

***¹Attachment and Cognitive Psychotherapy**

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Abstract

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Learning theory and its expansion as cognitive theory have revolutionized the formerly murky and subjective field of psychotherapy by creating evidence-based, theoretically informed psychotherapy. This talk focuses on how cognitive therapy might develop next, with an emphasis on contributions from attachment theory. These contributions are: functional diagnosis, affect and its contribution to self-protection, a model of psychological functioning and its relation to psychopathology; and a basis for selecting treatments such that risk of harm is reduced. Attachment theory points to perception of danger and protection of oneself from danger as central to psychopathology. Information processing suggests the independent importance of temporal order and affect for generating self-protective strategies that are applied, adaptively and maladaptively, to life circumstances. Together these suggest groupings of patients whose psychological and behavioral processes are functionally similar, even if their symptoms differ. Assessing patients in functional terms could lead to greater precision in the application of treatments to patients. The notion of purposeful eclecticism is introduced as a way to assess the effects of therapeutic techniques, thus increasing the range of tools available to therapists and the specificity of their application. Finally, the role of therapists as transitional attachment figures is considered.

¹ The asterisks * refer to an accompanying PowerPoint presentation, to be found on www.patcrittenden.com.

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The sign of a great thinker is not his conclusions, but rather his ability to elicit thinking in others. I've been reading a lot about cognitive therapy recently and I am impressed by how Aaron Beck's clarity of thought elicits thought on my own part. Some of my thoughts are in this talk - a talk that I hope will add to the dialogue between cognitive therapy and attachment theory.

Learning theory and its expansion in cognitive therapy have revolutionized the murky and subjective field of psychotherapy. They have created the possibility for evidence-based, theoretically-informed therapy. This talk will focus on how cognitive therapy might develop next, with a particular emphasis on what attachment theory might have to offer. A basic notion is that good theory is never static, it always changes and grows - or its time passes and it withers away.

There are several limits to the effectiveness of cognitive therapy as it is practiced now, each of which creates an opening for further development. But first, let me say clearly that I am aware that "cognitive therapy" is many different things; for economy I must speak in general, but I know the shoe cannot fit every foot. Further, I know that many researchers and clinicians within cognitive therapy are pushing precisely the limits that I will mention. I will address some of these, but if I omit your favorite thinker - or you yourself - I hope you will understand that the constraints of 35 minutes are very great.

*Let me address four limitations of cognitive therapy:

*1. The focus on symptoms, symptom-based diagnosis, and treatments directed to symptom reduction;

*2. An emphasis on behavioral and verbal/rational psychological processes to the relative exclusion of affect;

*3. Lack of a comprehensive model of psychological development and its relation to psychopathology;

*4. Limited exploration of the possibility that psychotherapy could harm patients (as opposed to simply being ineffective).

***1. Symptoms**

People usually seek therapy because they feel * distress. This is the central evidence that something functions poorly in the person's life - as experienced by the person him- or herself. * Often, however, therapists transform this signal into a list of symptoms that then are condensed into a symptom-based diagnosis. Once this happens, the patient's perspective risks being replaced by the therapist's.

In place of symptom diagnoses, the Dynamic-Maturational Model (DMM) of attachment theory offers * *self-protective strategies* (Crittenden, 1995, 1997a, 2000, 2002). Self-protective strategies permit us to look beyond symptoms to identify their *function* for the patient. In doing so, we need to keep in mind that each behavior can serve several different

functions. For example, a smile can invite closeness, hide anger, express embarrassment, or warn someone not to come closer. Focusing on the function of behavior can help to focus treatment on the reasons for the behavior.

* As Jeffrey Young notes, cognitive therapy is successful in 70% of cases, but only in the short-term. Symptoms reappear by 1 year post-treatment in 40% of successful cases (Young, Klosko, Weishar, 2003). That is, half of cognitive treatments are unsuccessful. Focusing treatment on eliminating the * *reasons* for the symptoms might improve the success-rate.

The DMM proposes that symptoms are part of self-protective strategies that were used to protect the self from danger in the past and are still used now in both truly threatening situations and also misperceived threat. It is the latter, *misperceived threat that elicits maladaptive self-protection*, that is the basis for psychopathology.

Therapy aimed at helping patients to more accurately identify threat and to organize more effective forms of self-protection might be more useful, in the long-term, than therapy to eliminate unwanted symptoms. Moreover, when symptoms are understood as being part of self-protective strategies, patients' view of themselves as being "crazy" or "sick" is transformed to one of seeing themselves as * competent, but more competent at dealing with threat than with safety. That is, the DMM offers a * strengths approach to treating psychological disturbance, as opposed to an approach organized around vulnerability.

