

CHAPTER 1

Reactive Avoidance and Risky Behavior

Roshawna is a 19-year-old woman who was brought to the emergency room (ER) by paramedics following an overdose on 20 Advil and eight Imodium tablets. She reports five previous ER admissions for suicidal or self-cutting behavior, two of which were in the last month, and a history of juvenile detentions for prostitution, shoplifting, and truancy. Previous medical records indicate, variously, diagnoses of major depression, polysubstance abuse, borderline personality disorder, posttraumatic stress disorder, and bipolar disorder. Roshawna describes having been sexually abused by her father from ages 4–12 years, and chronically neglected by her mother, including having been “kicked out” of her home as a 14-year-old, with no attention to her subsequent safety or well-being. Previous admission records also describe a history of multiple sexual assaults by peers, although she currently denies any such experiences.

A review of the clinical literature reveals a number of seemingly dysfunctional or self-defeating behavior patterns, all of which are more common among those with childhood histories of abuse, neglect, and/or insecure attachment. Beyond problematic substance use and dissociation, which are considered separately, they include

- Intentional self-injury (Briere & Eadie, 2016)
- Triggered suicidal behavior (Hjelmeland & Knizek, 2010)
- Risky or compulsive sexual behavior (Vaillancourt-Morel et al., 2015)

- Food bingeing and purging (Rosenbaum & White, 2013)
- Compulsive gambling (American Psychiatric Association, 2013)
- Compulsive shoplifting (American Psychiatric Association, 2013)
- Reactive aggression (Fite, Raine, Stouthamer-Loeber, Loeber, & Pardini, 2009)
- Thrill- or sensation-seeking behavior (Harden, Carlson, Kretsch, Corbin, & Fromme, 2015)
- Compulsive skin picking and hair pulling (Stein et al., 2010)
- Fire setting (Blanco et al., 2010)
- Extensive preoccupation with Internet activities (Charlton & Danforth, 2007).

Given the range of these behaviors, it seems unlikely that they share similar etiologies. Yet research and clinical experience suggest that multiple types of problem behavior tend to arise from the same processes, co-occur in the same individuals, and have certain characteristics and functions in common (Briere, Hodges, & Godbout, 2010; Goodman, 2008; Grant & Chamberlain, 2014; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996).

This overlap has led to several disorder-based theories concerning the development and maintenance of problematic or risky behavior. Specifically, activities such as self-injury, suicide attempts, angry outbursts, aggression, and compulsive sex, eating, or gambling have been linked in the clinical literature to one or more of three major psychiatric conditions: borderline personality disorder (BPD), impulse-control disorder, and behavioral addiction, as well as, in adolescents, conduct and oppositional defiant disorders. Although one might also include antisocial personality disorder in this list, that diagnosis focuses on less DRB-related problems, for example decreased empathy, callousness, lack of remorse, and an inflated sense of self (American Psychiatric Association, 2013)—issues that, although also potentially related to childhood adversity, generally fall outside the purview of this book.

Borderline Personality Disorder

BPD has been described as “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts” (American Psychiatric Association, 2000, p. 706). DSM-5 notes that BPD is characterized by episodes of disinhibition and impulsivity, during which time the client engages in risk-taking or potentially self-damaging activities, generally in response to unwanted events or triggered emotional distress, largely without consideration of personal danger.

Early descriptions of BPD stressed nonspecific “ego weakness” associated with a “borderline personality organization,” in which there was significant reality distortion, immature and maladaptive defenses, and primitive or disorganized internal representations of self and others (e.g., Kernberg, 1975). Critical to classic formulations of BPD, and still present in some clinical approaches, was the idea that self-endangering behaviors reflect “acting out” of distressing unconscious material, and/or intentional manipulation to obtain nurturance, attention, or support from others (Kernberg, 1975). These behaviors were often attributed to the mother of the soon-to-be borderline’s client, who was thought to punish the client’s early attempts at separation and individuation, primarily by withdrawing attention and affection (Mahler, Pine, & Bergman, 1975; Masterson & Rinsley, 1975). Such deprivation was hypothesized to lead to later, often desperate, attempts to avoid abandonment in close relationships.

