Psychobiological Conflict Management
Of Marital Couples

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“There is nothing in this world more difficult than another person.” – Shinzen Young, Buddhist Monk

It could be argued that no other relationship reanimates issues of early attachment as does the committed romantic relationship. It is especially notable that within the context of marriage infantile needs and fears from early childhood can and do emerge with high potency and persistence. The secure mother-infant and the secure romantic relationship share similar conditions and capacities. However, unlike the mother-infant couple, romantic partners enter the relationship equally dependent on one another and operate under a mutually constructed social contract. That difference aside, the similarities are such that attributions of secure and insecure can accurately apply to both partnerships as representing a primary attachment relationship. The secure primary relationship (mother-infant and adult romantic) commonly forms and maintains a shared exclusive mental-emotional space, protected from the outside world within which it generates frequent and extended periods of mutually amplified positive feeling, regulates negative emotional states by attenuating their intensity and shortening their duration, and tracks emotional state transitions via periodic unbroken attention. Partners are mutually influenceable and psycho-neuro-biologically connected with powerful but invisible bilateral “projections” that thicken over time. In this way, they begin to hardwire together.
A vital outcome of a mother’s primary preoccupation with her infant is the structural-functional development of socio-affective systems in the baby’s brain. This forms the foundation upon which all further development depends, and provides the pre-verbal, pre-cognitive landscape of the infant’s inner and outer representational world. Infant-mother interaction through prolonged face-to-face, skin-to-skin contact creates a demand for more neural complexity within the infant's brain (Porges, 1998; Schore, 1994, 2002c). It is only through interaction with a more complex human brain does this type of learning take place.

Relevant to adult conflict management is the early socio-affective development of right hemispheric limbic structures, most notably, amygdala, hippocampus, cingulate gyrus, insula, and orbitofrontal cortex. Much has been written about the right hemispheric dominance of these brain structures and their humanizing functions. Neuroimaging research currently offers an abundance of findings that underscore their importance in early infant development (Adolphs, 2001; Adolphs, Damasio, Tranel, Cooper, & Damasio, 2000; Adolphs, Damasio, Tranel, & Damasio, 1996; Hugo D. Critchley et al., 2000; Hugo D Critchley, Wiens, Rotshtein, Ohman, & Dolan, 2004; Damasio, 2000; Gainotti, 2001, ; Henry, 1997; Kimura, Yoshino, Takahashi, & Nomura, 2004; Loye, 2002; Mandal & Ambady, 2004; O'Doherty et al., 2003; Pelphrey, Singerman, Allison, & McCarthy, 2003; Schore, 1994, 1997, 2002a, 2002b, 2002c, 2002d; Shammi & Stuss, 1999; Spitzer et al., 2004; Tucker, Hartry-Speiser, McDougal, Luu, & deGrandpre, 1999; Weinberg, 2000). Via sensorimotor pathways, these structures hierarchically impact and regulate arousal and affect and determine
capacities for theory of mind, empathy, interoceptive sensitivity, self and other affective appraisal, autobiographical memory, frustration tolerance, and impulse control. Successful conflict management by couples requires these capacities, particularly when the couple is under stress. The couple’s capacity to regulate negative affective states varies according to individual attachment orientations. These orientations range from secure to insecure with and without co-morbid disorganization as elaborated by Mary Main, Eric Hesse, Karlyn Lyons-Ruth, and others (Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004; Main & Hesse, 1990). For the purposes of this paper, these designations will sometimes extend, to the couple system itself, thus allowing for a more representational view of dyadic regulation. Armed with attachment theory, the psychobiologically aware clinician can fashion interventions that help insecure couples develop more security through their approach to conflict management.

The Secure vs. Insecure Couple

Secure couples rely upon interactive regulation, a pro-social, symmetrical, reciprocal strategy whether or not they are under stress. Interactive regulation is a proto-conscious, rapid two-person process whereby two nervous systems continually attune, misattune, and re-attune through sensorimotor pathways. These pathways, or co-regulators, include vision, sound, smell, touch, and taste – with vision and sound playing a major role in conflict management.
In contrast, insecure couples, when under stress, default to less pro-social strategies of regulation that are distinctly asymmetric and non-reciprocal, such as distancing and clinging. Interactive regulation is a much more efficient system for calming and soothing than autoregulation, which is a primitive homeostatic mechanism of self-stimulation and self-soothing that, by definition, involves withdrawal from a two-person system. Distancing defenses, including dissociation, fall under the heading of autoregulation. Clinging defenses, including Talionic rage, demand interaction as a one-way strategy for internal state regulation often without the simultaneous ability to provide a reciprocal function. Insecure couples utilize avoidance and over-engagement as strategies to manage conflict, resulting in frequent and increasing bouts of mutual dysregulation.

