Psycho-neurobiological clinical challenges in working with disorganized partners in couple therapy:

A PACT® perspective

By Stan Tatkin, Psy.D.
The subject of disorganized attachment has been covered by many authors and theorists (Cassidy & Mohr, 2006; Hughes & McGauley, 1997; Lyons-Ruth, 2002; Lyons-Ruth, Bronfman, & Parsons, 1999; Main & Hesse, 1990; Main & Solomon, 1990; Schore, 2001; van Ijzendoorn, Schuengel, & Bakermans-Kranenburg, 1999), and many systems of classification have been used for disorganized attachment (Atkinson et al., 2009; Barnett, Ganiban, & Cicchetti, 1999; Fonagy et al., 1996; George, Isaacs, & Marvin, 2011; Hesse, 1996; Lyons-Ruth & Spielman, 2004). Working in the couple therapy setting must take into account the clinical vicissitudes associated with various forms of unresolved/disorganized attachment in adult individuals. For example, I have seen therapists in training become very confused about the distinction between disorganized attachment and disorganized pockets stemming from unresolved trauma or loss. People with these pockets may be deemed disorganized on the basis of results from the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1985; Hesse, 1999), with the classification of unresolved/disorganized (U/d) preceding the individual’s primary secure or insecure designation. For instance, it is entirely possible for a secure/autonomous individual to get the U/d label due to a single disorganized event in the transcript. Yet that person would not be considered to have disorganized attachment. Many partners in my practice reveal pockets of unresolved trauma or loss during therapy. Moments of disorganization or disorientation typically arise during a session using a psychobiological approach to couple therapy (Tatkin, 2011) due to the bottom-up nature of this approach. We are constantly using movement, surprise statements, poses (static positioning), and other techniques to elicit stress along the proximity-seeking and contact maintenance axes of attachment. In addition, we employ top-down techniques akin to the AAI that further stress partners by eliciting autobiographical responses to support declarative memories.

In this paper, I focus on the psychobiological issues a couple therapist is likely to encounter when working with severely disorganized individuals in couple therapy. The severely disorganized couple is
Partners who have an early, intense, and perhaps prolonged abuse and/or neglect history may present with disorganized traits instead of states. Extremely challenging, not only because of brain changes that arise out of unremitting, brutal early trauma, but also because many of these trauma victims have a personality disorder as well. Work with this population requires an experienced therapist and a very strong therapeutic frame. Couple therapists who have not had experience either working with highly traumatized individuals or those with personality disorders should have supervision while managing such a case. Individual therapists who read this article may wonder why certain treatment approaches are not discussed here. Individual treatment is, and should be, quite different from the treatment of disorganized individuals in couple therapy. For instance, Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2001); somatic experiencing (Heller & Heller, 2004); sensorimotor therapy (Ogden & Minton, 2000); cognitive behavioral therapy; and other preferred treatments for trauma may not be indicated for traumatized or disorganized partners in couple therapy. PACT therapists may incorporate some of these approaches and techniques, but that is outside the scope of this paper.

Severely Disorganized Individuals in Couple Therapy

Couple therapy with secure and insecurely attached persons who experience momentary disorganized or disoriented states is so common that it probably does not require discussion. However, partners who have an early, intense, and perhaps prolonged abuse and/or neglect history may present with disorganized traits instead of states. In other words, these partners tend to be highly disordered, at least in the area of relationships, and may present as dissociative, borderline, schizoid, paranoid, and psychotic. Persons with a psychotic core and individuals who have a highly fragile reality ego and a poor, low-level defensive structure may suffer long-term from early relational trauma and are by far the most challenging in couple therapy.

A diathesis model can help explain why some individuals are constitutionally predisposed to developing PTSD, borderline personality spectrum disorders, and dissociative identity disorder, while other individuals who experience a similarly abusive or neglectful childhood are not. In terms of prognosis, the distinction between these two groups may be important as a clinical matter. With the former, a poorer prognosis is expected.

The couple therapist should be alert to the likelihood that one disorganized partner may have pair bonded with another partner who is similarly disorganized and disoriented. Many disorganized partners are high functioning in their careers, but become disorganized in their love relationships. It is very likely that partners will come in at similar levels of psychological complexity and psychobiological disability. Due to brain reorganization stemming from unresolved and untreated trauma and neglect, highly disorganized individuals are more or less paranoid and fearful of novel situations. Couple therapy itself is a novel situation that requires complexity that may be beyond the comfort level of the disorganized individual or couple.