In contrast, recent research increasingly documents the role of child maltreatment and child-caretaker attachment disturbance—rather than maternal punishment of autonomy—in the development of BPD (e.g., Ball & Links, 2009; Godbout, Daspe, Runtz, Cyr, & Briere, 2018; Johnson, Cohen, Brown, Smailes, & Bernstein, 1999; Scott et al., 2013). The growing realization that BPD may arise, in part, from early abuse and neglect has led various clinicians and researchers to suggest that BPD may be equivalent to Herman’s (1992a) *complex posttraumatic stress disorder*, a trauma syndrome that involves similar symptoms, including emotional dysregulation, easily activated childhood memories, and triggered DRBs (Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014; Ford & Courtois, 2014).

Despite some similarities, however, these models are likely not equivalent (Cloitre et al., 2014), and neither (especially BPD) appears to fully explain the breadth and etiology of risky behaviors in maltreated individuals (for further discussion, see Briere & Scott, 2015; Cloitre et al., 2014; Ford & Courtois, 2014). Furthermore, the diagnosis of BPD, itself, is the subject of considerable methodological and theoretical debate (e.g., Dahl, 2008; Lewis & Grenyer, 2009; New, Triebwasser, & Charney, 2008; Paris, 2007), with some questioning whether it represents a unique disorder, or is, rather, a heterogeneous collection of symptoms and problems that overlap with other disorders—including those related to trauma and attachment disturbance (e.g., Akiskal, 2004; Briere & Rickards, 2007; Cloitre et al., 2014; Kulkarni, 2017; Paris, 2007).

Whatever the ultimate validity of BPD as an explanation for DRBs and related avoidance responses, empirically based challenges to early models of BPD have encouraged new treatment approaches. For example, recent evidence-based treatments no longer emphasize the need to “work through” client transference, projections, and split-off internal representations, as advocated by some psychoanalytic writers (e.g., Kernberg, 1975; Masterson, 1975; Stone, 2006). Instead, current treatments for BPD

tend to involve interventions that focus on relational processing of early memories, emotional regulation training, cognitive-behavioral treatment of specific symptoms, and, in some cases, psychiatric medications (e.g., Choi-Kain, Finch, Masland, Jenkins, & Unruh, 2017; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). Importantly, borderline “acting-out” behaviors are more likely to be seen as coping strategies in the face of triggered distress than as ego-defensive or manipulative activities.

Whither BPD?

The relationship of this book to research and writing on BPD is complex. On the one hand, DRBs, and other avoidance responses such as dissociation and problematic substance use, are commonly among those with this diagnosis, and one of the most rigorous and empathic approaches to DRBs available to date—dialectical behavior therapy (DBT; Linehan, 1993, 2014)—is a treatment for BPD. On the other hand, many (probably most) of those who engage in DRBs do not meet diagnostic criteria for BPD, and not all people diagnosed with BPD are equally prone to DRBs (e.g., Bracken-Minor & McDevitt-Murphy, 2014; Brickman, Ammerman, Look, Berman, & McCloskey, 2014; Paris, 2007; Turner et al., 2015). The lack of a one-to-one concordance between BPD and DRBs can also be seen in their respective rates in the general population. For example, whereas self-injury, alone, has a prevalence rate of 6–20% (Briere & Gil, 1998; Klonsky, 2011) the rate of BPD is approximately 1–2% (ten Have et al., 2016).

Given this variability, DRBs should not be considered a specific symptom or pathognomonic indicator of BPD. Although the subjects of this book may self-injure, binge and purge, and engage in compulsive sexual behavior, they do not necessarily “have” the other symptoms and difficulties thought to be associated with BPD, whether idealization-devaluation, splitting, identity disturbance, black-and-white thinking, or boundary confusion (e.g., American Psychiatric Association, 2001). In fact, it is unlikely that DRB-involved individuals can be characterized by any single diagnosis, BPD or otherwise. To the extent that most people who engage in DRBs do not meet diagnostic criteria for BPD, borderline-focused interventions may not always be appropriate.

Impulse-Control Disorder(s)

The notion of impulse-control problems, reified in DSM-5 as *disruptive, impulse-control*, and *conduct disorder* diagnoses, is based on the idea that some people have insufficient abilities to control their urges and

impulses, and thus behave in ways that nondisordered people would not. Such activities are generally categorized as risky to others or to oneself, and tend to violate social norms.

