"Maybe it would've been better if you didn't tell me you cared": Attachment-Avoidance and the Relational Encounter

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Abstract

Schizoid personality disorder (SPD) has been described as the most challenging of the personality disorders, with literature scarce and what studies exist supporting individuals diagnosed with SPD respond poorly to medicalized and manualized approaches. This article reviews what recent literature exists on SPD, and introduces alternative conceptualizations of the 'schizoid' personality not as a disorder, but as a relational interpersonal style of attachment-avoidance. A humanistic-interpersonal approach is presented that emphasizes immediacy and focusing acutely on SPD's most trying clinical challenge: the development of counselor-client proximity and relationship. This approach is dubbed the *relational encounter*. A long-term relational and instrumental case illustration bridges existing literature on SPD with practitioner scholarship on interpersonal and existential practice. Themes support practitioners working with SPD may have some success by focusing on the relationship, rather than the prescribed symptoms of the diagnosis.

Keywords: interpersonal practice, schizoid personality disorder, therapeutic relationship

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Establishing a relationship forms the basis for any successful therapeutic process, but building an intimate and authentic alliance is not always easy. Whether in schools, communities, rehabilitation, or the private sector, professional counselors and psychotherapists work hard to convey trustworthiness and empathy to their clients; to show that they care and are invested in the therapeutic process. Sometimes, clients come unprepared to trust or unwilling to connect. The practitioner dedicates time and energy, maintains unconditional positive regard, practices empathy, employs core and advanced skills, and still the client remains reluctant to participate in the process. As counselors and psychotherapists, we may ask ourselves, "Am I working harder than my client?" Recalling the adage that practitioners should never work harder than their clients or be more invested in the therapeutic process than the client, they may pull back under the belief that the client is shortchanging the counseling process.

But what if this – encountering an authentic relationship – should become the solitary focus of counseling? Here, I do not mean discovering the therapeutic effects of the relationship,

but the literal process of facilitating an encounter with a true relationship between the practitioner and client. The immediacy of the 'working-harder-than' intervention, where the client is confronted with an appraisal of their own investment in the therapeutic process, can oftentimes catalyze a therapeutic shift in client engagement. On the other hand, the 'working-harder-than' intervention can also backfire by affirming some clients' implicit expectation that relationships always end in breaks, dissatisfaction, or abandonment.

The adverse reaction may be especially the case when clients live with reactive and attachment-avoidant interpersonal styles, as with individuals meeting criteria for schizoid personality disorder (SPD), traditionally characterized by an asocial and relationship-averse disposition. As Danzer (2015) pointed out, direct confrontations of these clients' defenses or investment may lead them to withdraw further inward. Consequently, the intervention can cause significant interpersonal ruptures in the therapeutic relationship, which can then become incredibly difficult to repair due to an expertise in self-protection (Danzer, 2015; Gupta, 2017). For the client diagnosed with SPD, building a relationship becomes central to any therapeutic success.

Therapeutic change necessitates that clients let go of what is familiar, and some clients are not ready for this. In these cases, practitioners may point to the client's lack of commitment in pursuing treatment goals and mislabel this experience *resistance*. This label deflects the practitioner's responsibility in finding novel ways to relate with clients across a spectrum of attachment styles. Letting themselves off-the-hook so easily can cause practitioners to miss the interplay between intrinsic expectations of the therapeutic process (i.e. mutual trust, change-orientation, openness, and honesty) and the client's interpersonal inability or readiness to successfully navigate those expectations (Gold, 2008; Meyers, 2016). Again, I posit that this is poignantly true when working with individuals who actively protect themselves against any form of connection through detachment and withdrawal and have never encountered a genuine relationship.

If the only goal of counseling and psychotherapy becomes to establish a mutually shared relationship, then what if – at times – the best way of doing this *is* by working harder than the client? How does an anti-relational interpersonal style, like that of SPD, affect this endeavor; and, conversely, how do exceptional experiences of the *relational encounter* destabilize the applicability of that diagnosis? In this article, I aim to answer these questions, and challenge the idea that counseling and psychotherapy never involves working harder than our clients. I review Sullivan's (1953) interpersonal theory of human functioning, and how the theory diverts from pathological terminology—refocusing instead on attachment-avoidance as an interpersonal and relational trait. I discuss adjunct empirical challenges to the SPD diagnosis and how these align with a more interpersonal theory of functioning. This review provides the basis for *relational encounter* as an alternative approach for working with clients not on *disorder*, but on detached-withdrawn and attachment-avoidant interpersonal styles.

