APPENDIX B: Partner Attachment Inventory

A Psychobiological Approach to Couple Therapy

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APPENDIX B: Partner Attachment Inventory

This chapter focuses on the first tool, or intervention, which is part top-down and left-right, and ultimately right-left and bottom-up.

Remember that top-down refers to processes that begin with high left and right hemispheres and move downward toward the body.

Left-right refers to processes that begin with the left hemisphere to right hemisphere, crossing via the corpus callosum toward the front. For instance, someone asks me how I'm feeling about my mother, who is in the hospital. I answer that I'm not doing very well, and I begin to look and feel depressed (left/right, top/down). The question addresses my feeling state and triggers a mental picture of my mother looking sickly. The process goes from left (explicit/language) to right (implicit/experience).

Right-left refers to processing that begins in the right. For example, I suddenly recall a vivid memory of my mother's pained face when I last visited her in the hospital. The memory pops into my mind as an emotional event that was activated by someone telling a story about my mother.

Bottom-up refers to processes that begin as body sensation or emotion. As an example, my chest feels tight and my hands are clammy. I focus on these sensations, which leads me to a realization that I'm anxious about visiting my mother in the hospital later in the day.

The Partner Attachment Inventory is an assessment, intervention, and memory stress-test instrument that works across all the axes mentioned here.
This inventory is adopted and adapted from Mary Main and Erik Hesse's Adult Attachment Interview. This particular adaptation is not to be used as a research tool or as a method to assess your patients. Rather you can view it as an intervention tool to be used both during the initial session and throughout the course of therapy. I find it very important to capture the interest of the most avoidant partner at the very beginning of therapy. This is why I customarily use this attachment inventory at the very beginning, if possible, as a way to convert the most avoidant partner's ego syntonic behavior into something considerably more ego dystonic.

The actual Adult Attachment Interview (AAI) is an exquisitely designed instrument with a highly complex coding system that requires intensive two week training, and that's just the beginning. What follows is an almost yearlong process of becoming "reliable" at coding. Those of us who have gone through the training know that it can be a frustrating learning process particularly for psychotherapists because it is a fundamentally flat, linguistic research tool for determining adult attachment classification. Still, even if one does not follow through to become a reliable coder, the initial training process can be profoundly transforming for the psychotherapist.

**INSTRUCTIONS**

Do this interview with both partners present and administer to one person at a time. Complete both interviews without giving any explanation or interpretation. Do not allow the other partner to intervene or add information. We want to stress the interviewee's memory -- both declarative (left hemisphere) and
autobiographical (right hemisphere). In order to accomplish this, the interviewer (you) must have time and latitude to push the interviewee for concrete memories that support his or her narrative claims. Although it is best perhaps to do this in sequence, it is not essential. For instance, you may want to spend more time with a partner you suspect is most resistant to being in therapy and is least in distress. The other partner may hold less curiosity for you and therefore you may wish to spend less time. In either case be sure to follow up with the question set that asks for five descriptions of maternal and paternal relationships during childhood.

All questions start off vague. The power of this interview resides in the follow-up questions. The interviewer must push for detailed memories that support initial responses. For instance, the interviewee in response to the question, "Who did you run to when you were injured as a child?" says, "My mother." The follow-up question to this is, "Give me a memory when you were injured as a child and you ran to your mother." Drill down until you cannot elicit any more information specific to the question. Some patients may want to talk about other things and stray from the interview. Keep him or her focused on the interview.

Responses that are problematic and require follow-up:

1. I don't remember.

2. We always...

3. He or she always...
Because we are looking at the attachment relationship with primary attachment figures we want responses that are specific and personal that can be backed by autobiographical memory (experience).

THE INTERVIEW

1) When you were a child and you were injured who did you run to?
   a) Give me a memory when you were injured as a child and you ran to him or her.

   9. How fast could he or she comfort you? How good was that person at calming you down? Give me a number between 1 and 10 (terrible to wonderful; very incompetent to very competent; cannot calm you to can calm you very quickly).

   10. How did he or she react to your injury? What was the look on his or her face? Did he or she pick you up and hold you? What was the sound of his or her voice?

2) When you were a child and you were sick who took care of you?
   a) Give me a memory when you were sick as a child and he or she took care of you.

   9. What did he or she do to care for you? Did he or she spend time with you while you were sick? Stroke your head? Lie down with you? Read to you? Play games with you? Reassure you?

3) When you were a child and you got upset what happened?
a) [Some people cannot make sense of the word "upset" and need further prompting; if this happens restate the question first without changing the question.]

9. If further prompting is necessary you can say, "When you became upset either toward your parents or around your parents what would happen?" If this still confuses the interviewee you can say, "If you were crying or were upset about something or someone what would your parents do about that? How would either respond?" Or you might want to add, "If you got angry at someone in your family how would your parents react? And how would they react if you became angry with them?"

