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TRAUMA AND DISMISSING (AVOIDANT) ATTACHMENT: INTERVENTION STRATEGIES IN INDIVIDUAL PSYCHOTHERAPY

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Intrafamilial trauma is known to be associated with mental health-related challenges that place the individual at risk for the development of psychopathology. Yet, those trauma patients who are primarily dismissing (avoidant) of attachment also demonstrate significant defensiveness, along with a tendency to view themselves as independent, strong, and self-sufficient. Paradoxically, such patients present as highly help rejecting, despite concurrent expressions of need for treatment and high levels of symptomatic distress. Consequently, working with such individuals in psychotherapy can present a number of challenges. Prior theory and research has suggested that therapeutic change may be facilitated through direct activation of the attachment system and challenging defensive avoidance. Treatment strategies for working with this population are presented along with illustrative case examples. Such strategies include addressing the "I'm-no-victim" identity, using symptoms as motivators, noticing and using ambivalence, and, finally, asking activating questions around themes of caregiving and protection.

Keywords: attachment, trauma, psychotherapy, avoidant, dismissing

Considerable prior attention has been paid to treating individuals with histories marked by intrafamilial trauma (Briere, 1989; Courtois, 1988; Herman, 1992; McCann & Pearlman, 1990). These patients are often considered to be quite challenging, with difficulties arising from such issues as the complex nature of forming therapeutic alliances because of histories of interpersonal instability, emotional immaturity, and behavioral acting out (Chu, 1998; Davies & Frawley, 1994; Pearlman & Courtois, 2005), as well as issues arising from the emotional burden placed on the therapist (Alexander & Anderson, 1994; Dalenberg, 2000; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). The importance of treatment cannot be emphasized enough (Briere, 1988) because 48%–85% of trauma survivors show a lifetime prevalence of posttraumatic symptomatology (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997; Stovall-McClough & Cloitre, 2006), along with 76% showing an insecure pattern of attachment as adults (Muller, Sicoli, & Lemieux, 2000).

Recently, theory, research, and clinical techniques (e.g., Alexander & Anderson, 1994; Muller, 2006, 2007; Muller & Bedi, 2006; Slade, 2004) have begun to focus on a unique subset of the intrafamilial trauma population, those characterized by a dismissing (avoidant)

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attachment.[1] Unfortunately, there is only a limited literature on specific intervention strategies for working with such patients. Some articles have examined the role of attachment in the therapy of such individuals (Sable, 2000; Slade, 2004) and included populations like incest survivors (Alexander & Anderson, 1994) and individuals with complex trauma (Pearlman & Courtois, 2005). However, given their broader focus on different kinds of attachment patterns in the treatment of intrafamilial trauma patients, the emphasis in these prior studies has tended to be less specific in regard to particular treatment recommendations.

This article is intended to introduce the reader to specific intervention strategies for individual psychotherapy with this challenging clinical population. A synopsis of the unique defensive processes characterizing such patients is followed by an empirically grounded rationale in favor of an approach that activates the attachment system and challenges defensive avoidance. The remainder of the article then focuses on specific strategies for intervention, along with illustrative case examples, derived through the course of my clinical work with patients in the Trauma Treatment Project at York University, a clinical research program focused on intrafamilial trauma and attachment in psychotherapy (Muller, 2006, 2007; Muller & Bedi, 2006; Muller, Kraftcheck, & McLewin, 2004; Rosenkranz, Muller, & Bedi, 2007).

Dismissing (Avoidant) Attachment

Dismissing attachment is characterized by the avoidance of feelings, memories, or longings that might drive away the attachment figure (Slade, 2004). In Bowlby's (1988) view, this was avoidance in the service of proximity. Because attachment behavior has as its aim the maintenance of proximity, the function of this avoidance is to disable feelings and ideas that threaten the real or perceived relationship. By deactivating attachment in this way (George & West, 2001; George & West, in press), the patient shifts attention away from memories of potentially painful relationship episodes with caregivers, thereby avoiding possible threat to his or her characterization of the relationship. Freyd (1996, 2001), using the term *betrayal trauma*, explained such memory processes by viewing them as adaptive. That is, forgetting certain kinds of betrayal experiences, such as abuse from a primary caregiver, can be necessary for the individual's survival.

Related to deactivation is the minimization of negative experiences. In the case in which the patient is speaking of a traumatic event, particularly one that is attachment related, the tendency is to minimize the event's meaning or its perceived negative impact. Alexander (1992) noted the "self-deception" that occurs for such patients in an attempt to deal with painful affect. For example, during an Adult Attachment Interview (AAI), one such patient was discussing a childhood memory of her nanny's precipitous, unexplained tragic death; this nanny had almost exclusively raised her. With a matter-of-fact shoulder shrug, she stated, "It was no biggie . . . next question?" The tendency to minimize the meaning of negative life experiences may also be accomplished by putting a positive ending on an otherwise negative story, without much awareness of the resulting incoherence of the overall story (Hesse, 1999).