Schizoid Personality Disorder

Historically, *schizoid* described individuals who were "outwardly quiet, dull, suspicious, and morbid, yet were inwardly sensitive, attentive, and committed to the pursuit of vague interests" (Danzer, 2015, p. 57). Today, the Diagnostic and Statistical Manual of Mental Disorders (DSM) (5th ed.) describes SPD as a "pervasive pattern of detachment from social relationships and restricted range of emotions" (p. 652), lack of direction and goals, and difficulty responding appropriately to important life events (American Psychiatric Association, 2013). SPD is categorized as a Cluster A personality disorder, or one of the "odd or eccentric" (p. 646) personality disorders. Diagnostic criteria include the lack of desire for and enjoyment of close interpersonal relationships, the selection of solitary activities, lack of interest in sexual experiences, taking pleasure in few activities, lacking close friends other than first-degree relatives, appearing indifferent to praise or criticism, and "showing emotional coldness, detachment, or flattened affectivity" (p. 653). The ICD-10 characteristics of SPD include emotional coldness, detachment, reduced affectivity, withdrawal from emotional, social and sexual contacts, and preference for solitary activities.

Clinical and empirical knowledge is scarce surrounding SPD because the disorder is wholly under-researched (Danzer, 2015). This is partially due to the low prevalence rates of SPD in the general population, with studies demonstrating that SPD affects less than one percent of the population (Grant et al., 2004; Via et al., 2016). At the same time, SPD is described as one of the most challenging personality disorders to work with for mental health practitioners (Martens, 2010; Thylstrup & Hesse, 2009). Hess (2016) asserted that the work with SPD may be characterized by "marked periods of intense frustration, fury and impotence in [failing] to make meaningful emotional contact" (p. 58). When considering therapeutic achievement and building interpersonal relationships, SPD is the lowest functioning of the personality disorders (Triebwasse, Chemerinski, Roussos, & Siever, 2012). SPD presents a unique challenge to practitioners in its apparent opposition to the foundations of the therapeutic endeavor: that it is the relationship that heals.

Empirical Challenges to SPD as a Diagnosis

The lack of wide clinical and empirical support have led to challenges against SPD's validity and reliability as a diagnosis, some arguing it be removed from the DSM (e.g. Hummelen, Pedersen, Wilberg, & Karterud, 2015; Triebwasser et al., 2012). Triebwasser and colleagues (2012) asserted that prevalence rates of SPD do not provide substantial support for the validation of SPD as a diagnosis. They argue that SPD is altogether not a disorder, but a set of traits evident of an individual's detachment style. Hummelen et al. (2015) reaffirmed this through their findings that SPD maintains the poorest reliability and one of the lowest prevalence rates of all the personality disorders, arguing SPD may be a set of personality traits, but not a diagnosis in itself. Moreover, Hummelen and colleagues determined that individuals diagnosed with SPD shared only three consistent traits: social detachment, withdrawal, and restricted affectivity. They advocate for these to be the focus of therapeutic interventions, not a deeply seeded personality.

Conversely, Winarick and Bornstein (2015) argued that SPD be kept in the DSM due to the predictive correlates of social anhedonia with SPD, and the need to belong and internalized shame with avoidant personality disorder. The authors point out that these are significant differentiating correlates for clinicians to use. However, the study is limited by its focus on a single-university college-aged sample and the trait-based, rather than criterion-based, method for determining diagnosis. Interestingly, this trait-based method actually highlights the argument Hummelen and colleagues (2015) made, that the trait should be the focus of clinical work, and not the diagnosis of personality disorder. Emphasizing diagnosis over traits may interfere with the therapeutic endeavor, as practitioners work to navigate the subjective diagnostic presumptions of 'distress' and the influence of the client's own impression of experience—sometimes fogging the diagnostic lens (Bolton, 2010; Wakefield, 2010).