Behaviors often described in the psychiatric literature as involving inadequate impulse control, not all of which are listed as such in DSM-5, include aggressive outbursts, problematic or compulsive sexual behavior, compulsive hair pulling, repetitive fire setting, and impulsive stealing, as well as compulsive shopping and gambling. Because the “impulse-control” rubric is more descriptive than theoretically based, interventions are generally eclectic, focusing on treating the symptoms behaviorally (e.g., through emotional regulation skills development) or altering the neurochemistry of the response through psychiatric medication (Grant & Leppink, 2015).

There is nothing especially problematic about this model as a descriptive enterprise, except that it (1) can represent the medicalization of psychosocial problems, and (2) holds that DRBs arise due to inadequate neurological or psychological control, as opposed to the magnitude of the emotions that are to be controlled. For example, an individual who has a strong behavioral avoidance response to triggered memories of horrific trauma may not necessarily be suffering from impulse-control problems as much as responding to an internal state that most people would not be able to regulate. A reactive avoidance (RA) perspective, although also concerned with the development of emotional regulation capacities, equally highlights the role and strength of triggered memories and attachment schema. In such cases, it may be as important to help the client desensitize and process painful memories as it is to control what, for the client, has become uncontrollable.

Behavioral Addictions

As described by Grant, Potenza, Weinstein, and Gorelick (2010),

the essential feature of behavioral addictions is the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others. . . . The repetitive engagement in these behaviors ultimately interferes with functioning in other domains. In this respect, the behavioral addictions resemble substance use disorders. (p. 234)

Typical behaviors thought to be behavioral addictions include all of the activities described previously that can be seen as similar to substance use, except that they are referred to, for example, as “sex addiction,” “food addiction,” or “Internet addiction.” The primary concern with this

model is the assumption that all these behaviors necessarily share “common neurobiological processes” with one another, or, for that fact, substance addiction (Grant et al., 2010, p. 235).

Proponents of this model suggest that, like use of certain psychoactive substances, overinvolvement in euphoria-producing behaviors floods the pleasure circuitry of the brain (especially in the nucleus accumbens and orbito-frontal cortex) with dopamine and related neurotransmitters (Grant et al., 2010; Jentsch & Taylor, 1999; Volkow & Fowler, 2000). This process is highly reinforcing, leading to repetitive use of these behaviors to produce ongoing pleasure. Unfortunately, repeated activation of dopaminergic circuits leads to tolerance, as the brain responds to high levels of these neurotransmitters by down-regulating the associated receptor sites. As a result, the individual has to engage in more and more “addictive” activities to gain the same level of pleasure or well-being.

Although this research may partially explain why certain activities (e.g., problem gambling) are reinforced and can escalate over time, they are less informative about less overtly pleasurable behaviors, such as chronic self-injury, “impulsive” aggression, or repetitive suicide attempts. They also cannot explain why some individuals seem to become high-jacked by these brain dynamics, while others do not, or the absence of obvious withdrawal or tolerance effects among some so-called behavioral addictions, for example, compulsive sexual behavior or binge eating).

Perhaps most importantly, the addiction model has relatively little to say about the role of the most frequent correlates of so-called “addictive” behaviors: childhood abuse and neglect, attachment disturbance, high levels of emotional distress, and underdeveloped emotional regulation capacities.

Conduct and Oppositional Defiant Disorders

A final set of diagnosis commonly applied to those involved in DRBs are oppositional defiant and conduct disorders (ODD and CD, respectively), usually given to adolescents (as well as children) who routinely challenge authority and get “in trouble” on a regular basis. In the case of ODD, this can involve angry outbursts, frequent and intense arguments, interpersonal “vindictiveness,” and “defiant” behavior in the face of authority (American Psychiatric Association, 2013). In CD, there may be more extreme rule breaking, physical aggression, fire setting, compulsive stealing, problematic sexual activity, and other “antisocial” behaviors (American Psychiatric Association, 2013). As predicted by the RA model, both ODD and CD have been linked to child maltreatment and attachment disturbance (American Psychiatric Association, 2013; Theule, Germain, Cheung, Hurl, & Markel, 2016), and ODD is commonly linked

to emotional dysregulation (e.g., Cavanagh, Quinn, Duncan, Graham, & Balbuena, 2017).

