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Attachment Theory, Psychopathology, and Psychotherapy: The Dynamic-Maturational Approach

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Attachment theory is the newest major theory of adaptive and maladaptive functioning, but, in the roughly 50 years since its initial formulation by Bowlby (1969/1982, 1973, 1980), it has attracted a great deal of attention and many variants. The approach discussed here is the dynamic-maturational model (DMM) of attachment theory. In the DMM, attachment is a theory about protection from danger and the need to find a reproductive partner (Crittenden, 1995). As a developmental theory, it is concerned about the interactive effects of genetic inheritance with maturational processes and person-specific experience to produce individual differences in strategies for protecting the self and progeny and for seeking a reproductive partner. These strategies, i.e., the patterns of attachment, provide both a description of interpersonal behavior and also a functional system for diagnosing psychopathology. It is unlike other theories of psychopathology in that its perspective began with infancy studies and progressed forward developmentally, rather than beginning in adult disorder and attempting to reconstruct the developmental precursors of disorder. As a theory of psychopathology, it is concerned with the effects of exposure to danger and failure to find a satisfying reproductive relationship on psychological and behavioral functioning. Attachment theory is not, however, a theory of treatment. Instead, the dynamic-maturational model of attachment theory can help to redefine the problem, offer new methods of assessment, and suggest when and with whom to use the various existing tools for psychological change.

Five central ideas underlie the DMM:

1. Patterns of attachment (Ainsworth, Blehar, Waters, & Wall, 1978) are self-protective strategies.
2. Self-protective strategies are learned in interaction with protective figures (attachment figures, most often one's parents).
3. Symptoms are functional aspects of dyadic strategy (e.g., acting out, inhibition) or consequent to it (e.g., anxiety behaviors)
4. Strategies will change when they do not fit the context; symptoms of anxiety will disappear when one is not anxious.
5. Therefore, the focus of treatment should be the fit of strategy to context to yield maximum safety and comfort.

Organized self-protective strategies

Attachment theory proposes that humans have an innate propensity to organize self-protectively and, after puberty, sexually. The bases for this organization are universal (genetically transmitted) forms of information processing. Specifically, the strategies are the outcome of processing of two types of information: the temporal order of stimulation and its

intensity. These are processed separately by the brain to yield “cognitive” information about causal relations and “affective” information about the somatic feelings associated with contexts. *Cognition*, in other words, is the basis for learning theory whereas *affect* is tied to arousal, with high arousal often being experienced as anxiety (i.e., the preparation of the body for self-protective action even when the source of danger is unknown). These two forms of predictive information (temporal and contextual) lead to two basic attachment patterns, Types A and C, respectively. Individuals using a Type A strategy organize around expected outcomes. They minimize awareness of feelings and do that which will be reinforced and avoid doing that which will be punished. Disorders of inhibition and compulsion are tied to too great a reliance on cognitive information. Individuals using a Type C strategy are motivated by somatic feelings (tied to intensity and processing through the limbic structures). Lacking confidence in what will happen next, they focus on feelings as guides to behavior. The crucial feelings are negative in a gradient of increasing arousal from desire for comfort to anger, fear, sexual desire, and pain. Anxiety disorders are tied to too great a reliance on negative affect. Type B is the integration of the two sorts of information and consists of open, direct, and reciprocal communication of expectations and feelings. Intra-personal reflection (integration) and inter-personal discussion and negotiation are crucial to avoiding the biases inherent in sole reliance on either cognition or affect. The Type B strategy of psychological balance is, therefore, the least vulnerable to psychopathology.

Self-protective strategies and attachment figures

In infancy and childhood, attachment figures both provide protection and also teach children how to make meaning of the information available to their minds. After puberty, the protective function is integrated with the reproductive function and both are directed to a sexual partner. This relationship produces the next generation of children to whom parents will be protective attachment figures. In that role, they act on their own understanding of what is dangerous and safe, thus creating the environment in which their children learn to make self-relevant meanings. These meanings, however, reflect the child’s experience and, therefore, they may not be the same meanings and strategies used by the parents. Postulating the role of protection and reproduction in organizing human behavior permits attachment theorists to interpret psychopathological behavior as maladaptive attempts to protect the self or find a reproductive partner.

Transformations of information and expansion of the array of strategies

Transformations of information

The only information that we have is information about the past, whereas the only information that we need is information about the future. A central function of the brain is to transform information about the past to yield representations of the probable relation of self to context in the future. The simplest transformations are the cognitive and affective representations just described. Because the information directly reflects stimulation, it can be considered *true* information. Sometimes information is generated, but discarded from further processing such that it does not affect behavior. Individuals using a “pure” Type A strategy omit affective information from further processing and, thus, behavior whereas individuals using a “pure” Type C strategy omit cognition from further processing and behavior. This is *omitted* information. In addition, however, some retained temporal information is not causally related to outcomes and some retained somatic or psychological feelings are not indicative of danger. When associations are made between actual conditions and inaccurate

outcomes, the information generated is considered *erroneous*. Unnecessarily inhibited or compelled behavior and feelings that do not predict the safety or danger of context are examples of erroneous information. Infants are capable of making all three of these transformations.