The emphasis on *disorder* may then lead to *self-stigmatization,* or the client's internalization of prescribed traits and characterization attributed to the diagnosis (Ben-Zeev, Young, & Corrigan, 2010; Sulzer, Muenchow, Potvin, Harris, & Gigot, 2016). Practitioners may be forced to communicate assumptions regarding clients' personality and, often times, internalize those assumptions (Rogers & Dunne, 2011; Sulzer et al., 2016). Instead, a trait-focused orientation that emphasizes interpersonal style over disorder sidesteps the inherent power structures of the diagnostic process. This frees up room for counselors and psychotherapists to shift away from diagnostic terminology (i.e. SPD or schizoid), and toward relational terminology (i.e. attachment-avoidance or detachment/withdrawal). Sullivan's (1953) interpersonal theory provided the theoretical framework to implement the empirically supported recommendations of the scholars above, a relational and interpersonal approach: the *relational encounter*.

Interpersonal Practice

Individuals with detached/withdrawn interpersonal styles can benefit distinctly from interpersonal approaches to counseling and psychotherapy. Interpersonal approaches, to varying degrees of proximity, are grounded in Sullivan's (1953) interpersonal theory of psychiatry. Sullivan held a developmental view of psychiatry and believed that mental wellness or illness was evidence of function or dysfunction, respectively, in an individual's social interactions or social world. In an essentially humanistic view, the individual is recognized as being more complex than any one theory of psychology can capture. Instead, interpersonal practitioners focus on the ways that clients interact with others—learning about their actions, thoughts, and fantasies as they relate to others (Leary, 1957). These relationships become the focus of counseling.

Irvin D. Yalom, existential psychiatrist and prominent voice against superficial medicalization and manualization, offers a powerful existentially-rooted interpersonal approach to counseling and psychotherapy. Yalom contends that the interpersonal style of the individual will inevitably manifest within the therapeutic relationship, be it the relationship in individual, couples, family, or group practice (Yalom & Leszcz, 2008). Practitioners must be prepared to recognize whether a client is moving toward, against, or away from others (Horney, 1945, 1950; Yalom & Leszcz 2008). Terry (2010) presented four principles for interpersonal enactment that operationalize and build upon the works of these seminal interpersonal theorists. First,

individuals learn maladaptive interpersonal patterns (MIPs) in the past and maintain them in the present through *complementarity*, elicited and predictable responses from others that help in avoiding anxiety. Second, practitioners recognize that MIPs are usually rigid, marginal, and less reactive to changes in the interpersonal environment. Third, these MIPs inevitably emerge in the therapeutic relationship and the practitioner employs *here-and-now*, or present and in-the-moment, observations to challenge them. Finally, the practitioner provides *corrective emotional/interpersonal experiences* (Binder & Betan, 2013; Hill et al., 2014; Terry, 2010), or interactional experiences that break away from the complementarity to which the client has become accustomed. By relying on these four principles to guide their approach, practitioners can give greater appreciation to the relational encounter between themselves and the client.

Having regular conversations about this *relational encounter*, or the therapeutic experience where we encounter ourselves in-relationship to another, is central to both the success of the interpersonal therapeutic process and determining the attachment style of the client. These overt relational conversations provide the client with anticomplementary (see Kiesler, 1983; Kiesler & Watkins, 1989) interpersonal experiences, a going-off-script, sort of speak, that is different from the well-known interactions that individuals elicit in everyday life (Terry, 2010). When a client enacts hostility as a way of distancing themselves, the practitioner may directly comment on this and the intended goal of self-protection, working to also verbalize a desire for continued proximity with the client.

More important than *explaining* the ineffectiveness of MIPs, the practitioner provides *experiences* that confront clients' beliefs and expectations about interpersonal relationships (Terry, 2010; Teyber, 1988). Through an empathic relationship, the practitioner can both challenge MIPs and demonstrate that commitment and trustworthiness do not depend solely on complementarity. The practitioner models healthy and secure attachment by demonstrating that confrontation and anticomplementary interactions are not synonymous with a lack of caring or abandonment. The practitioner can identify the positive intent behind MIPs (i.e. self-protection), illuminate the process between counselor and client, and verbalize the implicit expectations the client(s) may have (Binder & Betan, 2013; Terry, 2010).