Notably, because ODD/CD diagnoses are often applied in the face of “bad” behavior, they run the risk of pathologizing responses that are actually socially or adversity based. Further, many behaviors considered symptomatic of these disorders (e.g., angry outbursts, “impulsive” aggression, fighting, problematic sexual behavior, or stealing) may be more accurately seen as DRBs arising from easily triggered trauma memories or insecure attachment schema that are evoked in the context of impaired emotional regulation capacities. From an RA perspective, the treatment of ODD/CD may be most fruitful when it does not rely on external behavioral control or incarceration, but rather addresses the effects of child abuse and neglect and teaches emotional regulation and trigger management skills.

A Functional Analysis

Although all four of these diagnostic perspectives are helpful in understanding the inherent contradiction of repetitively engaged self- or other-endangering activities, most tend to overlook the distress reducing or compensatory aspects of such behaviors. In contrast, recent research—as well as the self-help literature, client disclosures during therapy, and lay postings on, for example, self-injury or compulsive gambling websites—indicate that most individuals who engage in these activities find them useful in reducing painful emotions, thoughts, and memories.

A focus on the specific reasons for problematic activities is important, because a greater understanding of exactly why people do such things can help the clinician to (1) target the true etiologies of problematic behavior; (2) avoid pathologizing, patronizing, or stigmatizing clients based on the seeming illogic of what they do under stress; and (3) provide explanations for otherwise impulsive or addictive behaviors that make intuitive sense to clients, thereby increasing their “buy-in” for specific treatment interventions.

Calling on several decades of research on the phenomenology and functions of behavioral avoidance (e.g., Briere, Hodges, & Godbout, 2010; Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Linehan, 1993; van der Kolk, Perry, & Herman, 1991; Zeidner & Endler, 1996), this book introduces the RA model. This perspective does not consider self-injury or risky sexual behavior, for example, to necessarily be pathognomonic evidence of a medical or mental disorder, an addiction, or a borderline personality organization, but rather, as an adaptive—albeit often problematic—avoidance strategy. Importantly, RA interventions tend to focus on developing or increasing the client’s strengths, capacities, and emotional survival skills, rather than her presumed deficits or psychological illness.

The RA Model

From an RA perspective, many of what are considered maladaptive, dysfunctional, or self-defeating behaviors represent the individual's attempt to do what we would want him to do—to persevere despite sometimes great emotional pain, and to problem-solve rather than passively endure distress. These activities are reformulated in this book as DRBs, a more specific version of what was previously referred to as “tension reduction behaviors” (e.g., Briere, 1996; Briere & Scott, 2014). DRBs are viewed as immediately enacted avoidance responses to triggered distress and challenged emotional regulation capacities that, although somewhat effective, have significant longer-term downsides.

The idea of functional avoidance is not the sole province of RA; related perspectives are found in, for example, acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 2012) and DBT (Linehan, 1993). However, the RA model calls more directly on attachment and trauma theory, focuses extensively on trigger management, and devotes considerably more attention to emotional processing of both implicit and explicit memories.

Posttraumatic Stress and Dysphoria

The current trauma literature offers several principles that are relevant to the etiology and, ultimately, treatment of DRBs. The first is that exposure to upsetting events, especially those that overwhelm existing emotional regulation capacities, can create recurrent unwanted memories and enduring painful emotions. These posttraumatic states include intrusive recollections and flashbacks, hyperarousal, overwhelming anxiety, depression, and anger (American Psychiatric Association, 2013) and, in some cases, powerful feelings of shame, guilt, emptiness, and self-hatred (Herman, 1992a, 1992b). Although any highly adverse experience in life can likely produce these outcomes, they are most powerfully associated with complex trauma exposure, typically involving multiple forms of child abuse and neglect, often in the context of additional victimization experiences in adolescence or adulthood (Briere & Lanktree, 2012; Cloitre et al., 2009; Courtois & Ford, 2015; Herman, 1992a).