Other important features include such characteristics as the tendency to perceive and present themselves as strong, normal, self-reliant, and independent (Bartholomew & Horowitz, 1991; Eagle, 1996); the tendency to idealize one or both parents (Hesse, 1999), such that the characterizations of the parent in question come across as far more positive or glowing than the recalled events actually warrant (e.g., "My mother was loving because she only spanked us in private, never in public"); a tendency to have a weak memory for childhood, such that large blocks of time are unaccounted for or traumatic events are glossed over, forgotten about, blocked, or perceived as unnecessary to dwell on (Alexander et al., 1997; Slade, 1999); and the tendency to seek therapy

[1] In considering the question of treating trauma patients with dismissing attachment patterns, it should be noted that there is actually very little research examining the prevalence of different attachment patterns among individuals with intrafamilial trauma histories. Research by Stovall-McClough and Cloitre (2006) examined a group of 60 women who had experienced childhood abuse and found that between 10% and 23.3% (depending on the extent of posttraumatic symptomatology) were assigned to the primary AAI classification of dismissing. In comparison, the meta-analytic research of van IJzendoorn and Bakermans-Kranenburg (1996) looking at AAI classifications in nonclinical and clinical samples estimated the dismissing group at about 15% for nonclinical samples and 26% for heterogeneous clinical samples.

for symptom-based reasons (Dozier & Bates, 2004).

General Approach: Activating the Attachment System

Prior theoretical and empirical work on dismissing attachment (e.g., Berant, Mikulincer, & Florian, 2001; Edelstein, 2007; Edelstein & Gillath, 2007; Edelstein & Shaver, 2004) has pointed to significant health- and mental health-related consequences associated with defensive avoidance and has indicated that the defensive process of deactivation is highly effortful and prone to breakdown in the face of high stress in general and attachment-related distress in particular. In this section, I propose a general treatment approach that runs counter to the defensive strategy favored by such patients, that is, an approach that is activating of the attachment system, one that turns the patient's attention toward attachment-related experiences and challenges defensive avoidance. Without such challenge, the psychotherapist runs the risk of colluding with avoidant coping patterns that may evade distress in the short run yet turn out to be ineffective over time (Bernier & Dozier, 2002).

There are three empirically derived rationales for a general treatment approach that favors activating the attachment system. These are presented next.

Challenging Deactivation

Individuals who are dismissing of attachment put considerable psychological effort into closing off discussion of threatening issues. Unless challenged, such issues will likely remain closed off.

Deactivation, a central defensive characteristic of dismissing attachment, has as its goal to shift the individual's attention away from those feelings, situations, or memories that arouse the attachment system. It enables the person to diminish, minimize, or devalue the importance of attachment stimuli (George & West, 2001). Recent research (e.g., Edelstein, 2007; Edelstein & Gillath, 2007; Edelstein & Shaver, 2004) looking at attentional biases examined under experimental conditions has supported the hypothesis that dismissing individuals inhibit attention to negative and positive attachment-related material. More important, such inhibition occurs only when stimuli are attachment related, suggesting that such individuals' regulatory skills are specific to attachment-related material, as opposed to material that arouses strong affect in general. Further still, Edelstein (2007), Edelstein & Shaver (2004), and Edelstein & Gillath (2007) found that the dismissing individual's tendency to direct attention away from attachment-related stimuli breaks down under increased cognitive load, demonstrating that avoidant processing biases result from the effortful inhibition of attachment-related material. In other words, such individuals turn attention away from issues that activate the attachment system, and active suppression requires considerable effort. Similar findings have been reported by Dozier and Kobak (1992), who questioned participants about their attachment-related experiences and found that among the dismissing individuals, there were greater rises in skin conductance, indicating higher levels of anxiety when discussing attachment-related experiences despite verbally minimizing any distress, further corroborating the notion that for such individuals, suppression of attachment-related material is a psychologically effortful process.

Turning to individual psychotherapy, we correspondingly see that attachment as a topic of discussion is often closed for such individuals (George & West, in press) or else discussed in such a manner as to neutralize affect. Unless the attachment system is activated in treatment, attachment as a topic of discussion will likely remain closed or, as is often the case with brighter, analytic individuals, the underlying affective meaning of a given issue will remain closed (Slade, 1999), rendering it impossible to reappraise or restructure mental representations of self or other. The consequence would be an indefinite circling around disquieting topics without addressing them substantively. Researchers in the area of short-term dynamic psychotherapy have referred to affect phobias as the fear and avoidance of one's own emotional responses, such as anxiety, guilt, shame, or fear of rejection (McCullough, 1998; McCullough & Andrews, 2001). A number of investigations have lent support for focusing more intensively on affective experiences, demonstrating, for example, that the greater the ratio of affect to defenses expressed in session, the greater the improvement at outcome (McCullough & Andrews, 2001; Taurke, McCullough, Winston, Pollack, & Flegenheimer, 1990). In addition, recent neurocognitive studies (e.g.,

Lieberman, Eisenberger, Crockett, Tom, Pfeifer, & Way, 2007) have begun to lend support to the notion that affect labeling (putting feelings into words) can play a significant role in managing negative emotional experiences.[2]

With patients who have histories of intrafamilial trauma, the failure to activate attachment precludes the possibility of helping patients confront such important but painful questions as "If my mother were indeed so loving, why didn't she protect me from the abuse?" Thus, Bernier and Dozier (2002) cautioned against the therapist's natural inclination to respond to such patients by respectfully going along, engaging on superficial, nonthreatening issues. Instead, they encouraged a more challenging therapeutic stance.