***2. Affect**

Cognitive therapy emphasizes temporal contingencies and causal relations, particularly those expressed verbally, for example, "core beliefs." Attachment theory treats this "cognitive" information as different and distinct from affect in evolution, in neurology, and in implications for disorder and treatment of disorder.

To understand the DMM perspective on cognition and affect, I must speak a bit about memory systems. Endel Tulving's work is central (Schacter & Tulving, 1994). Memory systems can be thought of as different ways of transforming sensory stimulation to yield information that can organize behavior.

The "cognitive" memory systems are procedural and semantic memory. Both are familiar to cognitive therapists. * *Procedural memory* refers to sensorimotor schemas derived from previously learned temporal contingencies (i.e., feedback) and applied automatically and without conscious thought or language. That is, procedural memory is re-active. It is learned on the basis of experienced contingencies and, therefore, is precise and specific.

* *Semantic memory* refers to generalized understandings of causal relations, expressed verbally. Semantic information can be generated directly from experience or "borrowed" from others, for example, from parents, based on what they tell children. Or *therapists*, based on what they tell patients. "Core beliefs" are an example of semantic information.

Semantic statements include both generalizations about the past and prescriptions for the future. Semantic memory is the knowledge of (1) how it was as well as (2) what one *should* do or *ought* to do. The basis of a semantic statement is a when/then or if/then statement, but it

might become an absolute. Cognitive therapy routinely addresses maladaptive procedures and semantic beliefs.

*Affect is represented preconsciously as * *imaged memory* and verbally as *connotative language*. Affect alerts the person to the possibility of danger and prepares us to fight, flee, or freeze - prior to the first opportunity for experiential learning. Specifically, processing through the limbic structures heightens perception and physiologically changes the body to prepare it for self-defense. These changes constitute a state that we label "anxiety": furtive scanning of the environment, rapid shifts in attention, rapid heart rate and breathing, reduced digestion, etc. Under conditions of safety, anxiety is uncomfortable and not adaptive. But under conditions of danger, especially danger from a unknown source, hypervigilance and arousal are protective.

Imaged memory is pro-active. It depends upon genetically-carried responses to differing intensities of stimulation. As a consequence, imaged information is imprecise and over-generalized. The innate quality of this response is important because, in the first exposure to danger, an unprepared person could be injured or even killed. Sensory images represent what individuals know about dangerous and safe contexts whereas * connotative language not only brings the images to mind, but also communicates them to others who then can feel something similar - and understand better the meanings of the aroused person.

There are also two memory systems that * integrate cognition and affect. * Episodic memory is learned at about 3 years of age and integrates procedures with semantic recall and images all told in connotative language about a single occasion in time. Children learn to tell episodes in a dialogue with parents. If the parents won't tell the story, the children will not have episodic recall of the event. For very deprived children, this means there are no episodes to recall. For others, it means that certain episodes cannot be recalled.

* Reflective integration permits an individual to reconsider what is known and whether any of the information or responses are inappropriate. It begins functioning at about 7 years of age and matures throughout the life-span. It makes correction of error possible and creates the possibility of generating new responses. The downside is that it takes lots of time and interferes with scanning the environment. Consequently, people who are exposed to danger early in life do not learn to integrate reflectively and may, in fact, consider it a dangerous activity.

* Displayed visually the memory systems look like this:

*Each memory system is a representation of the relation between self and non-self. Each creates a disposition to action and these may be different. Each highlights some aspect of reality and distorts some other. The issue becomes which will underlay the action taken.

In the dynamic-maturational model of attachment, (1) temporal and causal contingencies and (2) affect are considered equal, but different contributors to the organization of self-protective behavior. Further, the implicit forms of cognitive and affective information are thought to regulate behavior disproportionately under conditions of threat. In particular, for

affect, theory regarding a * gradient of arousal might help to make symptoms more comprehensible.

Three points of arousal mark the dimension: * intense arousal (in response to perceived threat), * moderate arousal (in response to perceived safety), and * lack of arousal (in response to perceived futility). The end points of too high and too low arousal are death.

Between there is a series of person-defined states ranging from * desire for comfort that motivates approach with a request for help, to * anger that motivates approach with aggression, to * fear that motivates escape, to * sexual desire that motivates approach having variably comforting, aggressive, and submissive characteristics, and * pain that signals the absolute last chance to save the self. Moving through the lowered states of arousal, we have * boredom, * tiredness, * sleep, and, ultimately, * unconsciousness. These are the signs of depression.