The second principle is that when faced with overwhelmingly negative internal states, people almost always turn to some form of avoidance as a coping response. In general, there are two types of trauma-related avoidance. The first, *effortful avoidance*, involves attempts to avoid stimuli that otherwise might trigger distressing memories, thoughts, or feelings associated with adverse events (American Psychiatric Association, 2013). For example, a traumatized person might avoid certain people, places, situations, or conversations that would activate painful memories of a past

trauma. These responses are technically part of Criterion “C” of PTSD as described in DSM-5, but they are also found in many trauma survivors who do not meet criteria for a formal stress disorder.

The second, RA, involves the activities described in this book. They do not involve avoiding triggers, but, instead, are evoked in *response* to triggered posttraumatic distress and dysphoria. Some of these activities have been described as avoidance coping (Zeidner & Endler, 1996) or experiential avoidance (Hayes et al., 1996) in the literature, because they are invoked to decrease awareness of painful internal states, potentially allowing continued functioning in the face of significant emotional distress.

Functions of DRBs

Research and clinical experience (e.g., Briere & Gil, 1998; Dvir, Ford, Hill, & Frazier, 2014; Klonsky, 2007; Yates, 2004) suggests that DRBs typically pull attention or awareness away from emotional distress by providing one or more of the following:

- Distraction from painful internal states
- Self-soothing
- Distress-incompatible experiences
- Momentary interpersonal connection
- Displacement of negative internal experiences
- Communication of emotional distress in the face of desperation or social disconnection
- Relief from unwanted numbing or dissociation
- Self-punishment as a way to reduce guilt or shame
- An increased sense of control.

It might appear, then, that trauma and posttraumatic stress explain the existence of DRBs. Trauma can produce great distress, which then motivates activities that distract, soothe, or otherwise reduce awareness of emotional pain. There is empirical support for this possibility: As noted earlier, all of the DRBs described in this book are more prevalent among trauma survivors than others, and interventions that address traumatic stress are known to provide some assistance to individuals who engage in unsafe or problematic behaviors (e.g., Resick, Nishith, & Griffin, 2008).

However, there are significant problems associated with a trauma-only perspective on DRBs. First of all, not all people involved in self-injury, risky sexual activities, or binge eating, for example, report trauma histories (e.g., Linehan, 1993; Zanarini et al., 1997), and not all of those exposed to trauma exhibit significant negative effects (Bonanno, 2004), let alone engage in DRBs. In addition, treatment approaches that address

trauma-related distress are not always especially helpful in the treatment of DRBs, either because trauma per se is not the only, or the most critical, issue (e.g., Linehan, 1993), or because, as described in Chapter 8, other factors interfere with trauma processing.

One hint that we may have to look beyond trauma alone comes from research indicating that not all prior adverse events correlate equally with adolescent or adult difficulties, including problem behaviors. Instead, most studies indicate that early trauma, especially child abuse, is more likely than later traumas to be associated with adult symptoms and problems (Briere & Rickards, 2007; Messman-Moore, Walsh, & DiLillo, 2010; Zlotnick et al., 2008). Furthermore, when studies include child neglect or caretaker disengagement as potential etiological factors, these phenomena tend to predict DRBs even more than do physical, psychological, or sexual abuse (Briere & Eadie, 2016; Briere, Runtz, Eadie, Bigras, & Godbout, 2017).

This raises a question: Why do early traumas matter more in the prediction of symptoms and problematic behaviors than later ones, and why is childhood emotional neglect at least as predictive of DRBs as child abuse, when neglect—although strongly associated with a range of psychological difficulties (Briere, Godbout, & Runtz, 2012; Hildyard & Wolfe, 2002)—is not generally defined as a trauma (American Psychiatric Association, 2013)?

Attachment-Related Difficulties

The answer may partially reside in what developmental psychologists and clinicians refer to as *parent-child attachment*. Attachment theory proposes that early caretaker responses to the child interact with the child's inborn biological systems to determine the extent to which proximity and connection (attachment) can occur. When the caretaker(s) is attached, attuned, nonviolent, and caring, the child can perceive safety, develop positive expectations of others, and learn important relational skills (Bowlby, 1988). Attachment theory further suggests that it is during the early attachment period that children first learn how to regulate their emotions and to develop a stable sense of self (Bowlby, 1973, 1977).

