Studies by Ainsworth and colleagues (1978) found that different attachment patterns existed for infants (secure, anxious-avoidant, anxious-resistant, and disorganized). Secure infants experienced distress during separation with their caregiver, but were easily soothed upon reunion. Anxious-avoidant infants neither showed distress at separation or reunion. Anxious-ambivalent infants were extremely distressed at separation and were difficult to soothe upon reunion. They clung to their parents and often demonstrated anger and aggression. A fourth category of infants (Main & Solomon, 1986) was particularly ambivalent upon reunion with their attachment figure, both approaching and avoiding contact. (See the September/October 2006 issue of FTM on Attachment for further information on attachment theory).

These infants demonstrated a collapse in behavioral strategies for managing attachment distress (Hesse & Main, 2000). When researchers explored why these children were seeking protection from their caregivers, while at the same time pulling away, they discovered a significant percentage of them were abused by their caregivers. In other words, the person who was supposed to be a haven of safety for the infant was also the source of fear. Main and Hesse (1990) wrote that these infants were experiencing “fear without solution.” Main and colleagues also found that all four of these patterns persisted into adulthood.

Perpetrators of Domestic Violence and Attachment
Dutton’s groundbreaking studies on batterer typology (1988) found that there is not one type of batterer. This finding alone should have eroded the idea that one form of treatment intervention would satisfy all batterers; however, single intervention approaches have persisted over the years. Dutton (1995, 2006) found that the vast majority of male perpetrators have insecure attachment. Approximately 40% have dismissing (the adult version of anxious-avoidant) attachment (as compared with 25% in the non-clinical population), 30% preoccupied (the adult version of anxious-resistant) attachment (as compared with 10% in the non-clinical population), and 30% disorganized attachment (as compared with 5% in the non-clinical population). Dutton’s subjects were male batterers. It remains to be seen whether or not these patterns hold true for female perpetrators as well (Babcock, Miller, & Siard, 2003).
The development of violent behaviors is a complex phenomenon rooted in a combination of genetics, child development, family and social dynamics. Therefore, attachment theory does not offer a complete picture. However, these findings suggest that incorporating attachment theory into understanding the psychology of perpetrators may help devise interventions that will facilitate the process of adaptive affect regulation capacities (or, in attachment language, earned security). These findings also suggest that different interventions may be necessary for different clients, depending on how their particular form of affect regulation leads to violence.

Assessment and Treatment Strategies
Writers from both psychoanalytic and family systems perspectives have proposed specific attachment theory-based clinical models (Fonagy, 2001; Johnson, 2004). However, it is recommended that professionals treating perpetrators not completely abandon current interventions that have proven to have a moderate effect on treatment outcome (Babcock, Green, & Robie, 2004). Instead, integrate attachment theory, as well as findings from the cognitive neuropsychosciences (Sonkin, 2007a, b), into current treatment models. Acknowledging that perpetrators represent a heterogeneous group and viewing them through the lens of attachment status can be one way of organizing treatment interventions. Slade (1999) states, “In essence, attachment categories do tell a story. They tell a story about how emotion has been regulated, what experiences have been allowed into consciousness, and to what degree an individual has been able to make meaning of his or her primary relationships” (p. 585).

A step in integrating attachment theory and clinical practice is developing a working hypothesis as to how the client regulates attachment distress. (The various tools for assessing adult attachment are discussed elsewhere [Bartholomew, & Shaver, 1998; Shaver, Belsky, & Brennan, 2000]). Because batterers represent all three insecure attachment classes, a working hypothesis as to state of mind is an important part of the process. Each form of insecure attachment can be viewed as a method of affect regulation that was hard-wired in the brain as a result of many interactions that reinforced a particular response. You might say the brain is primed to respond in a particular fashion. Following are some general observations that may help identify attachment patterns, short of utilizing a specific assessment tool.

Clients with a dismissing attachment often lack awareness of their present emotional state, have difficulty empathizing, appear emotionally cold, and are disinterested in the psychological workings of intimate relationships. They often vacillate between being passive-aggressive and overtly critical and aggressive. Therapists may note it is difficult to feel empathy for these individuals—perhaps because it is difficult for these clients to feel their own emotions. They present a more analytical, sparse narrative. As one client put it, “I guess I need to incorporate an emotional soundtrack into my life.”

Dismissing individuals often say they don’t recall childhood, which makes sense, since we need emotion to punctuate important events. These individuals value self-sufficiency and usually disavow their needs for emotional connection, love and affection. Dismissing batterers may become violent when their partner’s emotional demands for intimacy overwhelm their typical coping mechanisms of withdrawal and avoidance. In more severe cases, these individuals may use violence in a sadistic and controlling manner to meet their needs.

Batterers exhibiting preoccupied attachment experience varying degrees of anxiety in relationships. Therapists usually sense the anxiety and may feel overwhelmed by the emotional material presented. Preoccupied individuals have learned to maintain connection by
sustaining negative affect. This may present as frequent complaints about a partner, criticism and anger. Though critical of partners, they will not easily leave, because anger keeps them connected, albeit negatively. When experiencing a threat to attachment, such clients experience anger and criticism more easily than more vulnerable emotions, and are likely to act violently as a means of keeping the partner from leaving.