I want to highlight the importance of sexual desire. I've been reading a lot about cognitive therapy recently. Anger and fear have been mentioned explicitly and desire for comfort has sometimes been implied, but sexuality is missing. Why? Sex is the best reason I can think of for giving up the protections of childhood! But more seriously, every person with serious psychological problems has sexual problems as well: too much, too little, at the wrong time, in the wrong place, misdirected to the wrong person. Shouldn't sexual desire - and its complex interaction with other feelings - be addressed in psychotherapy?

3. Model of psychological development and psychopathology

Cognitive therapy lacks a comprehensive model to explain (1) the relations among genes, neurology, information processing and behavior and (2) the developmental process by which maladaptation occurs. Attachment theory addresses both points.

* With regard to mental processing to yield behavior, Attachment Theory proposes that * *sensory stimulation* → * *transformations of information* → * *multiple dispositional representations* → * *enacted behavior*. Moreover, there are two basic transformations, a “cognitive” transformation and an affective transformation.

Because reality is not transparent, information *must* be further transformed to yield better predictions of danger. That is, * the only information that we have is information about the past whereas the only information that we need is information about the future. Thus, we must transform it to make more accurate predictions of the future. * Information may be accurate, omitted, distorted, erroneous, or false. Distorted dispositional representations exaggerate or minimize the probability of danger. This is self-protective when past experience indicates that the threat is too great to risk incurring again or, alternatively, that one must continue to deal with the source of threat and being aware of the threat would increase the danger. Information is falsified when past danger has been tied to deception. In extreme cases, the mind can learn to expect danger when safety is perceived.

* These two form the basis for a two-dimensional model of self-protective strategies. Horizontally, we have the dimension of source of information: cognition, affect, or their integration. Vertically, we have the transformation of the cognitive or affective information

from true to omitted and distorted, erroneous, and falsified (Crittenden, 1997b). The interaction of these creates an array of self-protective strategies. Let me go through the model in detail.

It is not important that you remember each strategy. It is important that their (1) basis in information processing and (2) function to protect the self in various sorts dangerous circumstances are understood.

Therapy should change the person's strategies by correcting processing errors, limiting the perception of danger to appropriate conditions, and assisting patients to develop new strategies, especially strategies for discovering safety and enjoying comfort.

Thus, instead of an assortment of symptom diagnoses or schemas, we have a model that relates self-protective strategies to one another and ties them to prior experience with danger. This both defines patients in terms of their strengths (in the face of danger) and also directs therapists to the areas of psychological and behavioral functioning where change is needed.

Like most schools of therapy, cognitive therapy has a top-down perspective on development. That is, experience with troubled adults is used to extrapolate an understanding of developmental processes and the contributions of parents and families to patients' disorders. If a developmental approach were used, beginning with the study of infants and their parents and progressing as the child matured, siblings were born, and parents developed, the picture would be very different. Parents would be seen to be well-intentioned, but sometimes misdirected. Dramatic symptoms would be seen to have a logical developmental course - and to be meaningful even in adulthood.

Attachment Theory's roots in development position it well to contribute to an understanding of the meaningfulness of human behavior, the lack of villains in human relationships, and the possibility of preventive interventions before adulthood.

***4. Treatment outcomes**

Cognitive therapy has moved the field of psychotherapy forward by carrying out research on treatment efficacy. A crucial lack, however, may be the limited investigation of the possibility of * *harmful* effects. Let me offer both a rationale for my concern and some case descriptions.

If the DMM notions of cognition and affect are more or less accurate, then "cognitive" self-protective strategies are the * psychological opposites of "affective" strategies. Thus they might need * opposite treatments. Indeed, a treatment suitable for a cognitively-organized person might *augment* the distortion of an affectively-organized person. For example, cognitively organized people inhibit negative affect and need treatments that help them to access and express negative feelings. But affectively-organized people exaggerate negative affect and need treatments that help them to minimize it. If this is accurate, the treatment that helped one could be detrimental to the other. Current diagnosis accounts for symptoms, but is uninformative about psychological organization.

To demonstrate my ideas, I offer two examples. I have chosen powerful examples because they highlight the cost of not considering the harmful effects of treatment.