Disorganized partners rely on lower-level, primitive defenses, such as projective identification, acting out, dissociation, withdrawal, avoidance, and denial. They are characterized by low-verbal articulation, problems maintaining a coherent narrative, and non-collaboration. Partners may appear to be holding secrets and may appear to be lying at times. Disorganized partners are often highly paranoid and suspicious of therapist interventions and interpretations.

Epigenetics and Brain Plasticity

The human brain and is an amazing, plastic organ that continually adapts to the environment—from the prenatal period throughout life. We know that a fetus’s brain development is influenced by the mother’s stress level, nutrition, and other matters of physical health (Cottrell & Seckl, 2009; Dobbing, 1990; Field et al., 2004; Matthews, 2002; Weinberg & Tronick, 1998; Welberg & Seckl, 2001). Babies born in war-torn areas of the world have shown prenatal changes in brain development in preparation for the environment into which the baby will be born (De Bellis, 2005; De Bellis et al., 1999; Schore,
Indispensable survival guide for the thinking psychotherapist

2001; Yehuda et al., 2005). For instance, a stressful environment may lead to building out the fetus’s posterior brain structures to emphasize visual, auditory, and sensory perception. The DNA of traumatized mothers and fathers may be altered enough to influence offspring for up to two generations via the mother’s eggs and the father’s sperm. PTSD and relational trauma have been known to alter the neurochemistry, brain function, and even brain structure of those who were exposed early in life (Bohacek, Gapp, Saab, & Mansuy, 2013; Dudley, Li, Kober, Kippin, & Brody, 2011; Lange, 2011; Yehuda & Bierer, 2007). General changes in brain volume, apoptotic pruning, and myelination have been found in children and adults with untreated early trauma histories (De Bellis, 2005; Glaser, 2000; Gudsnuk & Champagne, 2011; Schore, 2003). Persons with early severe trauma and neglect may carry what Bruce McEwen (McEwen & Wingfield, 2003) calls high allostatic loads, whereby chronic stress leads to the continual release of cytotoxic neurotransmitters and hormones (catecholamines and corticosteroids), causing increased neurological entropy; atrophy; and the wearing down of cardiovascular, autoimmune, inflammatory, and metabolic systems. Allan Schore (2002) and others (Bohacek et al., 2013; Dudley et al., 2011; Gudsnuk & Champagne, 2011; Gutman, 2002; Roth & Sweatt, 2011) have written extensively on the epigenetic effect of trauma and neglect on both the maturing infant brain and the mature adult brain.

The postnatal, experience-dependent development of the infant’s right hemisphere undergoes several critical periods during the first 18 months of life. During this time, fundamental regulatory organizations are set up that include not only autonomic structures but also the development of foundational systems necessary for future self-regulatory functions of the ventral medial prefrontal bundle and ventral vagal branch of the vagus nerve, which come online at around 10 to 12 months. Infant brain apoptosis, which normally occurs within the first year, operates on a “use it or lose it” basis, as well as Hebb’s law of neural connectivity. All this is to say that the first 18 months of life may be thought of as the first long-term damaging impact on a person’s life. Environmental interference with the development of the right hemisphere can have a long-term damaging impact on a person’s life. Add to this the diathesis model of genetic predisposition, and one can imagine how difficult the disorganized partner’s life journey might be.

It is well known that the untreated traumatized brain reorganizes itself adaptively to expect future trauma (Carrion, Weems, & Reiss, 2007; Cozolino, 2010; Nutt & Malizia, 2004; Stein, Hanna, Koverola, Torchia, & Blake, 1997; Woodward et al., 2006). This makes good sense: if you are in a dangerous environment, you would want your brain to adapt to that environment in order to keep you alive. However, PTSD victims are often noncompliant and will either not come to treatment or leave treatment early. Persons with untreated PTSD in combination with borderline personality disorder have been known to be much more complex neurobiologically than those with only PTSD, due to the confluence of these disorders and the particular damage to the brain. Problems have been noted in the amygdala, hippocampus, anterior cingulate, anterior insula, and orbitofrontal cortex (Bremner et al., 2003; Jelicic & Merckelbach, 2004; Sahar, Shalev, & Porges, 2001; Sala et al., 2004; Schore, 2001, 2002; Stein et al., 1997; Woodward et al., 2006). Of particular concern is the lack of influence the prefrontal medial bundle has on lower limbic structures, such as the amygdala.

In many cases, the amygdala itself is damaged, and cases of amygdala hypertrophy have been noted, along with parallel atrophy of the hippocampus and damage to the dentate gyrus, a region known to generate new stem cells (McEwen, 2000, 2001). Impairment in these structures necessarily leads to reality testing issues in the clinical setting. It also affects the individuals’ arousal regulation efficacy.