When caretaker responses to the child are characterized by abuse, rejection, loss, and/or emotional unavailability, however, insecure attachment is more likely (Baer & Martinez, 2006). In such instances, the child may not learn skills that otherwise would support the development and maintenance of secure relationships with others. Instead, he may generalize from early experiences of loss, lack of attunement, betrayal, or violence, and make incorrect, often blanket assumptions about the dangerousness of others in close relationships (Bowlby, 1988; Simpson & Rholes, 1998).

Attachment-related problems may be, in fact, the largest contributions—along with trauma—to the development of DRBs in adolescents and adults. Those who have negative attachment experiences are often subject to a host of painful memories, not only those involving classical trauma but also intrusive sensory and nonverbal recollections of early caretaker rejection, abandonment, or disengagement (e.g., Stern, 1985). As a result, it is not only traumatic stress that produces DRBs but also sensitivity to current relational stimuli (e.g., perceived rejection, betrayal, or nonresponsiveness) that trigger painful memories of early attachment disturbance. Thus, for example, the client with abandonment concerns or “authority issues” may perceive emotional unavailability or criticism in a current relationship, which then trigger powerful emotions and thoughts associated with early maltreatment or neglect, motivating seemingly out-of-proportion and problematic coping responses, including DRBs.

We may still not have enough information, however, to explain why some individuals engage in repetitive DRBs. As noted, there are many individuals who have experienced childhood trauma and/or attachment disturbance, who suffer as a result, yet do not engage in problematic avoidance responses, or who terminate such activities once their disadvantages become apparent. In order to complete this picture, there must be some phenomenon that mediates between triggered trauma/attachment memories and subsequent behavior—something that explains why one person might be triggered by current relational stimuli but not engage in DRBs, whereas another person would quickly turn to such behaviors.

Emotional Dysregulation

Research in the last decade or so suggests that this mediating variable is emotional regulation capacity (e.g., Briere et al., 2010; Dvir et al., 2014; Tull, Barrett, McMillan, & Roemer, 2007; Schore, 1994). Trauma or neglect early in life, especially when it produces attachment disturbance, is associated with later difficulties in tolerating and down-regulating painful emotional states (Levy, Johnson, Clouthier, Scala, & Temes, 2015). Although the reasons for this are not fully known, it is hypothesized that the unloved or maltreated child finds himself in an “emotional emergency”: Continued abuse and/or neglect engenders high emotional distress, which must be addressed in order for the child to maintain homeostasis and ongoing functioning. But especially when these adversities occur early in life, the child may have insufficient psychological capacity to effectively reduce pain and dysphoria. In this overwhelming circumstance, the development of emotional regulation skills may be extremely difficult—in some sense akin to trying to learn how to swim while one is drowning.

Recent research also suggests that early trauma or neglect may reduce the brain’s capacity to regulate stress, primarily by altering the

functions of the hypothalamic–pituitary–adrenal (HPA) axis (Tarullo & Gunnar, 2006; Van Voorhees & Scarpa, 2004). When this dysregulated neurobiology is sustained, chronic emotional dysregulation typically results, leading to a nervous system that is more easily overwhelmed by distress (Schoore, 2000).

Whether psychological or biological in nature, reduced emotional regulation capacity means that the formerly abused or neglected person is less able to tolerate—let alone regulate—painful internal experiences. This compromised capacity can easily lead to a reliance on avoidance strategies, whether “defensive exclusion” (Bowlby, 1988), in which the child reduces her awareness of psychological threats from caretaker(s), or later DRBs, in which the individual more generally learns to manage distress through seemingly “impulsive” or “maladaptive” behaviors (Schreiber, Grant, & Odlaug, 2012).

Activation–Regulation Balance

Summarizing the literature, it appears that triggered memory-related distress and insufficient emotional regulation are often both necessary in order for DRBs and other avoidance behaviors to occur at problematic levels. Importantly, neither distress nor inadequate emotional regulation capacity, alone, is usually sufficient to motivate clinically significant DRBs. For example, an individual might have a painful childhood history but have sufficient emotional regulation skills to keep from being overwhelmed by memories, and thus not need DRBs. Similarly, although less common, a person might have diminished emotional regulation capacities, but have a relatively benign childhood history, and therefore little potential for triggered distress, which would also result in an absence of DRBs.

