can be attributed to their shared avoidance or intolerance of low parasympathetic states that include affects such as sadness, grief, depression, and shame. Neither partner is equipped to interactively regulate painful affects; thus the calming and soothing function is missing in the couple. Commonly, both partners in such couples are angry-resistant—so, despite their fiery relationship style, they tend to stick together because of a strong clinging defense.

High-arousal partners have an extraordinarily rapid rate of kindling for anger and rage and typically accelerate into hyperarousal at the drop of a hat. Like the starting of a fire, the kindling effect refers to
activation of a system or sequence that leads to a biological, emotional, or psychological condition such as a seizure, depression, anxiety, panic, or a bipolar episode, especially upon recurrence of that condition. For instance, untreated depression may lead to future kindling of depression (Ferrando & Okuli, 2009; Fries & Pollack, 2007; Scaer, 2001).

When together, they are quite possibly on the upper boundaries of social arousal much of the time. The rapid kindling effect cuts both ways: They seem equally prepared for war as for passionate sex and can sometimes quickly shift between the two. Interestingly, many high-arousal partners have backgrounds of substance abuse, with a higher-than-average preference for stimulants, alcohol, and marijuana. (Nevertheless they are often resistant to controlled psychopharmacological intervention.) The couple therapist should always check for a history of legal and illegal drug use and a history of head trauma, and should also be alert to the possibility of frontal lobe impairment. (The almost complete disinhibition of the holding and waiting function may, among other things, be attributable to ventromedial prefrontal dysfunction.)

Because high-arousal partners lack impulse control, they continually “forget” about holding and waiting (impulse control), and their acceleration (disinhibition) tendencies and poor vagal brake (inhibition) function challenge the therapist, who would prefer to limit or interrupt in-session fighting. Once started, these embattled couples will not be stopped until they are good and ready; the therapist must wait to resume interaction with the couple until their arousal wanes.

Clinicians who are uncomfortable with high-intensity anger will find themselves holding onto their seats with high-arousal couples. Others will feel variously helpless, frustrated, impatient, and even bored: The repetitive rants can be exceedingly dull as well as discouraging. High-arousal couples do improve, but progress is slow: Although the capacity for self- and coregulation should improve with age and the developing complexity of the brain, mind, and body, arousal biases are not easily amenable to change (pharmaceuticals aside). As is the case with attachment structures, however, the goal is not to change partners’ arousal biases but to make their primary attachment relationship secure.
LOW-AROUSAL COUPLES

Low-arousal partners are biased at the low parasympathetic range of the ANS. Most often, both are avoidant. Their arousal profile shows a predominance of low mutual positives and low mutual negatives. The low positives are mostly due to their lifelong avoidance or intolerance of high sympathetic states (including vitality affects such as joy, ecstasy, or passion); because of this pattern, neither partner comes to the relationship equipped to interactively regulate high positive affects. The low negatives can be attributed not to skillful interactive regulation of painful affects but to limited interactive demands and a mutual preference for autoregulation. Low-arousal couples tend to keep the volume low on arguments . . . and everything else. Nevertheless, these couples are chronically anxious. Their anxiety seems to be a function of insecure avoidant attachment during infancy. They are unheld babies who literally have no internal method for calming themselves down, particularly during periods of inactivity and quiet, at nighttime and in the morning. Sleep disturbances are common among these individuals, as are symptoms of obsessions, compulsions, and hoarding.

Low-arousal couples appear rudderless at times as if waiting for instructions from a parent. For this reason, these couples often over-focus on daily tasks and organizational difficulties, the content of which can become compelling and distracting for the couple therapist. Their avoidance of interactive regulation, mutual dependency, and physical and emotional intimacy may convince the therapist that their management concerns are most important. As partners they appear stalled and clueless, often fluctuating between needing help and refusing it. Since they are avoidant, they are single-thinking in their orientation, often expecting themselves and the other to do things alone and without assistance. Yet neither does anything very well alone, so they make promises they cannot keep.

One can imagine two avoidant, low-arousal partners stuck outside in a snow storm, sitting apart and freezing to death, neither realizing that together they could generate enough heat to keep warm. Because of that inability to recognize valuable resources “right under their noses,” they perish. No matter how intelligent these folks are, their one-person psychological system of nonmutuality keeps them in an eternal state of neglect and aloneness. But because they are
low-arousal, they operate under conditions of low interpersonal stress and so remain separate, together.

**BIPHASIC COUPLES**

Some dysregulated couples display biphasic features, whereby one partner exhibits a preference for higher sympathetic states and the other partner exhibits a preference for lower parasympathetic states. Collectively, they appear bipolar. Because biphasic couples argue primarily over misattuned interactions, particularly at reunions—which can occur many times during a day, even as partners go their separate recreational ways (one to the television, one to the computer)—therapists may come to feel frustrated and hopeless about helping them.