Problems With Arousal Regulation

Highly disorganized partners experience frequent and intense periods of arousal and affect dysregulation. In cases of severe early neglect, the self-regulatory function of the medial prefrontal bundle may be impaired by

Highly disorganized partners experience frequent and intense periods of arousal and affect dysregulation.
the paucity of sympathetic and parasympathetic neurons in prefrontal regulatory regions, as well as by poor neural connectivity between orbital frontal areas of the brain and lower limbic structures. This may be due to apoptotic pruning in the first year of life. Infants and children exposed to life threat, whereby fight or flight was impossible, may also fall victim to a frequently engaged dorsal motor vagal complex, with bouts of severe and prolonged dissociation, episodes of syncope, anacistic depression, and suicidality. Many disorganized partners display a biphasic reaction to attachment stress inside or outside couple sessions, with rapid cycling between states of hyperaroused and hypoaroused. Hyperaroused states may appear dissociative, with suicidal or homicidal rage, cutting, violent acting out, and other dangerous impulsive behavior. Patients with dissociative identity disorder may exhibit arousal dysregulation, with the emergence of various alternate personalities that carry a state-dependent, discrete memory system, complete with its own arousal regulation strategy. Disorganized partners commonly use substances and behavioral methods for internal state regulation. Drug and alcohol addiction as well as sexual acting out are not uncommon. In some cases, ingestion of alcohol and certain street drugs can cause radical personality and behavioral changes in disorganized individuals.

Structural Issues Embedded in Couple Therapy

Couple therapy increases interpersonal stress by adding a third person, the therapist. Under normal circumstances, this increase in stress can be managed by the organized secure or insecure partner. However, in cases of the disorganization, the change from dyads to triads can present a threat to one or both partners. Unlike organized secures, insecure, disorganized partners may use secrets and deceptive behavior as part of their defense against the intrusive threat the therapist poses by simply being in the room. Alternatively, disorganized partners can become dyadically fixated on each other as a way to defend against the invading third person; in this case, the therapist. This can occur even if the partners ordinarily find each other unsafe. In the presence of a third, the partners become a safe harbor for each other. For example, the partners may come in and sit down and maintain eye contact with each other but not with the therapist. To the therapist, this may appear as secure-functioning behavior; however, an astute therapist will experience a discomforting countertransference.

The problem of threes can be developmental, and not simply a matter of fear or threat. Individuals with disorders of the self, otherwise known as personality disorders, may be developmentally unable to operate in a triadic therapeutic situation. This is not due to a trauma experience, but rather to delayed early development or lack of individuation due to separation. The pre-Oedipal child has not yet achieved object constancy and therefore still requires an intensely focused dyadic experience with a primary caregiver to assist that child in regulating painful states of loss and disappointment. In cases of pre-Oedipal developmental delay in adults, couple therapy is not necessarily perceived as dangerous, but tends to be intensely dyadic, with partners over-focusing on the therapist. In either case, the disorganized partner or couple presents a particular challenge to the couple therapist attempting to create a therapeutic alliance.

Management of Acting Out Behaviors

A challenging part of working with the disorganized individual or couple is the need for the therapist to cope with acting out behaviors, both within and outside the therapy office. As mentioned already, it is not uncommon for disorganized individuals to act out by using sex, drugs, cutting, violence against the partner, suicide attempts, and criminal activity. The couple therapist is bound by laws pertaining to imminent threat to self and other, child abuse or child endangerment, and danger to elders and other dependents. Having said that, when faced with dangerous behaviors or the threat of acting out behaviors by either or both partners, many couple therapists act out their own countertransference. These dangerous behaviors are not reportable events, but rather self-defeating or self-harming behaviors that may alarm the couple therapist.
This may lead the therapist to break the therapeutic frame in some way and thus endanger both the therapist and couple. For instance, a self-harming hospitalized partner may cause the couple therapist to overreact and perform functions that are inappropriate to the therapeutic frame, such as visiting the hospitalized partner. Or the couple therapist may be drawn into the acting out of other family members, and even of other treating professionals who are equally panicked by the dangerous behavior.

Aside from reporting obligations, the couple therapist must maintain a firm therapeutic frame and therapeutic stance at all times. The therapeutic frame includes time, fees, payments, scheduling, roles, and other rules of treatment. The frame exists to protect the couple and the therapist from improper behavior. The therapeutic stance must also be clear and coherent because it clarifies how the therapist views the goals of treatment.