Research on Noncomplementarity of Attachment in Treatment Relationships

Dismissing individuals appear to do better in psychotherapy when paired with clinicians who have a tendency to be more activating of attachment. Recent psychotherapy research has begun to elucidate the match between client and therapist attachment patterns. Although only a handful of studies have directly addressed this matter, some initial patterns are beginning to emerge. Increasingly, such studies have demonstrated stronger effects when clients and therapists have an interpersonal stance that is noncomplementary, or contrasting of client expectations (Dozier & Tyrrell, 1998). Studies evaluating adult attachment patterns in therapist–client dyads have begun to show that therapists and clients with dissimilar attachment tendencies on the preoccupied–dismissing dimension have a greater likelihood of treatment success. Bernier and Dozier (2002) indicated that in such dyads, the therapist's natural style makes it more likely that she or he will take on an interpersonal stance that runs counter to what the client pulls for, consequently disconfirming client expectations and perceptions. In one study (described in Bernier & Dozier, 2002), Bernier, Larose, and Soucy (2001) administered the AAI to counseling dyads in an academic setting. They found support for the noncomplementary hypothesis, using both objective and subjective measures of outcome, such that for dismissing students, the most effective matches were with counselors who valued relationships, connectedness, and interdependence. In a similar study, Tyrrell, Dozier, Teague, and Fallot (1999) found that for psychiatric patients and their case managers—all of whom had been administered the AAI—better results were reported for the noncomplementary dyads. Of relevance here, patients considered to be dismissing worked significantly better and demonstrated better outcomes when paired with clinicians who were more activating of attachment.

It is important to note that among the few investigations to date on attachment patterns in treatment dyads, none have been conducted specifically with trauma patients. The Tyrrell et al. (1999) study did look at patients with serious psychiatric disorders, many of whom were diagnosed with varying degrees of depression and comorbid substance abuse disorder. However, as noted by Bernier and Dozier (2002), considerably more research is needed on the role that noncomplementarity of attachment plays among patient and therapist in psychotherapy. What is also unclear at this point is the full range of factors that may give some therapists the capacity to adjust their style of attachment activation, depending on the client's particular needs. Dozier and Bates (2004) suggested that securely attached clinicians are likely in the best position to make such shifts. Indeed, Dozier, Cue, and Barnett (1994) found that secure clinicians demonstrated the greatest flexibility and were the most likely to adjust their style of intervention so as to provide noncomplementary responses to clients.

Despite their limitations, these few studies do initially suggest that for patients who are inclined to defend against attachment-related distress through the use of deactivation, improved likelihood for successful outcome may be found with a clinician who is more activating and therefore more likely to present a challenge to the patient's usual experience of relationships. This notion is consistent with Bowlby's (1988) view that a ther-

[2] Neuroimaging studies have begun to suggest a possible neurocognitive pathway for the process by which affect labeling (putting feelings into words) can help manage negative emotional experiences. A functional magnetic resonance imaging study by Lieberman et al. (2007) indicated that affect labeling, in comparison to other forms of encoding, diminished the response of the amygdala and other limbic regions to negative emotional images. More specifically, the results suggested that affect labeling may diminish emotional reactivity along a pathway from the right ventrolateral prefrontal cortex to the medial prefrontal cortex to the amygdala (Lieberman et al., 2007).

apist applying attachment theory provides the conditions in which the patient can explore, reappraise, and restructure prevailing representational models.

Defensive Breakdown

The defensive strategy of deactivation, favored by dismissing patients, is prone to breakdown under high stress and is associated with significant health- and mental health–related costs. Thus, helping patients build healthier coping patterns may yield tangible, meaningful benefits.

Research in the area of developmental psychopathology has examined the extent to which the dismissing attachment pattern is associated with risk for compromised functioning. Regarding this question, some clear patterns emerge, whereas others require qualification. Where security–insecurity is concerned, there is wide agreement that insecurely attached individuals, regardless of the way attachment is measured, demonstrate higher levels of risk for the development of psychopathology across the life span (Muller et al., 2004). However, in comparing dismissing individuals with those who are preoccupied, it appears to depend on contextual factors. Studies of adults not in treatment have reported dismissing individuals to be lower on general psychopathology symptoms, lower on trauma-related symptoms (Muller, Lemieux, & Sicoli, 2001), and lower on symptoms of depression than their preoccupied counterparts (Carnelley, Pietromonaco, Jaffe, 1994; Murphy & Bates, 1997). However, in clinical samples (Dozier & Lee, 1995), dismissing individuals score higher on symptomatology than those who are preoccupied.

It is possible that some of the inconsistency in the psychopathology literature may be because of the effect of context on dismissing defenses. There is a growing view that the defenses used by dismissing individuals become ineffective when they are under high levels of situational stress. Thus, deactivation may work adequately as a defense when demands are minimal. However, in more psychologically demanding contexts, such as stressful life events (e.g., illness), or during periods of developmental shift (e.g., birth of a child), dismissing defenses can become incapacitated (Edelstein & Shaver, 2004). Evidence that dismissing defenses break down under stress can be found in research by Mikulincer and Florian (1998). Deactivating coping patterns (e.g., ignoring, distancing, and not seeking social support) were linked to subsequent psychosomatic symptoms attributable to stress in survivors of Scud missile attacks. Similar findings have emerged in studies of maternal reactions to the birth of a child with congenital heart disease (Berant et al., 2001) and in clinical case studies (Sable, 2000).