While not the focus of this article, practitioner scholars have transformed theory-informed approaches into effective manualized treatment methods such as Interpersonal Psychotherapy and Interpersonal Counseling (IPT/IPC) (e.g. Kontunen, Timonen, Muotka, & Liukkonen, 2016; Markowitz & Weissman, 2012; Weissman et al., 2014). These approaches focus on improving interpersonal relationships or changing the client's expectations of them, while strengthening social supports to alleviate interpersonal distress (Stuart, 2006; Stuart, Robertson, & O'Hara, 2006). IPT/IPC practitioners identify clients' interpersonal problem areas (e.g. interpersonal disputes, role transitions, grief and loss, and interpersonal sensitivity/deficit) and work to focus the therapeutic process on accomplishing interpersonal successes and reducing setbacks (Markowitz, Bleiberg, Pessin, & Skodol, 2007; Markowitz & Weissman, 2012; Stuart, 2006). IPT/IPC is driven by the question, "How can this client be helped to improve here-and-now interpersonal relationships and build a more effective social support network?" (Stuart, 2006, p. 542).

Working toward the *relational encounter* through interpersonal theory illuminates that the trying nature of working with detached/withdrawn and attachment-avoidant interpersonal styles is not simply due to a disordered state, but to dissonant feelings that *manifest* as emotional detachment while masking an inner sensitivity, a fear of intimacy, and a yearning for closeness (Danzer, 2015; McWilliams, 2006). Thylstrup and Hesse (2009) called these dissonant feelings *intrapsychic dynamics of ambivalence*, I reiterate them as dynamics of *relational* ambivalence. This ambivalence commonly exists in the initial stages of the therapeutic process as *approach-avoidance*, or conflict between assumptions about counseling and psychotherapy that prompt hesitation to think about problems, and the attempts to think of these problems in order to address them (Paige & Mansell, 2013). This approach-avoidance can continue well beyond the initiation of counseling and psychotherapy for individuals with attachment-avoidance or detached/withdrawn interpersonal styles, individuals who do not regularly experience relationship intimacy. Clients experiencing this continued ambivalence may not respond well to short-term, goal-oriented, and change-focused modalities (Thylstrup & Hesse, 2009), because they necessitate trust and rapid commitment in the practitioner—an important consideration as treatment approaches continue to become more and more short-term, goal-oriented, and change-focused.

Method

To illustrate how *relational encounter* can destabilize the dynamics of relational ambivalence within attachment-avoidant and detached/withdrawn interpersonal styles, I recruit an instrumental and relational case illustration. The case illustration is the best method here because "theories need work" (Stiles, 2007, p. 122). The case illustration provides the opportunity to demonstrate how empirical findings can inform practice, as much as practice confirms or refutes theory. Case illustrations have the potential to bridge the "research-practice gap" (McLeod, 2002, p. 265) and help practitioners improve their practice (Falco & McCarthy, 2013). Case illustrations produce context-dependent knowledge and facilitate greater insight from intense observation (Flyvbjerg, 2006). This helps the practitioner scholar to understand a phenomenon in a way much more intimate than observation or empirical results independently (Doughty Horn, Crews, Guryan, & Katsilometes, 2016).

Given low prevalence rates of SPD and the potential usefulness of the case to practitioners, a purposeful and extreme/deviant (Flyvbjerg, 2006) sampling approach guided the case selection process. The focus of this case illustration is a young man who came to counseling due to dissatisfaction with his social detachment and apparent apathy toward interpersonal relationships. While identifying information has been concealed and background information altered to generate a more composite client, relevant interactions and themes have been maintained. This client was selected because he met almost all criteria for the DSM-5's (2013) SPD diagnosis, including disinterest in and lack of enjoyment of close relationships, predominantly choosing solitary activities, taking pleasure in few activities, lack of close friends, indifference toward praise or criticism, and emotional coldness and flat affectivity.

His case provides an opportunity to observe a client's development from inflexible attachment-avoidance to repeated moments of *relational encounter*. This composite client,

heretofore referred to as Slate, completed the consent for research required by all clients in a counseling clinic. Institutional review board approval was pursued, but determined unnecessary due to the lack of generalizability inherent in case illustrations. The methods followed best practices for case studies, adding additional rigor to analysis and discussion (Doughty Horn et al., 2016; Falco & McCarthy, 2013).