PACT, for example, discourages individual sessions with partners in couple therapy. One guideline in the therapeutic frame is to see the couple only. Breaking this frame can cause a multitude of problems for both therapist and couple, many of which can result in the case unraveling due to transference and countertransference issues. Also, the PACT therapeutic stance focuses on secure-functioning behaviors and principles. The therapist views the couple as a self-contained unit, with partners in each other’s care. Partners picked each other and are in each other’s care, and the therapist’s job is to move them toward secure functioning. Thus, the frame and stance for couple therapy are quite different from the frame and stance for individual psychotherapy.

Because the acting out of disorganized partners and couples is often frightening to those around them, including other treating professionals, the couple therapist is in the best position to case manage and deal with other treating professionals. Again, this is where the couple therapist’s adherence to his or her own frame and stance can be tested by forces inside and outside couple therapy. The fears and concerns of other treating professionals can pressure the couple therapist to take actions inappropriate to the therapist’s frame and stance. Failure to adhere to a preset frame and stance can prove calamitous for the couple therapist.

**PACT With the Difficult Partner or Couple**

PACT was designed for the most difficult partner relationships. We have successfully treated partners with thought disorders, traumatic brain injury, axis II disorders, autistic spectrum disorders, eating disorders, addictions, and other challenging treatment conditions. Because we focus on secure functioning as the primary goal of therapy, axis I and axis II disorders, as well as insecure and disorganized attachment issues, need not be addressed directly. Secure functioning focuses only on the couple’s safety and security system, which may include attachment and arousal issues as well as other psycho-neurobiological concerns.

Couple therapy for the disorganized person is far more threatening than individual therapy, although individual therapy is likely no picnic, either. Interpersonal stress may be highest in individuals who areavoidantly attached. Disorganized, avoidantly attached individuals and partners are not only paranoid but also contact averse, approach avoidant and distancing. Compared with avoidantly attached partners, prognosis is better with highly disorganized, angry resistant (ambivalent) partners and couples. The angry resisters’ need for proximity seeking and contact maintenance, as well as their clinging defense, makes them easier to work with. The same holds true when severe disorganization is present. It is uncommon for a highly disorganized, securely attached individual to appear in psychotherapy. The designation of being highly disorganized rules out the possibility that the individual is securely attached.

**PACT Therapeutic Frame**

The PACT therapist titrates session length and frequency according to each partner’s capacity to endure the stress of couple therapy. A maxim often used for psychotropic treatment of medication-sensitive and elderly patients is “Start low, go slow, but get there.” I think the maxim fits also for working

**Aside from reporting obligations, the couple therapist must maintain a firm therapeutic frame and therapeutic stance at all times.**
with highly disorganized partners and couples. Starting slow means the couple therapist must address the initial elephant in the room, which is the dangerous third person embodied by the therapist.

Going slow means the couple therapist must focus on the safety and security system and forgo delving deeper into trauma history until a strong therapeutic alliance has been achieved. Going slow also means that, unlike a partner with organized attachment, the highly disorganized individual is unpredictable. Implicit indicators used in couple therapy with organized attachment systems (e.g., the interpretation of facial micro-expressions and bodily micro-movements) can not only prove useless, but also threatening to the disorganized partner, who may view the therapist’s attention to details as dangerous to the self. It is not uncommon for a disorganized partner to view the therapist’s attention to implicit behavioral details through a paranoid lens of persecution and criticism. Going slow also means the couple therapist delays any intensive historic attachment interview until such time as a strong therapeutic alliance exists. Session length should be titrated following an initial longer session so the couple therapist can get a good sense of capacity and tolerance. For instance, one partner may show signs of decompensation during the latter part of a two-hour session. The therapist should consider paring the session length down to an hour and a half. Session frequency should be determined according to the amount and intensity of dysregulation. The more the dysregulation, the higher the frequency should be in order to contain partner acting out. The higher the frequency, the shorter the length of the session should be, as well.

Going slow also means the couple therapist uses furniture that is mobile and allows partners and the therapist to move about the room easily and comfortably. In PACT, we prefer chairs with wheels. Allowing partners to remain mobile during the session can decrease implicit and explicit threats that partners may experience if seated on static furniture. Movable furniture also allows the couple therapist to turn partners toward each other and engage in interactive regulation strategies.