The first is a cognitively, logically organized man whose feelings are inhibited. As a child, he watched his father repeatedly abuse his mother. When he attempted to protect her, he was attacked as well. If he cried, his father mocked him - and possibly hit him. His father derided his masculinity, calling him a sissy, a wimp and teased him for his feelings. He cowered and longed to help his mother - and to be protected by her. He began to idealize vulnerable people like his mother and to fear and hate powerful and aggressive people. He was ashamed of his feelings - and he hid them far away inside himself where no one could see them, especially not he himself. He became a timid boy who watched other people very closely to discern what they expected of him so that he could do that thing immediately. If the action failed, he construed it as his fault - and felt more ashamed. When he went to school, he was a lonely, odd child who was mocked by the other children. Sometimes they bullied him. His only friends were other outcast children or maybe an older man who befriended lonely, troubled boys. His first truly affectionate relationship came in adolescence when his emerging sexual feelings and loneliness pushed him precociously into sexual contact with an equally troubled girl. Forever after, comfort and sex would be linked pleasantly for this boy.

As an adult, he has a wife. She is the sort of woman who can love and accept a vulnerable, needy man. In fact, she knows a lot about neediness herself. They love each other. Because he wishes to protect his children from a lonely, cold childhood like his own, he attends to their slightest signals and protects and comforts them as if they were as vulnerable as he feels. In response to their childish coy signals, his comforting touching sometimes becomes sexual. Still neither his wife, nor his children think of him as an incestuous sexual abuser and they want to continue to live together as a family.

In prison, he is offered CBT. He is encouraged to take the perspective of his victim, to think about the harm he caused, to set his own feelings aside, and to take responsibility for his shameful behavior. From the perspective of the DMM, he is encouraged, under the guise of "therapy", to do more of what he already does madadaptively! Will such therapy enable him to reverse his psychological pattern of attending to other's desires, denying his own feelings, and accepting responsibility for others' behavior such that he sees accurately the needs of his children and responds in new ways to them? Will it stop the sexual abuse?

If the treatment fails because it reifies his existing psychological and behavioral patterns, will his therapist take responsibility for failure to understand his psychological organization and to provide an appropriate treatment? Or will he be labeled a pedophile and told that pedophilia is incurable? If it is the latter, he might be put on a public register of sexual offenders, thus being shamed and ostracized for the rest of his life - as he was at home, in school ...

Or consider a woman whose parents provided for her physical needs and didn't abuse her, but they didn't want her born, they had very little time for her, and, being overwhelmed by their own troubles, they were largely unaffected by anything she did. As she grew up, she almost entirely lacked useful information about contingencies and logical thought; instead she organized around distorted negative affect. She exaggerated her displays of anger to obtain

her parents' attention and created situations in which she needed their protection. The more her parents failed to respond, the more she escalated the displays, from angry outbursts to provocative behavior to self-endangerment. She acted out. She took risks. She got in trouble. These are common symptoms, but, as described here, they are part of a strategy to wring responsiveness from a reluctant environment. Nothing she did caused the world to respond contingently and tenderly to her. By adulthood, the slightest insult sent her spinning into an unpredictable oscillation between rage and despair. She thinks of suicide.

Let's consider two different approaches to treatment. In one, she hears about a treatment with a good success rate - and, in a burst of hope, she calls. In the other, maybe in a moment of despair, she tries psychiatry.

Her cognitive therapist offers her a manualized treatment in which she must adapt to the manual, complying with the homework, moving in prescribed steps through the sessions. She mentions her thoughts of suicide, but they don't fit the diagnosis, aren't in the manual and aren't pursued in the therapy. After 20 sessions, the therapy is complete and discontinued.

Her psychiatrist offers her a pharmacological therapy. The drugs calm her rages and buffer her lows, but they moderate her right out of contingent interaction with the world around her. She calls her shrink from time to time when she feels especially desperate, but he doesn't provide psychotherapy and he decides that she is one of those hysterical sorts. They make an agreement that she will notify him if she becomes serious about committing suicide.

Neither her cognitive therapist, nor her psychiatrist adapts their behavior uniquely and specifically to her. Neither forms a personal, caring relationship with her. Instead, she must adapt to their understanding of what she needs. It's childhood all over again.

One day she kills herself.

The irony here is that the intense feelings of the woman had functioned to elicit, as much as possible, responses from an unresponsive family. When medication reduced her responsiveness, she felt doubly disconnected, being unable even in *her* arousal to compensate for their unresponsiveness. Without a therapist to function as a transitional attachment figure, medication alone risked leaving her calmed from the perspective of others (i.e., she made *us* less uncomfortable) and despairing of even existing herself (i.e., having defined herself affectively and now losing access to her intense feelings, she felt her 'self' as if not existing at all). Death only confirmed what she already knew, in that deep inner way that we all know ourselves.

We perceive our connection to others in two ways: contingencies and feelings. Take them both away and what is left? Her bursts of connective anger felt like attacks, not connections, even to her therapist, but she had little else to offer. There is a role here for a transitional attachment figure - a priest, spiritual guide, therapist, analyst, or just a mature friend. Someone who is thoughtful and caring and just far enough out of the fray to survive her intensity, but close enough to her psychological reality to both confirm it and also offer a new way forward.