Definition of the Case

Slate is a young single self-identified cisgender white male with an intentionally unspecified sexual diversity. His family of origin includes parents who are still married, siblings, a middle-class background, and traditionally conservative family culture. Slate was identified as gifted at a young age, and this giftedness was a topic of multiple conversations around the social dimensions of giftedness (i.e. emotional vulnerability and social isolation) (Olszewski-Kubilius, Subotnik, & Worrell, 2015). Slate expressed that his early-education teachers had concealed his giftedness by integrating advanced coursework into his curriculum. Although he did not deny his giftedness, he minimized therapeutic relevance. Still, we frequently contextualized therapeutic concerns (e.g. perfectionism and anxiety), even if momentarily, in relation to the socialization of gifted students (Cross & Cross, 2015). The therapeutic process with Slate lasted for a two-year period. He had not previously received psychopharmacological treatment or psychotherapy. The counselor (this author) at the time was a doctoral candidate with expertise in clinical mental health, and identifies as a queer cisgender Latino of color.

Data Collection

At the same time as this case illustration was informed by a combination of clinical experiences, a substantial portion of data were drawn from a memorable case defined above. The therapeutic process of this case also inspired this article. To collect these data, I drew upon three sources of information that also helped to triangulate the analysis. To increase validity, I relied on case notes written immediately following counseling sessions, concurrent with video recordings of those sessions used to verify client responses. In addition, the case illustration is informed by a process journal that was made parallel to the therapeutic process. This journal includes reflections and observations made immediately following each counseling session by the counselor.

Findings

Three exploratory questions guided the data analysis in order to construct the essential case illustration. First, how did Slate's perception of the relationship change from the *relational encounter*? Second, what did the *relational encounter* mean to Slate? Third, how did focusing on the *relational encounter* destabilize the diagnostic relevance of the SPD diagnosis? Capturing the essence of the case with the aim of answering the first two questions warranted a thematic analysis of client-counselor interactions, as well as my own self-reflection on the *relational encounter*. For this reason, the discussion of themes includes both Slate's thoughts and feelings, and my own reflexive observations during the case. This reflexive and interpretivist approach makes for a more rigorous exploration (Crowe et al., 2011). To answer the third question, isolating SPD as an independent pragmatic theory to individual personality (McLeod, 2002; Stiles, 2007) was necessary. Delineating SPD in this way underlines the assumptions about

behaviors and personality style inherent in the diagnosis. The themes below were identified by their repeated occurrence during the therapeutic process and their significance as interpersonal milestones. Each theme is given context in the therapeutic process and briefly discussed.

"I know why I am here, and what I have to do to get the most out of this."

One of the most striking characteristics of our work together was Slate's emphasis that he always knew what he needed to do to change. He expressed awareness that he was "missing out" by avoiding intimate relationships, and explained that he needed to be more "proactive," less "apathetic", and stop "repressing" his feelings. Slate hoped to appropriate traits he associated with interpersonal competence: "open[ness] to others' interests…having more interest in them…and [being] helpful." Danzer (2015) and Gupta (2017) pointed out that despite knowing what needs to change, executing changes can be incredibly difficult for individuals with attachment-avoidance.

Slate maintained skepticism about the therapeutic endeavor, despite consistently attending appointments (never missing or canceling even one appointment). He had difficulty concretizing an action-plan and committing to change. He questioned the value of interventions and interpretations, while insisting that the changes he wanted to make were very important to him. When asked directly about issues such as loneliness and likability, Slate would become immediately uncomfortable and question the understandability of those questions. This approach-avoidance continued throughout the counseling process, even as *relational encounter* became more familiar.

"That sounds like a possibility…but that's just how I am."

Slate frequently withdrew and detached from the therapeutic relationship at points where the closeness of *relational encounter* was looming. He enacted a fear of both judgment and the inability to succeed at interpersonal relationships, characteristic of this interpersonal style (Martens, 2010; Thylstrup & Hesse, 2009). This strategy manifested most frequently in two ways: (1) anxiety-avoidance by attributing blame to others and (2) questioning the counselor/counseling process.

Blaming others: "**They should keep pushing."**

Slate explained that interpersonal relationships demanded a high degree of trust that he was not prepared to give. Overtime, he characterized his strategies for minimizing the interpersonal risk involved in these relationships as "avoidance" and "deflection." Paradoxically, Slate also feared being misunderstood or saying the wrong thing and coming off as an "asshole" or "unavailable." He recognized that the detached/withdrawn interactional style he maintained was more likely to result in him being perceived as cold or unavailable, but held fast to this defensive strategy.