10. You may have to remind your patient that this memory must be before the age of 13.

4) When you were a child who put you to bed at night?

a) Did you have a regular bedtime? What time was it? Was there a ritual? Did he or she read to you? Did he or she ask you about your day? Did he or she sing to you?

b) Do you remember feeling safe at night in bed? Could you call out for one of your parents and would they come to you? What happened when you had a nightmare?

5) Did either parent hold you, kiss you, scratch your back, or was affectionate with you in any way?
a) Give me a specific memory?

6) Who stood up for you (adult)?
   a) Did he or she stand up for you in public even when you did wrong?
   b) Did he or she reprimand you in private?

7) Give me five adjectives that would describe your relationship with your mother when you were a child. Afterward I'm going to ask you to support each adjective with a memory.

8) Give me five adjectives that would describe your relationship with your father when you were a child. Afterward I'm going to ask you to support each adjective with a memory.

9) Did anything frightening happen to you when you were a child?
   a) Give me the memory.
      9. Who was involved?
      10. Did either parent comfort you; help you to cope with the event?

10) Did you suffer a big loss of any kind when you were a child?
   a) Give me the memory.
      9. Who was involved?
      10. Did either parent comfort you; help you to cope with the event?
11) Did either parent ever look at you in the eye and say something like, “I really love you,” or “I am so proud of you,” or “you are a terrific kid,” or anything fresh and positive that was meant for just you?

FOLLOWING UP

Now let me take these one at a time and elaborate. By the way, by child I mean before the age of 13. In all cases we are looking for specific memories involving the interviewee with the attachment figure.

1. We want specific memories and we want detail especially in regards to the attachment figures reaction and ability to calm and soothe the patient.

2. Same as above but we also want to know the attitude of the parent the amount of time parents spent with the child and what kind of soothing, stimulation, and engagement that took place.

3. The word upset is general and that's a good place to start. We want to know what happened when the child became sad, frightened or angry though you may not say those words unless all other options have been exhausted. Did he or she interact with the parents, the family pet, or remain by him or herself. Did he or she express anger and if so how did each parent?

4. I think it is interesting to know the sleeping habits set in childhood especially the transition period between wakefulness and sleep. Was there an ushering of that transition by one or both parents? Was the child read to or sung to at night? Was there a routine? Did he or she have to put him or herself to bed
all the time? I find there is a correlation between wake/sleep transitioning in childhood and the adult romantic relationship. This is especially so if one partner commonly falls asleep before the other.

5. We want to know if there are memories of being held, hugged, rocked, cuddled, or kissed by early caregivers. Your interviewee may answer this quickly but fail to come up with a specific memory. On the other hand, he or she may remember with fondness sitting on a caregiver's lap, or riding atop the caregiver's shoulders. Lots of physical affection, particularly if it is recalled as personal and special to the interviewee, is a marker for secure attachment.

6. We want to know if somebody, namely an adult, protected the child in public when under attack. However we also want to know whether that parent in private utilized the situation for learning proper behavior, right from wrong, taking responsibility, etc.

7. Make note of the adjectives and whether or not they're all positive, all negative, or a mixture. Ask the patient one by one to provide a memory from childhood that would support the adjectives. We want proof. Look for a clear-cut memory with detail involving just the patient and that person. Look for responses such as "I don't know" or "she always did such and such" or "she took us to..." We only want dyadic with them experiences between the attachment figures and the child.

8. Same as above but with Father.
9. This is an open-ended question for checking early trauma and whether or not an adult caregiver attended to the interviewee’s fright. In the absence of an attentive, sensitive, and soothing caregiver the therapist should remain alert to the possibility that the trauma remains unresolved.

10. Similar to checking for frightening events is powerful experiences of loss, such as a death of a relative or other important person or a pet. Again, if the interviewee reports having been unattended to during or shortly following the loss, the therapist may want to track this event as possibly unresolved and affecting the current adult primary attachment relationship.

11. Sustained, loving gaze from an adult caregiver during one's childhood can directly affect the gazing one does with and tolerates from an adult partner. Lovers who gaze at one another in close physical proximity often experience a positive amplification of feeling, sometimes referred to as a dopaminergic rush. If nothing else, they experience a spike in sympathetic arousal. In addition, the emotional memory of producing a twinkle in a caregiver's eyes can be enormously moving for the interviewee.

To sum up we are looking for several things contained in the interviewee’s responses to our questions -- including amount of detail, mixture of negative and
positive descriptions of attachment figures, real support of the adjectives, fresh responses and not ones that are rehearsed, et cetera.

**INTERPRETATION**

What follows is an overview of the interpretation process which may very well be confusing for those unfamiliar with attachment systems. The interpretation process involves much more than is written here and in much more detail. The analysis I provide makes use of my knowledge of neurological structure and function as well as memory systems such as explicit and implicit systems of the left and right hemispheres, respectively. With that in mind I offer this brief and woefully incomplete synopsis of this very important final step of this interview.