When questioned about childhood, they present detailed, convoluted stories and often get sidetracked, providing extraneous and irrelevant material. Their emotions run the show rather than their thoughts. Unlike their dismissing counterparts, they need to develop emotional self-soothing capacities to better utilize cognitive structures necessary to constructive social problem solving. These individuals are likely to become violent as their emotions begin to overwhelm their usual cognitive inhibitory functions.

The disorganized or unresolved batterer will manifest elements of both dismissing and preoccupied patterns. They demonstrate the characteristic approach and avoidance behaviors seen in borderline personality disorder. As children, these individuals were put into the untenable position of feeling terrified of the attachment figure from whom they sought comfort and protection. As a result, they have been primed to respond in extremely contradictory ways. There are differing theories about the exact pathway for the transmission of violence with disorganized children, however one current theory is that it is a combination of genetics and environment. Attachment researchers George and West (1999) suggest that some of these individuals may have learned to become aggressive toward their caretakers in order to jump-start the parent’s caretaking system (negative attention is better than no attention at all). These clients may move into a dissociative state when traumatic memories triggered by current events overwhelm both emotional and cognitive functions. Resolution of early childhood trauma is key to these individuals learning to manage interpersonal distress in a more adaptive manner.

In the 80s, Sonkin and Durphy focused on batterer treatment in regard to behavioral and cognitive interventions. Many of these techniques are valid today in approaching violent behavior; however, technique has its limitation in promoting lasting change. In more recent works (Sonkin, 2005; Sonkin & Dutton, 2003), the importance of the therapeutic alliance is discussed, as is the integration of recent findings in the affective neurosciences into the treatment of perpetrators. Attachment theory can be a useful lens to understand how to create a secure base relationship in psychotherapy from which clients can explore not only the past, but their present relationships, as well as changes they want to make in the future. This is a critical part of treatment (perhaps even more than behavioral techniques) because many studies report that the most robust predictor of therapeutic change is the therapeutic alliance between client and therapist (Luborsky, 1994). Also of critical importance are recent findings in the cognitive-affective neurosciences (Panksepp, 1998; Damasio, 1999; Siegel, 2001; Schore, 2003a, 2003b; Davidson, 2004; Iacoboni, in press) that enable therapeutic interventions to be tailor-made to address specific maladaptive regulation strategies common to the different types of batterers.

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**TO CREATE A SECURE BASE**

**relationship in psychotherapy from which clients can explore not only the past, but their present relationships, as well as changes they want to make in the future.**

**How Does Attachment Status Inform Work with Perpetrators of Violence?**

As a result of certain parenting experiences, some clients will either up-regulate or down-regulate affect. For example, batterers with a dismissing attachment status down-regulate affect because their attachment figures were consistently non-responsive to their emotional needs. Therefore, interventions need to focus on helping these individuals identify disavowed emotions, and learn constructive ways of representing feelings and needs in a relationship context.

Conversely, preoccupied clients are primed to up-regulate attachment distress in response to an insufficiently sensitive attachment figure. These individuals need to learn how to self-soothe when activated (to make better use of cognitive strategies) and not depend solely on proximity maintenance with their attachment figures. In both cases, many of the techniques commonly utilized with violent individuals, such as emotional sensitization exercises (focusing on the body to find out what one is experiencing) or positive self-talk can be useful techniques to help clients compensate for their particular affect regulation strategy.

Most importantly, attachment tells us that these pervasive strategies with
attachment figures are not solely reserved for intimate relationships. Therefore, therapists will have the opportunity to see these strategies at work in real time. Bowlby (1988) believed that the therapist could also become an attachment figure to a client over time. By being present, attentive and responsive, the therapist can create a secure base from which the client can explore not only their own mind, but also how they interact with attachment figures, including the therapist.

Disorganized batterers present a challenge to therapists for many reasons. First, their characteristic approach and avoidance pattern makes treatment extremely demanding if they are not receiving sufficient intervention time. Frequent calls between sessions may indicate the client needs additional sessions per week. If the therapist does not recognize this need for a change in treatment, they will likely find the client’s needs overwhelming (mirroring the client’s sense of overwhelming emotions). Also, some disorganized clients may become extremely aggressive or critical of the therapist in order to protect themselves from the vulnerability they experience in close relationships. Again, therapists may find themselves feeling fear or anger toward these clients.

Frequent clinical consultation may be necessary to manage the intricacies of the treatment, as well as the therapist’s counter-transference. These clients may experience a collapse of cognitive and emotional capacities when a current emotionally competent stimulus triggers a flood of implicit emotional memories of a frightening, or frightened, caregiver. These individuals need to resolve early traumas and losses in order to break the victimizer-victim cycle; otherwise, they will not likely utilize all the benefits treatment has to offer. Although the behavioral goal of domestic violence treatment for each of these attachment categories is similar—cessation of violence—how that goal is achieved will differ depending on how each client regulates attachment distress.

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