The immediacy that inevitably arose from these exchanges – the trust and openness that Slate was allowing himself – byproducts of the *relational encounter* with me, immediately resulted in an ebb of engagement if brought to his attention. Slate withdrew, detaching himself from relationality and responsibility by insisting that others needed to "push deeper" or "keep pushing", despite his maladaptive interpersonal pattern when uncomfortable. He argued that

others in his life did not do enough to know him, and that he expected I, as his counselor, to also push past his interpersonal hostility in order to connect with him. In this moment of *relational encounter*, we learned that blaming others' lack of persistent interest in him was easier than working through the dissonant feelings of wanting intimate connection and being fearful of failing at them.

Doubting the counselor/counseling process: "What do you mean?"

In addition to an interpersonal shifting of blame, Slate also met moments of *relational encounter* with doubts toward my role as counselor or the counseling process. Prior to my familiarity with Slate's interpersonal style, to my frequent feelings of ineffectiveness and frustration, my attempts to establish a therapeutic relationship or facilitate deeper discussions were met flatly with, "I don't want to talk about that." I met Slate's attachment-avoidance complementarily, respecting his defenses and forging trust that could function as groundwork for a more therapeutic relationship (Danzer, 2015; Kiesler & Watkins, 1989). Attempts at shifting these MIPs, engaging attachment-avoidance with anticomplementary responses, were met with further detachment and withdrawal. For example, when discussing Slate's fears of being rejected and interpersonal failure and asking if his attachment-avoidance functioned to avoid this anxiety, Slate would repeatedly ask, "What do you mean?" My clarifications or interpretations would lead to a bid to terminate the discussion by stating, "That could be a possibility…but that's just how I am."

When discussing my own *relational encounter* with him, Slate often withdrew, introducing distance between us by questioning the relevance of my feedback about our relationship. Instead of treating these moments as interpersonal ruptures, I treated them as opportunities for the anticomplementary use of immediacy and self-disclosure (Danzer, 2015). I questioned the usefulness of Slate's apparent distancing strategy, and shared its effects on our relationship. This strategy illuminated Slate's feelings about the counseling process, attachment style, and his interactional behaviors in the therapeutic relationship (Hill et al., 2014):

> C: You mention being skeptical of others, and them having less incentive to put up with you. I wonder, what makes you think they *put up* with you? I enjoy working with you; I like you and care about you as a client.
> S: [Immediately] What do you mean?
> C: There's that "what do you mean?" I mean I enjoy meeting with you, and that I care about your success and wellbeing as a client.
> S: Well, you *have* to like me, you're a therapist. This is an artificial environment.
> C: An artificial environment?
> S: Yes. It's not like the real world. You're predictable.
> C: I'm predictable. I don't have to like you, you know. Counselors don't always like their clients. You don't know what will happen when I walk in, how I'll react. I'm wondering how it feels to hear me tell you I like you? That I enjoy working with you?
> S: It's nice, I guess…[Silence]
> C: [After a few minutes] What are you thinking about?
> S: Nothing, I'm just waiting for you to finish your monologue.

As we near a *relational encounter*, recognizing that I care for him despite his defenses, we challenge his interpersonal expectations of being unlikable and closed off, and, therefore, not worth putting up with. Slate reintroduces distance between us through a detached interpretation of the therapeutic relationship as artificial and predictable, perhaps testing my reaction. I choose to remain close and engaged with him, instead of reflexively pulling away when feeling slighted by his characterization of the relationship. Weathering distancing/withdrawing interpersonal behaviors eventually led to the formation of a deeper relationship, allowing Slate to navigate and expand the limits of our relationship and providing experiences that corrected his relational expectations (Hill et al., 2014; Terry, 2010) . Slate ultimately shared that he revealed more in our sessions than he ever had before, and that the way we were with one another had the biggest effect on him. In one particularly insightful session toward the end of our work, when Slate reflected on the above exchange and how our immediacy had made distancing himself in session more difficult, he admitted sardonically, "Maybe it would've been better if you didn't tell me you cared.*"*

"I'm afraid I won't change the world."