Insecure angry/resistant/preoccupied individuals will tend to have narratives that are angrier. Their descriptions and memories may contain extensive content. Their descriptions may be more negative.

Insecure avoidant/dismissive individuals will tend to be vaguer and less detailed. Memories are often lacking. They may report all positive in their adjectives but they may report all negative as well. Their responses will not be fresh.

Many people will claim that their memory is poor. However, autobiographical memory is highly resilient even at the start of dementias. Resilient memories are encoded by experiences that have emotional valence,
and emotions, particularly those produced by the amygdala, lead to the production of adrenaline necessary for encoding these memories. Interactions, especially those with attachment figures, tend to amplify arousal and affect. These can be negative or positive amplifications but the stimulus is the emotionally valenced interaction with important attachment figures. These are interactions that are meant for us and us alone and thus we remember them. Chronic lack of autobiographical memory involving early attachment figures often points to neglect in the following manner: Likely both parents dismissed attachment behaviors too often avoiding face-to-face, skin-to-skin interaction with their children.

Patients with incoherent autobiographical narratives, such as those violating Grice's maxims\(^1\), may be viewed as having unresolved loss, trauma, or

\(^1\) I am unable to fully elaborate Grice's maxims here. To greatly simplify, Grice's maxims referred to the speaker's ability to maintain a narrative with a coherent flow for the listener. In other words, the speaker is able to make certain the listener can follow along. Errors involve gross confusions with regard to person, place, and time. An example might be to speak of an attachment figure who is dead as if he or she is alive and then moments later as dead again. Another example might include confusion between self with other, switching from first person to third person, speaking as if eulogizing, long pauses of 30 seconds or more after which there is a change of subject without transition, and so forth. For further reference see endnote in this paper.
both. Patients with unresolved trauma or loss may at times appear disorganized or disoriented, yet their attachment status can still be that of secure or insecure.

After completing the interview with both partners, the therapist can make comments both about the couple system and individual partners. We are establishing our basis for treatment through the lens of early attachment formation and using the information from the interview to help explain to the couple how, at least in this one area of attachment, they might be well matched but also expected to have some difficulty. The majority of the time partners are already surprised by information heard during the interview process. The interpretation process by the therapist helps the couple understand not only the purpose of the interview but its meaning as well. Proper explanation of the purpose for the attachment interview depends upon the therapist's knowledge and understanding of neural networks and memory systems. In addition, the therapist, in order to make proper interpretations, must possess a thorough understanding of internal working models. This is especially important with regard to the most avoidant partner for whom the therapist must bridge theory to the patient's real experience and suffering. The therapist's interpretation of the interview may appear to the patient as mind reading or fortune telling because the therapist will describe experiences and limitations for which the patient has "felt" and "known" as true but has never been able to articulate. Spontaneous confirmation of the therapist's interpretation may also come from his or her partner.
The interview is expected to have a particular impact on the most avoidant partner in the couple system. The therapist hopes, by the end of the session, to gain that partner’s curiosity and interest in further sessions.

THE PRESENCE OF LOVINGNESS IN EARLY ATTACHMENT

Loving experience does not include the basics of feeding, shelter, clothing, transportation, medicines and medical treatment. It also does not include pressure to succeed or perform academically. And of course it does not include absence no matter what the reason. During the interview of the therapist is listening for real loving experiences by attachment figures that are memorable. For instance, hugging, kissing, holding, looking into the eyes with interest, making fresh, loving remarks that are meant for just the patient -- all are loving behaviors that are experienced dyadically and interactively and thereby lead to mutually amplified positive feelings. Of course all the aforementioned behaviors could be negative as well: Hugging, kissing, holding, and looking into the eyes could all be experienced as invasive and even abusive. Loving remarks could also be experienced in a variety of ways many of which may not be felt as "loving." But for our purposes here, we are looking for the subjective experience of lovingness as backed by specific memories.

CONCLUSION

The grossly abbreviated and rather customized attachment interview provided here is for clinical use only and is not meant in any way to resemble the
exquisite instrument that is the Adult Attachment Interview. I am continually adding and refining this interview according to my own findings while working with couples. I encourage you to experiment with this interview.

ENDNOTES

Grice's Conversational Maxims

The philosopher Paul Grice proposed four conversational maxims that arise from the pragmatics of natural language. These maxims are:

Maxim of Quantity:
1. Make your contribution to the conversation as informative as necessary.
2. Do not make your contribution to the conversation more informative than necessary.

Maxim of Quality:
1. Do not say what you believe to be false.
2. Do not say that for which you lack adequate evidence.

Maxim of Relevance:
Be relevant (i.e., say things related to the current topic of the conversation).

Maxim of Manner:
1. Avoid obscurity of expression.
2. Avoid ambiguity.
3. Be brief (avoid unnecessary wordiness).
4. Be orderly.
FURTHER READING