Therapists may also begin to harbor split feelings, negative or positive, toward one or the other partner, and might experience a strong countertransference in line with the couple’s own suspicions that they are mismatched and wrong for one another. Of course, these couples, like all others, are not so much mismatched as unprepared to manage their opposing arousal biases, which amounted to a lesser problem during courtship when extended undistracted time together probably facilitated an averaging out of their extremes.

**WHAT TO WATCH FOR**

Therapists can identify dysregulated states in couples by observing changes in partners’ voices, gazes, movements, facial expressions, breathing patterns, skin color, and so on. In a case of hyperarousal, the voice may change in pitch (up), volume (up or down), and tone (sharper); skin may become reddened and tauter; movements may appear faster, jumpier, arrhythmic, and menacing; the body may appear more rigid and constrictive. In hypoarousal, the voice may change in pitch (down), volume (down), and tone (dead); skin may become blanched and flaccid; movements decrease and slow; the body may appear collapsed or crumpled; the posture may suggest surrender and hopelessness or even nausea.

Therapists can also watch for signs of dysregulation in the cou-
ple’s interactions. What distinguishes dysregulated couples from those merely in conflict is that they do not have the ability to coregulate during times of strife. If they were standing in a boat together, they would not be capable of balancing it, as a result both would land in the water.

Regulated couples are able to go in and out of conflict, to tense and relax, without ever pushing either partner into hyperarousal or hypoarousal. These couples maintain a sense of play, whereas dysregulated couples do not. Well-regulated couples know how to hold on and let go; dysregulated couples do not. Well-regulated couples recover quickly from occasional spikes in their arousal system; dysregulated couples do not.

When dysregulated partners begin talking about an area of importance (something around which they argue), their interaction devolves into warring behavior: They interrupt each other, use dangerous words and phrases, and repeat the same arguments. One of the surest signs of incipient dysregulation is content-spreading, which is a branching out of complaints against another person. The growing litany of complaints is a symptom of interpersonal distress or injury in wait of repair. Therapists can be sure arousal is increasing and dysregulation is imminent when partners start adding to their complaint list or bringing up the past or bringing up other people (kids, parents, friends) to bolster their arguments.

Dysregulated couples typically do not hold, wait, or balance expansion and contraction, at least not very well. Holding, waiting, and limiting expansiveness are vital self-regulatory, executive functions of the right orbitofrontal cortex, an area of the brain that shuts down in situations of hyper- and hypoarousal. (In some cases the inability to hold and wait may point to a real neurobiological deficit.) The therapist must help the dysregulated couple regain and increase their capacity for holding and waiting if the therapy is to move forward. Effective interventions include those that have a regulatory impact on the couple system. One such intervention is the therapist’s expectation that partners exercise their capacity to hold impulses and wait their turn, as well as limit the duration of the turns they take, because long narratives create flooding in the waiting partner.

While couples are in the throes of a threat response, hierarchical processes involving the prefrontal cortex give way to subcortical
Dysregulation processes to ensure survival. During these periods of dysregulation, the ability to accurately represent and sequence events is highly compromised; so too is the ability to appraise intention. Yet insecure couples often become entangled in arguments involving the reconstruction of past events. In the clinician’s office they will present wildly differing recollections as to content, sequence, and intent, and will remain locked into a painful, isolated reality of violent misattunement and persecution.

It is neurologically impossible for partners to set the record straight. The unrelenting attempt at reconstruction of a traumatizing event is itself retraumatizing. In addition, intense and repeated dyadic dysregulation is traumatizing and leads to threat-related psychobiological reorganization within and between partners (Charney, 2004). Memory undergoes a reconsolidation process, whereby visual and auditory reactivating cues associated with earlier dysregulated events become reintegrated “into an ongoing perceptual and emotional experience and become part of a new memory” that is contextualized around fear and connected with inhibitory avoidance mechanisms (Charney, 2004, p. 207). Thus couples cannot adequately regulate by trying to reconstruct past events. Attempts at repair must also fail as long as both partners believe that recall of such events is possible. The therapist should instead attend to the dysregulation occurring in the here and now.

The therapist should also assess highly dysregulated couples for prior histories of relational trauma, paying special attention to histories of neglect, because more often than not it results in alexithymia, focal affective blindness, and other sociocognitive and socioaffective disabilities, as well as in a psychobiological intolerance of close physical contact of even brief duration. (Traumatized individuals can appear physically and sexually compliant with their partners but dissociate in order to do so.) The therapist should gear the pace of treatment to the person less able to tolerate closeness, both in terms of physical proximity and duration.

The psychobiologically attuned couple therapist is always concerned with deficits relevant to social–emotional functioning, since they result in acute or chronic misattunement and poor error correction and thus interfere with skillful interactive regulation. Some deficits themselves point to early attachment, whereas others may be organic, drug-related, or due to other developmental or constitu-
tional issues. Someone may appear affectively blind to particular emotions, for instance, or may have a difficult time finding detail in a partner’s face or eyes or in intuiting a partner’s thoughts, intentions, or emotions.