Practitioners scholars have suggested that the social and intrapsychic difficulties experienced by individuals with a detached/withdrawn interpersonal style can be attributed to an unresolved self-concept (see Coolidge, Estey, Segal, & Marle, 2013; Nirestean et al., 2012**).** Slate and I discovered evidence of an unclear inner experience and lack of self-understanding in the rare moments of interpersonal vulnerability that are possible for individuals with attachment-avoidance (Hess, 2016). Slate admitted to fearing that his own worldview was responsible for his isolation, asking, "If I don't see a point in life, then what's the point of relationships?" He then labeled himself a "cynic," and "sarcastic, arrogant, and adversarial." Nirestean and colleagues (2012) explained that how others see us is inextricably connected to our *self-concept*, how we perceive ourselves in relation to the social world. Slate believed others saw him as barely tolerable, self-absorbed, and someone to be put up with. In a self-fulfilling prophecy, Slate admitted to continuously moving against others, having little trust in those that came interpersonally close to him because it is what he thought they expected him to do.

Slate's interpersonal expectations and view of relationships played an integral role in our therapeutic process. As he developed insight surrounding his interpersonal style, connections were drawn between his attachment-avoidance in counseling, his internal ambiguity, and larger existential fears:

> C: Slate, what you're saying about wanting to connect, being afraid to fail, and not wanting to change who you are reminds me of a presentation that I recently attended. The presenters proposed that all problems stemmed from two innermost fears: being alone and not being good enough.
> S: Yeah. I think that makes sense…I mean I definitely agree with both of those.
> C: Can you tell me more?
> S: Where do you want me to start?
> C: Wherever feels right to you.
> S: Well…I don't know.
> C: What about fearing not being good enough?

> S: Yeah well, I guess I'm afraid of not being good enough…of not mattering. I have this dream of changing the world and making a difference. I'm afraid I won't change the world…I'm also afraid I won't meet someone, I won't procreate and pass on my genes to a future generation.
> C: So, you fear that you will not matter and that you won't meet anyone because of the way you say you are. You fear not being accepted, and so you don't try because that possibility makes you anxious.
> S: Exactly, if I don't try then I don't have to worry about it.

His own responsibility in making relationships meaningful and doing something in life that mattered functioned as a boundary situation for Slate (see Yalom, 1980), experiences that brought him face-to-face with deep existential factors: meaninglessness and death. Together we discovered that he was avoiding not only interpersonal vulnerability, but also the responsibility that would come with interpersonal success. This discussion on meaning heralded a new phase of the therapeutic process; catalyzing conversations about meaninglessness, self-sabotage, and the risk inherent in allowing others to matter.

Discussion

The interplay between feelings of loneliness and the fear of judgement and interpersonal failure, and the interpersonal style enacted to allay these feelings can facilitate a self-sustaining ambiguity toward the therapeutic process (Martens, 2010). This internal conflict can lead the individual to see the world as dangerous and chaotic, while having a desire to participate fully in it. This may drive the individual to subconsciously sacrifice intimacy in favor of autonomy, and shape their identity in ways that minimize meaning in interpersonal relationships in favor of risk management and control (Esterberg, Goulding, & Walker 2010). These inner developments can result in feelings of emptiness, and reactive anxieties that emerge as building relationships becomes more difficult and demands a further exploration of relational roles (e.g. acquaintance, friend, lover, enemy) and everyday relationship dynamics (e.g. intimacy, attachment, distance, loss) (Coolidge et al., 2013; Nirestean et al., 2012).

Building insight about the complexity of interpersonal relationships only fed Slate's attachment-avoidance and ambiguity toward therapeutic change. Immediacy surrounding his hesitation toward the therapeutic process provided rich corrective interpersonal experiences where he confronted how he was getting in his own way (Binder & Betan, 2013; Terry, 2010). The *relational encounter* included Slate's confrontation with his own attempts to shape his relationship with me, bringing him face to face with his own responsibility over himself, his life, and his actions and inactions—the anxiety of groundlessness (Yalom, 1980). Danzer (2015) pointed out how immediate self-disclosure about the relationship itself can help clients engage in a "reciprocal and connected way…the ultimate goal in doing therapy" (p. 61). This was distinctly powerful in our work.