Consistent with findings on defensive breakdown under conditions of high stress, a number of researchers have found negative consequences for well-being over time (Shedler, Mayman, & Manis, 1993). Empirical studies in developmental psychopathology and health psychology have demonstrated associations between higher levels of avoidance and subsequent increases in depression (Edelstein & Gillath, 2007), as well as associations between emotional suppression and risk for the development of cardiovascular disease (Mauss & Gross, 2004) and elevations in blood pressure (Jorgensen, Johnson, Kilodziej, & Schreer, 1996). Recent research by Edelstein (2007) has demonstrated that among dismissing individuals, active inhibition of attachment-related material is predictive of increased psychopathology over time, suggesting that the use of defensive avoidance has long-term psychological costs. In a detailed review, Shedler et al. (1993) concluded that the process of inhibiting thoughts and feelings entails physiological work, reflected in the short run in autonomic reactivity and in the long run in increased health problems.

In summary, prior research has pointed to significant physical and psychological consequences associated with defensive avoidance and indicated that the defensive process of deactivation is highly effortful and prone to breakdown in the face of high stress in general and attachment-related distress in particular. Prior research is also suggestive of a general treatment approach that runs counter to the defensive strategy favored by such patients, namely, an approach that is challenging of defensive avoidance and therefore disconfirming of patient expectations and perceptions. Without such challenge, the clinician runs the risk of colluding with avoidant coping patterns that may evade distress in the short run yet turn out to be ineffective over time.

Treatment Paradox

Intrafamilial trauma is now known to be associated with a host of psychological factors and challenges that place the individual at risk for the

development of psychopathology across the life span (Briere, 1988; Muller et al., 2004; Stovall-McClough & Cloitre, 2006). When coming for therapy, trauma patients are often polysymptomatic. Yet, those who are dismissing of attachment demonstrate the tendency to be highly help rejecting, defensive, and minimizing. Horowitz (1976, 2001) described the appearance of denial and general emotional numbness that follow traumatic events for many such patients. Despite a psychological vulnerability that arises from a history of trauma, the individual puts forth significant defensive efforts to maintain a view of self as strong, independent, and normal. These opposing factors converge so as to put the patient—indeed, the therapist as well—into a dilemma. Considering and talking about traumatic events flies in the face of defensive avoidance. Yet, failing to recognize one's own history flies in the face of reality. In treatment, empathic statements recognizing how difficult or painful a particular traumatic experience must have been for the individual are met with cool, cavalier denial (Pearlman & Courtois, 2005). But for the therapist, keeping things light would be complicit in the act of minimizing traumatic events and failing to provide the patient with a psychologically safe environment within which to explore painful experiences. Previous trauma theorists have described the countertransference that emerges with such patients as the tendency to engage in a mutual avoidance (Alexander & Anderson, 1994), which provides relief for both the therapist and patient (Davies & Frawley, 1994).

Consequently, such patients have considerable difficulty engaging in the psychotherapy process. They possess a combination of characteristics that make therapy necessary but at the same time highly threatening.

Development of Proposed Intervention Strategies

Treatment strategies presented in the sections to follow were developed through the course of my clinical work with patients in the Trauma Treatment Project at York University, a clinical research program focused on intrafamilial trauma and attachment in psychotherapy (Muller, 2006, 2007; Muller & Bedi, 2006; Muller et al., 2004; Rosenkranz et al., 2007).

Patients were self-referred and were seeking individual psychotherapy for self-identified, symptomatic concerns. All completed a set of standardized preliminary screenings administered over the phone by trained research assistants unaware of the purposes of the project. Patients were invited to the clinical interview if they met criteria on both trauma-related symptomatology and attachment pattern (dismissing attachment). Screening tools included the Trauma Symptom Checklist−40 (Briere & Runtz, 1989; Elliot & Briere, 1992) and the Reciprocal Attachment Questionnaire (West & Sheldon-Keller, 1994). Prospective patients were unaware of the purposes of this project and of screening criteria. History of intrafamilial trauma (physical, sexual, or psychological abuse; domestic violence exposure; or early death of an attachment figure) and dismissing attachment pattern had to be clearly confirmed in a subsequent clinical interview for continued inclusion. When consent was obtained, the initial interview and treatment sessions were videotaped.

Psychotherapy was carried out by a psychodynamically trained, experienced clinical psychologist (myself) over the course of a 3-year period on 15 patients. The mean and median number of sessions were 15.4 and 14, respectively, and ranged from 6 to 30. Participants included 8 men and 7 women (mean and median ages = 34.5 and 36.5, respectively). Sessions occurred at the project clinic, once a week or every 2 weeks, depending on patient preference and practical limitations.

Intervention Strategies

As described earlier, there is a limited literature on specific interventions for working with intrafamilial trauma patients characterized by dismissing attachment patterns. The few extant articles examine the role of attachment in the psychotherapy of such patients (Alexander & Anderson, 1994; Pearlman & Courtois, 2005; Sable, 2000; Slade, 2004). However, these articles focus more broadly on the ways in which different attachment patterns unfold over the course of treating such patients. Thus, the emphasis in these prior studies tended to be less specific in regard to particular treatment recommendations. The remainder of this article, then, focuses on specific strategies for the treatment of this challenging population.