Neurological deficits resulting from brain injury, learning disabilities, and organic problems may present as problems with empathy, reading faces, interoceptive cues, theory of mind, and mutuality; these deficits may be constitutional or developmental in origin. Problems and limitations involving Axis I psychiatric disorders, such as mood and anxiety disorders, somatoform disorders, and relational trauma, including PTSD, can be viewed from the psychobiological plane. Problems having to do with cultural norms—when partners are from different cultural backgrounds—may be seen as deficits on the cultural–philosophical level. Attitudinal limitations about how partnerships are supposed to work can be understood as deficits stemming from a vision or belief system that guides them toward conflict rather than harmony.

We all have deficits in some area of performance—no one’s brain is good at doing everything—but in most cases we are able to circumvent those deficits by utilizing clever workarounds, such as getting other people to do things that we are not particularly skilled at doing. So most deficits are not discovered unless we are faced with a particular task that tests our ability to do this or that. A couple may go for 20 or 30 years and never know that at least one partner has a deficit in a significant area that affects skillful coregulation. Partners may even come to believe that certain failures in attunement are purposeful and deliberate. Awareness of deficits can profoundly shift a couple’s sense of what is wrong and what to do about it.

Secure couples rely upon interactive regulation—a prosocial, symmetrical, reciprocal strategy—whether or not they are under stress. They realize that they cannot thrive in the couple system by ignoring the affective arousal state of the other. In therapy they approach conflict-charged areas with some measure of care and mindfulness, and they mutually titrate levels of tension and relaxation. They can move in and out of conflict without resorting extensively to avoidance and withdrawal, and they are able to revisit areas of importance without fear of becoming overwhelmed.

Their two nervous systems continually attune, misattune, and re-attune through sensorimotor pathways and coregulators that in-
Dysregulation include vision and sound (which play major roles in conflict management) as well as smell, touch, and taste. Secure couples are good at generating mutually experienced positive feeling, on the one hand, and at repairing and shortening periods of mutually experienced negative feeling, on the other. Theirs is a process of frequent proximity seeking and contact maintenance.

Insecure couples reverse this formula by withholding efforts to generate shared positive feelings while producing frequent and extended periods of mutually amplified negative states. Their default strategies for managing conflict—avoidant disengagement and intrusive overengagement—produce frequent and increasing bouts of mutual dysregulation and constitute, at once, cause and effect of their interactive patterns. Those regulatory strategies are distinctly asymmetric, nonreciprocal, and decidedly not prosocial. Distancing defenses, including dissociation, fall under the heading of pathological autoregulation, which, as a primitive homeostatic mechanism for self-stimulation and self-soothing, by definition involves massive withdrawal from a two-person system. Clinging defenses, including retaliatory rage, demand interaction, but in the context of a one-way strategy for internal state regulation that often is not accompanied by simultaneous ability to provide a reciprocal function.

Partners who attend to one another’s eyes and faces are literally in an exquisite position to “read” each other’s nervous systems. Doing this without dissociating enables a true interactive regulatory process that is inherently empathic because it picks up the somatoaffective resonance in the face and eyes of the partner. Full moment-to-moment engagement in this fast-acting process limits the influence of negative internal representations and helps reduce misappraisals of intent.

If, however, either partner moves into hyper- or hypoarousal (fight, flight, freeze, or conservation withdrawal), both will likely disengage from the interactive process and drop face-to-face contact, which may lead to dysregulation of the couple system itself. The insecure couple may develop an avoidance of face-to-face conflict management and disengage from real interactive regulation in response to threat. Since together they manage intensity and duration of negative arousal poorly, their dysregulatory process snowballs psychobiologically into a learned response whereby partners eventually view one another as predators.
In or out of conflict, engagement and disengagement within an insecure dyadic system involve issues of psychobiological dysregulation that the therapist must track and address. Chronic dyadic dysregulation as a product of an insecure couple system radically increases over time and becomes the central challenge to delayed therapy, and as such, degrades prognosis.

But failure to regulate should be viewed as a no-fault biological matter. There is no natural law that says that two nervous systems should get along—although our job as psychobiologically oriented couple therapists is to help partners do just that. While observing and tracking the wavelike arousal patterns of couples in treatment, therapists need to be mindful of the fact that, as each primary attachment dyad is intersubjectively unique, each forms a correspondingly unique regulatory team. It is entirely feasible, even likely, that couple therapy can succeed by helping partners view themselves as such while moving them toward improved regulatory competence. Safety and security within the couple system will improve as well.

The ANS is of particular significance to couple therapy because of its widespread affect on arousal, affect, behavior, stress, and recovery. In fact, ANS arousal is one of the fulcrums of the psychobiological approach because the arousal system is principally responsible for moving romantic partners toward and away from one another (in keeping with their respective attachment blueprints) from love to war. ANS regulation is foundational to attachment, and reparation of attachment injuries is foundational to successful intimate relationships. Neural development, attachment organization, and arousal regulation are intertwined, inseparable, interoperable, and circular, each affecting and determining the other.