Secure couples are better at generating mutually experienced positive feeling and they are better at repairing and shortening periods of mutually experienced negative feelings. Theirs is a process of proximity seeking and contact maintenance. Insecure couples eventually reverse this formula by withdrawing efforts to generate shared positive feelings while producing frequent and extended periods of amplified negative states. Theirs is a process of proximity and contact avoiding that is as much cause as it is effect.

**Conflict Management**

Secure partners realize that they cannot thrive in the couple system by ignoring the affect-arousal state of the other. They approach "areas of
importance” with some measure of care and mindfulness, mutually titrating levels of tension and relaxation. They can move in and out of conflict without the use of avoidance and withdrawal and are able to revisit areas of importance without fear of becoming overwhelmed.

Because they are attending to one another’s eyes and face, partners are literally in an exquisite position to “read” each other’s nervous systems. Doing this while not dissociating enables a true interactive regulatory process that is inherently empathic to the immediate somatoaffective resonance through 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 hypo arousal (fight, flight, freeze or conservation withdrawal), they will likely disengage from the interactive process (e.g. drop face-to-face contact) which will likely 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. Dysregulation results from their inability to alternate between tension and relaxation. Together they poorly manage intensity and duration of negative arousal and this process psychobiologically snowballs into a learned threat response with partners eventually viewing one another as predators. The clinician must understand this psychobiological phenomenon as a condition unique to insecure and/or disorganized couples (in which either or both partners have an unresolved trauma history).
Effective interventions with these couples are interventions that have a regulatory impact on the couple system. One such intervention is the clinician’s expectation that partners exercise their capacity to hold impulses and wait their turn, as well as limit the duration of the turn they take. Long narratives create flooding in the waiting partner. 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 hypo arousal. The therapist must help the dysregulated couple regain and increase their capacity for holding and waiting if couples therapy is to move forward.

Arguments Involving Reconstruction of Events

Insecure couples often become entangled in arguments involving the reconstruction of past events. They will present in the clinician’s office with wildly differing recollections as to content, sequence and intent. They seem locked into a painful, isolated reality of violent misattunement and persecution. The dysregulated couple’s unrelenting attempt at reconstruction is itself a re-traumatization of a traumatizing event. As previously mentioned, 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 becomes
part of a new memory.” (Charney, 2004, p.207) These cuing memories (stored in
the amygdala) affect fear memory (stored in the hippocampus) that is contextual
and associated with inhibitory avoidance mechanisms (Charney, 2004). This is a
system essentially driven by the amygdala with a right hemisphere acuity for
rapid habituation and picking up threatening facial and prosodic cues (Kimura et
al., 2004; Nomura et al., 2004) In extreme hyper- or hypo-aroused states,
hierarchical neuro-regulatory processes involving the ventral-medial prefrontal
cortex give way subcortical processes to insure survival. During these periods of
dysregulation, the declarative ability to accurately represent and sequence
events is highly compromised; so too is the ability to appraise intention. It is
impossible for partners to “set the record straight” and as such, the couple cannot
adequately regulate via this method. Attempts at repair must also fail as long as
both partners believe recall of such events is possible. The therapist would be
unkind to allow this process to continue. Instead, the therapist should attend to
the dysregulation occurring in the here-and-now.

The clinician should assess highly dysregulated couples for prior histories
of relational trauma. It is important to pay special attention to histories of neglect
as, more often than not, neglect results in alexithymia, focal affective blindness,
and other socio-affective disabilities. Early relational neglect can often result in a
psychobiological intolerance of close physical contact of even brief duration. As
in physical and sexual abuse, traumatized individuals can appear physically and
sexually compliant with their partners but are dissociating in order to do so. For this reason, the clinician should gear the pace of treatment to the person least able to tolerate closeness, both in terms of physical proximity and duration.

It is important to note that organized forms of moderate to severe insecure attachment look similar to disorders of the self. Indeed, both evolve out of infant object relations; however, the former more clearly implicates a disordered two-person system. These personality (or attachment) organizations lack complexity due to their predictable, rigid adherence to rules of engagement and disengagement with another person. Though one or both partners of an insecure couple may be personality disordered, that knowledge by itself might be of little help and may even be defeating to the clinician dealing with couples. Rather, the designation of “insecurely attached” couple provides a systems context from which the therapist can work. In addition, engagement and disengagement within an insecure dyadic system, in or out of conflict, involve issues of psychobiological dysregulation that the clinician must track and address. 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. Nevertheless, it is entirely feasible, even likely, that couples therapy can succeed by helping partners view themselves as a regulatory team, moving them toward improved competence in this area. By doing so, safety and security within the couple system will improve as well.
References