Addressing the "I'm-No-Victim" Identity

One of the challenges in working with this population is related to the strong contrast between the traumatic events that have ostensibly touched these people's lives and the usual ways in which they view themselves. Commonly recognized trauma-related language is very off putting. *Trauma, abuse,* and *victim* all conjure up images of weakness and vulnerability, and affective states associated with trauma, such as grief, disappointment, despair, and ambivalence, are very uncomfortable and are inconsistent with the dominant identity such patients work so hard to construct.

Keeping these two worlds separate requires a process of splitting information along two separate story lines. Such *cognitive disconnection* (George & West, 2001, in press) keeps a very real and important aspect of these people's lives separate and unexamined (Chu, Frey, Ganzel, & Matthews, 1999). Consequently, when asked about memories of traumatic events, when they are remembered, stories are told in highly distorted form (Freyd, 2001). It is common that such stories are recounted in the guise of light, humorous anecdotes.

Consider an excerpt taken from the AAI of a 36-year-old successful investment banker, presenting with symptoms of chronic binging and purging that have persisted since early adolescence. Here, the patient describes discipline in the family of origin.

> I think once when we were like 6 years old, or something, or I'm 8 and my sister's 10, or whatever the case may be. And we were playing in the living room, and, like I guess, wrestling or whatever. We were jumping on the couch, and we knocked a lamp over, and everything over, and we were trying to clean it up quickly before my dad came. But he came, and he was mad. So he took off his belt. And we each got spanked . . . I don't know how many times . . . but it didn't really hurt. And then we went out to the backyard. And we just laughed and laughed about it because we had candies stuffed into our back pockets, so it didn't even hurt. So it wasn't really that scary or anything . . . to me. We just thought it was funny.

In the early phases of therapy, traumatic memories were recalled in highly distorted form, and the patient was not at all critical of parental choice of discipline, working very hard to convey to the clinician that the parent in question was in all respects flawless, indeed, highly admirable.

Ironically, not only do such patients put forth efforts to suppress painful stories and their emotional meanings, but many also communicate unapologetically harsh attitudes toward other victims, including a strong tendency to blame victims (Muller, Caldwell, & Hunter, 1994), when they learn of others' abuse experiences. This is reflected in an ideology that dismisses psychological causation and assumes that victims should just get over it. The conspicuously harsh language used in reference to other victims leads the clinician to wonder just how harsh the self-criticism would be if the patient were to view him- or herself as the victim. By keeping up a self-image of strength and normality (as opposed to that of a victim), they can protect themselves from both the vulnerability connected to having been victimized and the criticism that may be applied to them for any perceived role they may have played in their victimization. Equally as compelling, they protect the represented attachment relationship from the destabilization it would suffer if the individual were to view him- or herself as victim of the very parent she or he idealizes (Davies & Frawley, 1994; Fairbairn, 1943/1990).

In working with such patients, it is generally unrealistic to try to quickly reconcile discrepant storylines. Attempts to get them to face the reality arising from trauma-related events are likely to fall flat (Sable, 2000), as are attempts to push onto the individual the *trauma survivor* label or victim-related language. Such patients will patently reject the labels of *abuse* or *victim* and will quickly dismiss the therapy as irrelevant to them.

Instead, the clinician can notice and expresses interest in narrative discrepancies found in the patient's personal stories, that is, drawing attention to the ways in which different elements of the stories do not add up. The clinician may adopt a stance of curious exploration (Pearlman & Courtois, 2005), asking the patient what she or he makes of the seeming inconsistencies. Although the patient attempts to keep separate his or her self-image of strength and experiences of vulnerability, the clinician nevertheless inquires about how they might fit together, for example, "I notice that earlier on you described having a 'totally normal' childhood; is this [e.g., traumatic event] an example of that, or is this different in some way?" or, with the patient who laughs as she tells of abuse experiences, "As you told that story, you looked like you found it really funny. Is that the *only* thing you were feeling?" This may be followed up with "Who in your family finds that story most or least funny?" Examining such nar-

rative discrepancies builds shades of gray into the patient's understanding of his or her own story and opens the door to examining experiences and feelings that are uncomfortable and closed off.

Finally, it is important that gentle but consistent pressure be kept up to help the individual stay focused. The clinician resists the temptation to rescue (Pearlman & Saakvitne, 1995) the patient from the anxiety surrounding difficult attachment-related material. When the patient responds with "I don't know; I never thought about that before" and then stares at the clinician or searches uncomfortably for a distraction, instead of rescuing the individual with another question, the clinician asks the person to take his or her time, and think about it right now, even if it is the first time she or he has ever thought about it. This is then followed by a period of attentive, engaged silence. Such an approach undermines deactivation and is therefore experienced as quite challenging.

Using Symptoms as Motivators

For such patients, the decision to start psychotherapy is often linked to a period of defensive breakdown (Pearlman & Courtois, 2005), wherein coping resources are overextended (Sable, 2000). Initially, the presence of symptoms and the wish to make them disappear can be highly motivating and can provide a buy-in to therapy. However, early on in treatment, it is important to help the patient make a shift toward a position in which the psychotherapy starts to be important to him or her on a deeper level (West, Sheldon, & Reiffer, 1989), one in which the person begins to experience a more meaningful connection to the process. If the individual's motivation for psychotherapy stays at the level of simple symptom relief, she or he may become disillusioned with the process and terminate treatment prematurely.