Taken together, this research suggests that it is the balance between level of triggerable distress and existing emotional regulation capacities that determines whether an individual is internally overwhelmed and has to turn to DRBs. Throughout this book, this is referred to as the *activation–regulation balance*, a construct that will be called upon to explain not only avoidance behaviors but also the degree to which DRB-involved clients can tolerate exposure-based interventions.

The Integrated Model

In summary, the RA perspective suggests that a cascade of events lead to the development of DRBs and other problematic avoidance behaviors. This process may proceed as follows:

- The child is exposed to complex childhood traumas involving some combination of abusive, neglectful, and disengaged parenting.
- These negative experiences produce easily-triggered memories and associated emotional pain.
- In combination with genetic and neurobiological factors, this chronic and often unpredictable distress disrupts the natural parent-child attachment process, which generally requires environmental safety and stability.
- Subsequent insecure attachment and, potentially, dysregulated neurocircuitry precludes the development of emotional regulation capacities.
- When the (now older) person encounters stimuli in the current environment that are reminiscent of early adverse experiences—whether perceived rejection or lack of attunement, or more frank experiences of betrayal, abandonment, or maltreatment—she is triggered into childhood-era emotional distress.
- This emotional distress may be overwhelming or not, generally based on the client's activation-regulation balance.
- When the activation-regulation balance tilts toward overwhelming distress (i.e., when emotional pain exceeds available emotion regulation skills and neurobiology), the person is motivated to quickly (seemingly impulsively) invoke DRBs.

See Figure 1.1 for a graphical representation of this process.

Notably, all aspects of this model are supported in the attachment and/or trauma literature, whether it is the role of childhood trauma and neglect in DRBs (e.g., Homma, Wang, Saewyc, & Kishor, 2012), the additional importance of attachment disturbance in this process (e.g., Tatnell, Kelada, Hasking, & Martin, 2014), or the contributions of emotional dysregulation or intolerance in the etiology of maladaptive avoidance (e.g., Briere et al., 2010; van der Kolk, 1996).

Trigger Chaining

In some cases, triggering may be more complicated than described above. For example, a current adverse event (e.g., an assault) may lead to feelings (e.g., shame or anger) that then trigger recollections of a previous trauma (e.g., child sexual abuse) in which similar emotional reactions were present and encoded. When this occurs, RA theory refers to *trigger chains*: A cognitive or emotional response to a current event or stressor can serve as a stimulus that triggers similar emotional memories of one or more previous traumas. In the case of complex trauma, in which there are multiple traumas and, often, multiple painful attachment memories, there