By discussing his desire to matter and fear of not being good enough, Slate encountered how he flees from trying: protecting himself from interpersonal failure behind an inflated sense of autonomy and feigned lack of interest. His *why-try?* attitude (Corrigan, Bink, Schmidt, Jones, & Rüsch, 2016) revealed that his supposed apathy was driven by a belief that a lack of

attempting meant an impossibility of failing. Slate had branded himself as unavailable, intolerable, and ultimately socially inept by shaping a stigmatizing self-concept that included accepting that change was impossible.

I deeply believe that Slate's attempts at distancing himself in our therapeutic relationship, through doubt or criticism, were moments where he tested whether or not I would provide an interpersonal experience different than what he expected, if I would do more than just tolerate him. Gupta (2017) argued that practitioners need to shift our clinical lenses to account for social and cultural context, especially with attachment-avoidance. For the author, "some people's apparent brand of madness may actually be invoked as their sanest means of survival…" (p. 171). Slate's fixed attachment-avoidance may have been – as Hess (2016) described – grueling, slow, and monotonous at times, but it was also evidence of his inlaid desire not to be hurt. Slate acknowledged an everyday performance of protecting his "self" from the social world, despite being unsure of who that "self" truly is (Gupta, 2017). Slate illustrated this by recognizing multiple levels of interpersonal defenses, but no longer knowing what he was defending.

This case illustration was guided by three exploratory questions: (1) how did Slate's perception of relationships change? (2) what did the *relational encounter* mean to Slate? (3) how did focusing on *relational encounter* destabilize the diagnostic relevance of the SPD diagnosis? At the initiation of the therapeutic process, Slate presented with a disinterest and apathy toward interpersonal relationships. Overtime, he admitted that relationships mattered more to him, and that he had shared more with me than he had with others in his life. He expressed that interpersonal relationships were important to his overall wellbeing, even if he needed to develop a greater capacity for building them.

I define the *relational encounter* as an ontological experience wherein we encounter ourselves in-relationship to another. Slate's attachment-avoidance and how it functioned to protect him from interpersonal risk only became apparent through repeated experiences of *relational encounter*. As an approach, *relational encounter* stresses the importance of challenging interactional expectations through immediacy, closing relational distances through self-disclosure, and weathering interpersonal ruptures by working hard to interrogate and maintain the intimacy of the practitioner-client relationship. In a 'Goodbye Letter' provided at the end of our work together, Slate responded to the *relational encounter* and the unconditional desire for closeness by saying, "To the average person this may seem nice, but somewhat trivial. To me, this was the greatest gift I could've received."

Destabilizing the diagnostic relevance of SPD came as a byproduct of immersed interpersonal work. The focus on *relational encounter* destabilized the diagnostic relevance of SPD by illuminating how Slate shifted outside the margins of the diagnosis, building insight about his interpersonal style and expectations. This loosened the diagnostic boundaries, bringing agency for change back to Slate and the therapeutic relationship. More importantly, the *relational encounter* achieved relative success, as reported by Slate, while avoiding the internalization of pathologizing terminology and self-stigmatization.

Conclusion

Interpersonal theory reorients the therapeutic paradigm toward recognizing personality as a relational process and not a fixed way of being. While Slate's work will continue beyond our time together, there is evidence that his progress may have been hindered by a more medicalized or manualized approach. During the two years that Slate participated in counseling, cognitive-behavioral interventions were attempted to address social anxiety. These interventions were met with skepticism about their effectiveness or outright ridicule. For example, role-play was attempted as a starting point in addressing Slate's distress in social situations. Slate responded by critiquing the artificial environment of counseling, and the consequently inevitable ineffectiveness of the technique. It is my opinion that Slate withdrew, his defenses were too directly confronted (Danzer, 2015). This withdrawal made it apparent that a more relational approach was needed, and immediacy was used to bring attention to his withdrawal.

Relational encounter as an approach for working with attachment-avoidance emerged from the aversion to intimacy marked across the therapeutic process with Slate. Instead of viewing attachment-avoidance as pathology, it was engaged as a self-protective strategy (Gupta, 2017). This led to repeated moments of rupture, immediacy, proximity, corrective experience, and re-rupture, and side-stepped the necessity to engage any "working-harder-than" intervention. Future research is needed to validate the *relational encounter* approach—not as manualized treatment, but as an orientation that emphasizes immediacy and the experience of being-in-relationship. For practitioner scholars, difficulty being-in-relationship is an experience that we see extending beyond one categorical diagnosis, a deeper understanding of it is essential.

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