To address this issue, the therapist can make use of the symptomatic presentation to help such patients find a much more meaningful connection to psychotherapy. One way is to draw a connection between symptoms and attachment-related issues. The therapist may ask about relationship-based themes in the initial pattern of symptom presentation. Doing so helps the patient recast symptom-based problems and goals into attachment-related ones. For example, the individual who allows him- or herself to make the shift from viewing the problem as depression and loneliness to that of self-isolation or keeping people at arms' length is far more likely to find psychotherapy meaningful.

One such patient, who was self-referred for depression and loneliness, arrived to one of her earlier sessions incensed by her new boyfriend's accusation that she was "insanely independent." Although defensive at first, within a short time she was able to acknowledge that, indeed, this was a problem for her. In fact, she went on to confess that she often felt "smothered" and "latched onto" by her boyfriend, the only romantic partner in her history who never physically abused her. In time, she came to view her depression as closely tied to "insane independence" and decided to refocus psychotherapy onto gaining greater understanding of this repetitive pattern in her life.

Symptoms can be used with this population as a productive means of sparking initial interest in therapy. But subsequent meaningful connection of symptoms to attachment-related experience can make continued engagement in psychotherapy that much more compelling.

Related to the distress caused by symptoms in and of themselves is a certain emotional injury that goes along with having become symptomatic in the first place, a process I refer to here as *dismissing disillusion*. The term refers to the idea that when such patients become symptomatic, they can experience a profound sense of disillusion. As detailed in both the clinical and the experimental literatures (e.g., Berant et al., 2001; Edelstein, 2007; Edelstein & Gillath, 2007; Muller, 2006, 2007), such individuals are able to effectively cope with the vicissitudes of life as long as attachment-related distress is kept to a minimum. But when defenses no longer work effectively and they become symptomatic, they find themselves shocked that they are no longer holding it together as they used to, asking themselves, "Why can't I handle things anymore?" Their current symptomatic state is inconsistent with their proclaimed self-image. So they become disillusioned. One patient put it very succinctly, following an out-of-character suicide attempt. As she forced a wide toothy smile, with eyes welling up, she insisted, "But I am a happy person! So . . . why am I *crying* all the time?"

This sense of disillusion is very distressing. However, the therapist can connect with the patient by noticing and highlighting the disillusion

and by allying with the patient's motivation to understand just why she or he would suddenly be feeling so much worse than before. Given the tendency toward competence and self-reliance, such patients feel considerable disappointment in themselves for becoming symptomatic. There is a sense of failure and shame for having fallen apart or self-directed anger for being so needy, along with a desire to figure out how to protect themselves from falling apart in the future. Such emotion can be highly motivating, and the therapist can ally with the patient, using his or her sense of disillusion as a motivating force in the service of the therapy.

For one such patient, who saw herself as "tough and level-headed," her unmanageable feelings surrounding an inexplicable, out-of-character, 3-month drinking binge reportedly made her feel a sense of outrage and anger at herself and served as a motivator to seek therapy.

By connecting with the patient around the sense of disillusion and by allying with the patient's motivation to understand why she or he would suddenly be feeling so much worse than before, the clinician can ask about and listen for the meaning attached to symptoms, and where such meanings are suggestive of *themes of vulnerability,* these are pointed to, asked about, and examined. Part of the reason such patients feel disillusioned appears to be because of a painful awareness of their own vulnerability. Helping them gain greater acceptance of these vulnerabilities (Sable, 2000) is an important part of the treatment process.

For example, consider a patient who declares *spinelessness* as his word to describe the meaning of depression to him. This word can be contrasted with the patient's usual backdrop of, say, self-proclaimed strength. The therapist and patient can then reflect on this vulnerability. The clinician inquires about its history in the patient's life. "When was the first time you showed anyone your spineless side?" "On those rare occasions that it occurred, how did your parents deal with such spinelessness on your part?" "How have you reacted to spinelessness in others?" "How is it that your sister got the opportunity to be spineless, and you had to keep your spine so strong?" Specific answers to questions are less important than the process of self reflection. For such patients, recognizing feelings around having become symptomatic and then connecting that to other experiences of vulnerability makes it possible to help integrate a far more textured and realistic view of self, a view wherein stories of strength and weakness, independence and spinelessness, can come to coexist.

It is noteworthy that the process of examining themes suggestive of vulnerability may yield feelings such as anger toward the therapist, especially early in treatment. After all, the individual's attention is being turned toward uncomfortable emotional needs. However, such transference reactions may also present an opportunity (West et al., 1989) to explore the experience of appearing vulnerable and weak in the presence of an important other.[3] The expression of vulnerability is likely to repeat itself in treatment because vulnerability is a basic prerequisite for intimacy.

Listening for, Noticing, and Using Ambivalence

One of the challenges in working with this population is determining what to do about patient reluctance to face personal traumatic events. Even in the case of severe parental abuse or neglect, there is a tendency to idealize one or both parents and to paint portraits of parental competence that are unsupported by the facts of the patient's own stories (Hesse, 1999), leaving the therapist with the impression that the person is fooling him- or herself. Such patients will minimize (Slade, 1999) traumatic events to make them more socially appropriate; they will put a positive spin on trauma stories so that everything turns out well in the end; or they will distort the facts of their own lived experiences (Dozier & Bates, 2004).