**PACT Therapeutic Stance**

The PACT therapeutic stance of secure functioning tends to be a safe platform upon which disorganized partners can operate without the immediate dangers of experiencing implicit triggers of unresolved trauma or loss. The couple therapist focuses on interactive regulation; partners’ care for one another; partners’ distress relief; and agreements based on fairness, justice, and sensitivity between partners. In the case of threat activation between partners, the couple therapist can work individually with each partner within the same session (i.e., with both parties present) to help with self-regulation. Highly disorganized individuals can have difficulty with self-regulation and may from time to time require assistance from the therapist. This can be achieved while posing partners face-to-face, either during interaction, or during silence, with the therapist sitting perpendicular to the partner requiring assistance in self-regulation. In this manner, the therapist is regulating the regulator, or rather, helping one partner maintain social engagement (i.e., of the ventral vagal system), while interacting with the other stressed partner.
Interactive Regulation

Though the couple therapist may assist disorganized partners in self-regulation, the goal of couple therapy is to encourage interactive regulation between partners, which itself can help bolster each partner’s capacity for self-regulation. Getting there means the PACT therapist not only ensures a secure-functioning relationship for the couple, but also helps them work through their trauma histories. In the beginning of treatment, the therapist may have to tolerate an extended period wherein he or she is the target of negative projections by one or both partners. A skilled therapist is the best proxy to manage harsh internal object representations stemming from early abuse or neglect. Disorganized couples, at least early in therapy, are unreliable at managing these projections. Disorganized partners become rapidly dysregulated by each other’s perceived dangerous facial expressions, vocal expressions, movements, and words.

The unpredictable nature of highly disorganized partners places both partners and the therapist in the precarious situation of not knowing where the landmines are hidden. Therefore, the therapist must always be prepared to repair sudden and sometimes inexplicable ruptures in the intersubjective field. The PACT therapist uses his or her skills at reading arousal and affective shifts and changes in both partners and remains sensitive to implicit nonverbal signals of distress.

Therapeutic Alliance

Bottom-up or triadic working through of early traumatic experiences (e.g., with psychodrama, empty chair work, or any other technique in which the other partner is a proxy for historical figures) is not recommended during the early stages of treatment. The therapist can and probably should do individual therapy, as needed, alternating between partners while both are in attendance. Individual therapy without both partners present simultaneously is not recommended. Only at the point when the couple therapist is confident that he or she has achieved a full and continuous therapeutic alliance with both partners should the use of both partners as proxies for historical figures be considered. A full and continuous therapeutic alliance means that both partners are able to sustain object constancy, collaboration, and therapeutic task-centered focus (i.e., understand the task of psychotherapy). Acting out should no longer be center stage. Instead, partners are fully on board with the task of helping one another work through and repair early relational injuries.

Conclusion

The couple therapist working with highly disorganized partners or couples must maintain a firm therapeutic frame and a clear and coherent therapeutic stance if couple therapy is to succeed. With this population, the therapist is advised to start low, go slow, but get there. Working through unresolved trauma should take a back seat to gaining a therapeutic alliance with both partners and making the therapeutic intersubjective experience safe and secure.

Couple therapists may become intimidated by the highly disorganized partner or couple and want to refer to individual therapy, or in fact, may believe that these persons are best served in individual psychotherapy. However, this idea dismisses the purpose of couple therapy, which is to help partners care for each other in a safe and secure manner. The need for partner safety and security cannot and should not be delayed because of PTSD, mental illness, drug addiction, or any other affliction that complicates a couple’s well-being. Instead, the therapist should consider the idea that all partners, no matter how impaired, deserve a secure-functioning relationship, especially if they come to therapy for help with their relationship.

All too often, couple therapists are guilty of outsourcing their difficult cases. It should be noted that highly disorganized partners or couples not only do not benefit from outsourcing, but their acting out often increases. This, in turn, can create a much greater clinical problem for the outsourcing therapist. Highly disorganized partners and couples are a challenge, to be sure, but like
We, as couple therapists, can approach these challenges not only as rewarding work, but as work that is much needed by the people who seek us out for help with their valued relationship.

everyone else, they deserve a safe and supportive adult attachment relationship with a chosen equal, and not simply a hired professional.

Disorganized individuals come in a variety of shapes and sizes. Some have experienced extreme and continuous relational trauma early in life; some have been subjugated to enormous neglect; some have been born to parents with unresolved histories of PTSD; and some have PTSD, with or without personality disorders. Moreover, some are resilient, while others have an unfortunate combination of trauma, neglect, and genetic predisposition. We, as couple therapists, can approach these challenges not only as rewarding work, but as work that is much needed by the people who seek us out for help with their valued relationship.

References


Main, M., & Hesse, E. (1990). Parent’s unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parent behavior the linking mechanism? In M. Greenberg, D. Cicchetti, & E. Cummings (Eds.), *Attachment during the preschool years: Theory, research, and intervention* (pp. 161–182). Chicago, IL: University of Chicago Press.