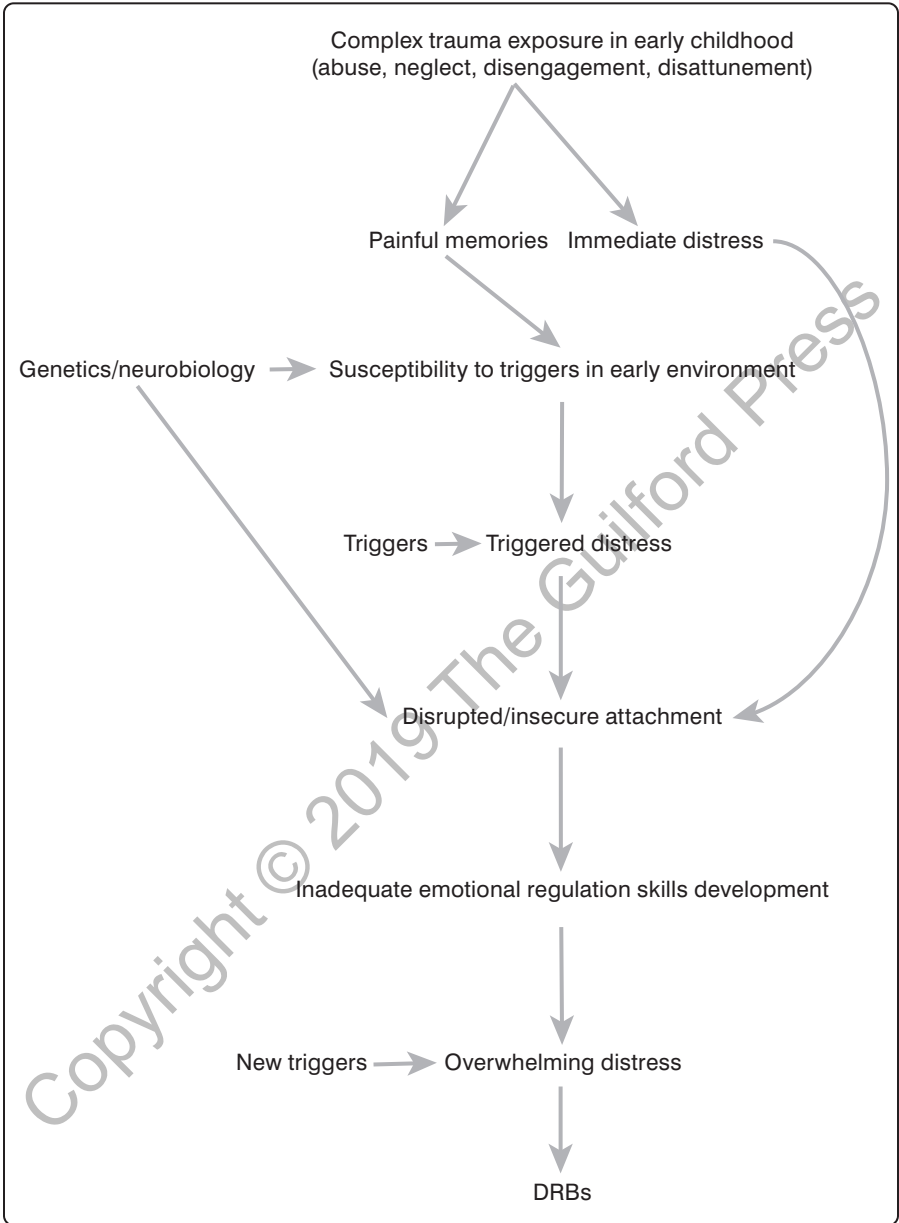


FIGURE 1.1. DRB development.

may be an extensive trigger chain: Thoughts/emotions associated with event 1 may trigger thoughts/emotions associated with event (or attachment experience) 2, which triggers thoughts/emotions associated with event or attachment experience 3, and so on. This is likely an explanation for why some individuals with a history of many traumas and attachment breaches have especially dramatic reactions to current stressors, ranging from more severe and complex outcomes (Briere, Kaltman, & Green, 2008; Cloitre et al., 2009) to greater risk of PTSD (Briere, Agee, & Dietrich, 2016; Karam et al., 2014). In fact, it appears that most traumatic stress disorders occur in the context of a history of multiple prior traumas; despite previous DSM criteria (American Psychiatric Association, 2000), it is surprisingly uncommon for them to arise from a single stressor alone (e.g., Briere, Agee, & Dietrich, 2016; Briere, Dias, Semple, Godbout, & Scott, 2017; Karam et al., 2014). In many cases, those with cumulative trauma and attachment disturbance suffer from insufficient emotional regulation capacities and experience a plethora of different triggered emotional responses to a range of previous adversities. As these emotions accumulate, interact, and trigger one another, the likelihood of a DRB increases.

Other Factors

Although triggered attachment or trauma memories are strongly implicated in the development of DRBs, there are additional phenomena that also can lead to problematic behaviors. These include not only the neurobiological aspects described earlier but also developmental disorders, such as autism, that motivate self-injury or related behaviors (Samson, Wells, Phillips, Hardan, & Gross, 2015), psychotic delusions or hallucinations that encourage harmful behaviors (Shawyer, Mackinnon, Farhall, & Copolov, 2008), and social systems or families that are highly stressful and demand perfection or aggression as problem-solving strategies (e.g., Butler, Lee, & Gross, 2007; Krahé, 2013). In some of these cases (e.g., autism), altered neurobiology may reduce emotional regulation capacities and lower the threshold for overwhelming distress (Mazefsky et al., 2013); in others, a mental disorder (e.g., schizophrenia or another psychotic disorder) may produce frightening internal states that overwhelm existing emotional regulation capacities (Lu, Mueser, Rosenberg, Yanos, & Mahmoud, 2017) or involve command auditory hallucinations to self-harm (Rogers, Watt, Gray, MacCulloch, & Gournay, 2002). For this reason, it is important that applications of the RA model include attention not only to attachment and trauma dynamics but also biological and social systems that impact the DRB-involved individual.