But some things are hard to avoid indefinitely.

[3] Recently, Wallin (2007) argued in favor of letting such patients in on the therapist's own experience of the relationship because such self-disclosure is thought to provide a route to "otherwise inaccessible feelings, thoughts, and memories" (Wallin, 2007, p. 213). In the context of a well-developed therapeutic relationship, such an approach may have the advantage of giving rise to a therapeutic climate in which vulnerability is seen as more acceptable in the presence of another because the therapist himself or herself is taking a risk, making it that much less threatening for the patient to do likewise. However, such an approach may also yield the unintended consequences of stirring both the patient's defensive contempt for others' vulnerabilities and anxieties surrounding the therapist's ability to be strong enough to rely on. The strength of the therapeutic relationship would likely play a pivotal role in the effectiveness of such an intervention.

The very nature of intrafamilial trauma is such that over time, associated thoughts and feelings are bound to get triggered (Wilson & Lindy, 1994). Horowitz (1976, 2001) stated that warding off thoughts about traumatic events may alternate with intrusive repetitions across different relationships. When attachment-based life changes occur, these can serve to destabilize the suppression of traumatic material. Such life changes would include actual or perceived losses, medical illnesses, family crises, and important developmental shifts (e.g., anticipation of becoming a parent or of getting married). Sometimes, trauma-related thoughts and feelings can be triggered by external factors that may include, for example, exposure to trauma-related material in various forms of popular culture.

When relevant life changes trigger thoughts and feelings related to trauma, the patient may present signs of ambivalence, and the therapist may gain the impression that on one hand, the patient wants or needs to discuss his or her trauma experiences, but on the other she or he refrains from doing so out of anxiety or fear. Such moments of naturally occurring ambivalence can serve as windows of opportunity to move the therapy forward.

One such patient, presenting with sexual difficulties and infertility, described years of sexual abuse by her older brother as being "irrelevant" because she had "dealt with it long ago." When I inquired as to why she would bring it up at all if she felt it were irrelevant, she shrugged, "I don't know. Must be all the Oprah Winfrey I watch," jokingly referring to sexual abuse as an ongoing discussion topic on that television program. After this, she promptly changed the subject. For several months, she refrained from any discussion of the abuse, focusing instead on her panic disorder and poor organizational skills at work. Nevertheless, she came back to the topic in the session after her 40th birthday, when a friend told her that since she was 40 her difficulty becoming pregnant might now be a permanent condition. In one of her more emotional sessions, she confessed that if she could become a mother without having to endure sex, she would, after which she asked me if I thought this sexual problem had anything to do with the years of sexual abuse her brother had put her through. I replied with a simple "I don't know . . . what do you think?" Her response was quite striking, expressing feelings related to her abuse history that came across as far more genuine than anything she had expressed previously. She acknowledged, for example, that her parents had been quite unresponsive to the ongoing abuse, mostly ignoring it. Such an admission was terribly frightening to her because it meant confronting her more usual tendency to idealize her childhood relationship with her parents. Nevertheless, this became something I could make reference to, ask her to make connections to, and encourage her to expand on in subsequent sessions. In this case, the threat of lost motherhood in part served to help mobilize the patient toward greater self-reflection. During periods of attachment-based change and psychological transition, defenses can become less rigid, and such individuals may present signs of naturally occurring ambivalence, opening an opportunity in the therapy.

The other side of ambivalence is the piece the clinician brings; that is, the extent to which the therapist turns his or her own attention toward trauma-related material when it arises (Dalenberg, 2000). Previous theorists have described countertransference with such patients as the tendency to engage in a "mutual avoidance" (Alexander & Anderson, 1994), which provides relief for both patient and therapist (Davies & Frawley, 1994). When trauma-related references arise, they do so in a minimizing, vague, contradictory, or perfunctory manner. The therapist is left to make decisions on whether she or he will focus on such references, seek clarification or embellishment, show special interest in such material, come back to trauma-related references made months earlier, make such material a focus of treatment even if the patient does not initially see that as necessary, and so on.

In such a case, the therapist is left holding the ambivalence that the patient cannot tolerate. The pull is for the clinician to resolve this by going along with what the patient is ostensibly asking for (Bernier & Dozier, 2002). Where the patient minimizes the magnitude of the trauma, there is pressure on the therapist to do so as well. Where the patient conveys dismissal of the therapist's questions regarding trauma, the therapist accommodates. Such patients can respond to questioning about trauma-related feelings by rejecting them outright, minimizing or laughing off therapist observations, or using defenses such as intellectualization to dampen the intensity of therapist comments. In response, the clinician may react (Mills, 2005; Pearlman & Courtois, 2005)

to such rejection or minimization with a variety of emotions (e.g., frustration, irritation, hurt, or disappointment), with different therapist responses depending on the clinician's own personal history and attachment pattern (Dozier & Tyrrell, 1998; Gelso & Hayes, 1998; Mohr, Gelso, & Hill, 2005). Over time, the clinician may accommodate to the patient by way of collusion (Wilson & Lindy, 1994), such that the topic of trauma becomes unspeakable or severely watered down.