Did the treatments simply fail to help or is it possible that both sorts of treatment were harmful and that, regardless of which she selected, treatment augmented the woman's sense of invisibility as a unique person. Can the failure of hoped-for-help leave a patient more distressed than never having hoped or sought help?

To be clear, I am not saying that CBT or pharmacological treatments are always inappropriate. I am saying that careful functional diagnosis that accounts for both the history of the disorder and its current role in the patient's life is needed before treatments are selected.

I am also saying that a treatment that is effective with one person may be *harmful* for another, even if their symptom-based diagnoses are the same. We need good research on the psychological and behavioral effects of each treatment strategy we use. To carry out this research, we need mixed patient groups, containing both cognitively-organized and affectively-organized individuals who receive the same treatment. If my thinking about affect and cognition is correct, there should be desirable effects on some people and undesirable effects on the oppositely organized patients. If this were done systematically, for example in a series of doctoral dissertations, we could develop a "*Psychotherapists' Desk Manual for Psychotherapeutic Techniques*."

Does this imply that therapists need to work in constant fear of doing harm? I think not. Everybody makes mistakes; the issue is whether they can discover and repair the mistake. A central idea in the information processing model of attachment theory is that, in well-functioning individuals, discrepancy elicits reflection and change. Enacting this openly for, and with, patients is itself very possibly the best reparative strategy. Of course, it is not possible to manualize such unique and dyad-specific processes.

Relying too much on empirical data supporting the use of particular therapies can undermine the effectiveness of therapy. In part, it could reduce the therapist's experimental attitude by creating false confidence. Alternatively, by over-shadowing the therapist's intuitions and feelings, too much reliance on data can deny therapists access to affective information. Maintaining a reflective, observing position (including consideration of both the effects on patients of treatment and the feelings aroused in oneself) can alert therapists to unwanted outcomes and initiate a process, with the patient, of reflection and change. This, of course, is the crux of maintaining both balanced and adaptive functioning and also satisfying relationships.

Conclusions

Cognitive therapy has brought the whole field of treatment forward in content, in precision, and in the use of empirical evidence to evaluate treatment outcomes. It is still the case, however, that more than half of patients are not helped - and some may be harmed. I think that ideas from the DMM can help us to further close the gap between our intentions and our performance.

* Which ideas would I offer?

* The importance of understanding the self-protective function of symptoms.

- * The strategic organization of all persons, patients included.
- * The importance of affect.
- * The structure of human psychological organization as consisting of two opposite processes and their integration - with patients rarely displaying integration.
- * The possibility that treatments may have different effects on people with similar symptoms, but opposite psychological organizations.
- * The important of therapists knowing both the organization of each patient and also the effects on psychological functioning of each treatment technique that they employ.
- * The importance of the therapist being, uniquely for each patient, a transitional attachment figure who helps to create enough safety and comfort for change to be explored.

Possibly, the last of these smacks too much of psychoanalytic treatment? Possibly all therapists need to be more eclectic, more *purposefully eclectic*.

Would you go to a physician who already knew what treatment he would offer even before you had met him? Would you go to a physician who limited himself to the drugs of only one pharmaceutical company? Why do therapists receive only one sort of training and then offer it to everyone who comes to them?

Do the best therapists do this? I think not. The best therapists are intuitively eclectic. Intuition, however, is hard to teach. A good theory of psychological organization around self-protection could provide the bones, the skeleton, upon which the flesh of effective treatment can flourish. If I push my metaphor, cognitive therapy is like brains and muscles, having both logic and power. But a heart is needed and the human touch of skin on skin. Feelings are essential for adaptive functioning - and for happiness. Affect needs to be added to the empirical approach of cognitive therapy before truly healing human relationships can be established with patients. Only in such close relationships can we join patients, at least as companions and possibly as guides, on the journey from their experience of danger and threat to our reality of the possibility of safety and comfort.

Attachment theory has no special form of treatment to offer, nor do I think that it should. We have enough treatments. We need to know better how to use those which we already have. It is my hope that the DMM can offer a provisional structure not only for fleshing out cognitive therapy, but also for integrating the strengths of other approaches into a more comprehensive, more effective approach to healing psychological distress.

Of course, theory too is dynamic; it changes all that it touches and, in turn, is changed by it. Inclusion of ideas from attachment theory will change cognitive therapy - as cognitive therapy has already changed attachment theory. That is how it should be.

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