The challenge facing the therapist is to make active attempts to turn his or her attention toward trauma-related material; to listen for it, notice it, ask about it, and facilitate rather than avoid such painful topics (Slade, 1999). If not, the risk is that of replicating the rejecting response of the parent who reacts to the child's abuse revelations by discounting or minimizing their importance.

Asking Activating Questions Around Themes of Caregiving and Protection

Bowlby (1980, 1988) considered the tendency to form attachment relationships as representing survival value in humans. He conceived of the attachment behavioral system as a biologically based system oriented toward seeking protection and maintaining proximity to the attachment figure in response to real or perceived threat or danger. In examining the ethological concept of behavioral systems, George and Solomon (1999) and Hinde (1982) indicated that the attachment system is but one of a number of behavioral systems that has evolved to promote survival and that behavior is the product of the interaction among different behavioral systems. Working in concert with the attachment system is the caregiving behavioral system. George and Solomon detailed the reciprocity between attachment and caregiving, noting that the goal of attachment behavior is to seek protection. In complement, the goal of the caregiving behavioral system is to provide protection. Similar internal and external cues associated with fear and danger activate both the attachment and the caregiving systems. As with the attachment system, individuals vary in mental representations of caregiving. When the caregiving system is activated, the individual calls on a host of behaviors whose goal is to ensure protection of the child (George & Solomon, 1999).

The psychological link between attachment and caregiving appears to be strategically useful in therapy. With the current population, activation of caregiving mental representations and questioning around themes of protecting others can be clinically productive. The rationale is that for such patients, this approach is often highly motivating. It engages in ideas that are active rather than passive (Weiss, 1986), ideas that have a future orientation, and ideas that are related to doing rather than being done to. The victim orientation, so distasteful to such patients, assumes passivity. In contrast, protecting others is reflective of the capacity to act (George & West, 2001) and the wish to make things better. As presented earlier, such patients have tremendous difficulty engaging in honest critique of their own parents. Instead, they deny feelings of rejection or vulnerability and minimize the failure of their own parents to provide adequate protection. Nevertheless, they are more willing to engage in discussion regarding the protection of others, such as romantic partners, their own children (Slade, 2004), or their own imagined future children.

Of course, this is not to say that such patients are actually protective of their own children or provide adequate caregiving in their actual behavior. In fact, it is well known that dismissing attachment among parents represents a risk factor for insecure attachment among the children (Hesse, 1999). Rather, it is just to say that within the psychotherapeutic context, the act of thinking about protecting others is one in which such patients are willing to engage, and do so much more readily than the act of thinking about their own failed protection.

For example, one patient who had been physically and psychologically abused by his mentally ill mother came to therapy unable to make a commitment to any of his three girlfriends, with whom he had fathered at least one child each. He was bright, yet shallow emotionally, expressing little understanding of others' feelings. Although lacking awareness of children and their psychological motivations, he still considered himself to be a good father who provided for financial needs. Salaried as a paramedic, he had managed to pay off a portion of three mortgages on the three homes he would rotate between throughout the week to be with his different families. Typically even keeled, his most emotional sessions would take place in the months after the abandonment of his 8-year-old son, Matthew, by the mother. Although initially reacting primarily to

the crisis and situational factors (e.g., enlisting help from his sister), over several months he came to speak of Matthew more often than not. He became deeply concerned with Matthew's well-being, focusing heavily on protecting him at home and at school. In fact, in uncharacteristic form, he became visibly angry at a parent–teacher meeting when told that Matthew might have a learning disability, feeling an uncontrollable need to protect him from such a fate.

From the standpoint of treatment strategy, once mental representations of caregiving have been activated and discourse on the act of protecting others has been opened up, such patients can more easily tolerate activation of the attachment system, and there becomes some softening to the idea of looking inward. The therapist can now ask about similarities or differences among the patient's experiences of protecting others and experiences around being protected (or not) as a child. In the case presented above, discussion of the patient's protectiveness of Matthew yielded many fruitful connections to his own history, namely, the patient's identification with Matthew, the patient's own sense of abandonment in childhood whenever his mother would be psychiatrically hospitalized, and his guilt for failing to protect Matthew adequately in the first place. Once the patient was able to speak of his son Matthew as feeling "heartbroken" and of his wish to fix that, he was able to admit more freely to times in his own childhood wherein he wanted, more than anything else, to make that heartbroken feeling go away forever.

Concluding Comment

Although working with such patients can be very challenging, psychotherapy may help by providing opportunities for productive reappraisal if the clinician addresses attachment patterns and challenges defensive avoidance. Intrafamilial trauma both develops in a climate of troubled attachment and acts so as to further disrupt attachment. Through a psychotherapeutic process that values focusing on these disrupted attachments and their emotional meanings, the therapist provides a holding environment for the safe exploration of issues that up to now have been far too threatening to examine.

It is important to recognize that when such patients begin treatment, there is a deeply rooted vulnerability, hidden hurt, and an underlying yearning for love and care (Sable, 1992, 2000, 2004), as much as there is a minimization of traumatic experiences and an insistence on independence and self-sufficiency. Although they have spent many years turning their attention away from the consequences of their own difficult histories, this strategy is no longer effective. The challenge in treatment, then, is in helping such patients find a way to tell a story too painful to speak, but too compelling to ignore.

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