More complex representations are generated as the brain matures and information can be processed through additional parts of the brain; these meanings create a gap between what was experienced and what is represented. That is, appearances are not always reality and more complexly transformed information is needed to reflect that. For example, older infants can omit some information about the past from further processing, thus distorting the representation of the probable future. Either cognition or affect can be *distorted*. Preschool-aged children can distort part of the retained information while concurrently excluding other information from behavior; the effect is greater distortion than was possible in infancy. For example, an aroused preschooler can display exaggerated anger while inhibiting display of desire for comfort and fear. Information can also be *falsified*. Preschool-aged children can falsify affect. Children (and adults) using the Type A strategy often transform true, but forbidden, negative affect into apparent false positive affect. By the school years, children can falsify cognition, that is, they can represent the opposite of what is expected and, by acting on that representation, they can mislead others about their future behavior. These five sorts of transformations enable individuals to regulate the probability with which they identify danger. The more an individual feels threatened by imminent and severe danger, the less error can be tolerated; consequently, distorting transformations usually increase the probability of over-identifying danger. They are also used more often by people who have been endangered.

The mind and representation

These transformations yield dispositional representations, i.e., patterns of neurological activity that dispose individuals to act in some manner (Damasio, 1994). Depending upon whether the representation is based on temporal order or intensity of stimulation, individuals are disposed to behave based on expected consequences or on feelings. The various representations that are generated may dispose an individual to incompatible responses. In that case, the mind must either select which response to enact or construct a new response. This occurs in the cortex, the last portion of the brain to mature fully.

When the estimation of danger is very high, individuals are propelled into action on the basis of the precortical representation that signaled threat most clearly. This representation is likely to be an over-estimation of threat, and because it has been processed only precortically, error is not easily discerned or corrected. Thus, behavior will often be maladaptive. When this happens sufficiently often, it is deemed psychopathological. Because of cortical immaturity and greater vulnerability to danger, children are at particular risk for over-attributions of danger and maladaptive responses. Maturation and development promote the correction of these errors - except in cases of severe, on-going, and deceptive danger. In these cases, the pervasive and ambiguous nature of threat increases the probability of incompletely processed information regulating behavior. Together with increasingly sophisticated precortical distortions of representation, the outcome in adolescence or early adulthood can be very complexly distorted patterns of behavior.

Self-protective organizations of behavior

Ainsworth's classic work identified three basic patterns of attachment (Ainsworth, 1979). Type A individuals tend to omit feelings from processing and to act in accordance with expected consequences. Type C individuals do the opposite: they act in accordance with their feelings with little attention to consequences. Both tend to over-estimate the probability of danger and act in an unnecessarily self-protective manner. Type B individuals use both sources of information; they have balanced mental processes and adaptive behavior. See Figure 1.

Both Crittenden and Main have expanded the Ainsworth model. Main's ABCD model is based on the work of Main and Solomon (1990) and defines everything outside of the Ainsworth patterns as "disorganized" or "cannot classify." Empirically, it reduces the Type C category, subsuming most Type C children within the "D" category (van IJzendoorn, Goldberg, Kroonenberg, & Frenkel, 1992). See Figure 2.

Crittenden in her dynamic-maturational model of attachment (Crittenden, 1995, 2002) has expanded the array of strategies to include compulsive Type A strategies and obsessive Type C strategies. The higher numeral strategies reflect transformations of information and organizations of behavior that infants cannot manage. The array of patterns increases in synchrony with maturation, with psychopathy becoming possible only in the early 20's. These compulsive and obsessive strategies reflect commonly recognized forms of maladaptive behavior. They differ from symptom-based diagnoses in that strategies are seen as a functional attempt to reduce danger as represented, or misrepresented, by the individual. See Figure 3.

Representation as a mediating variable

Information processing yields numerous dispositional representations (DRs). In a simplified description of a complex and incompletely understood process, one could say that, at each level of transformation (of cognition and affect), a new representation is generated. Three levels of transformation, yielding six memory systems (Schacter & Tulving, 1994) can provide a working model of how behavior is disposed by representation. (See Figure 4).

The preconscious, non-verbal forms of cognition and affect are procedural and imaged memory, respectively. They operate from birth, rapidly and self-protectively. The slower, but fuller forms of cognition and affect are semantic memory and connotative language. Semantic memory is verbal and consists of generalizations regarding how things have been in the past and how they should be in the future. Connotative language both communicates feelings (or the absence of them) verbally and also elicits feelings in the listener. Although these representations can be integrated with information about the immediate temporal and spacial context in working memory, transforming integration is associated with two more complex memory systems. Various representations of cognition and affect can be knit together to yield occasion-specific episodes (either recalled or imagined) beginning at about three years of age. After about six years of age, reflective functioning can be used both to modify existing information and also to generate new information. Because this requires extensive cortical processing, it develops slowly across childhood and into early adulthood and takes longer to complete than preconscious processing. Consequently, integrative reflection is rarely used when danger is close in time or space.

Causation and representation

Recognizing that behavior results from the process of mental representation helps to explain why individuals exposed to similar dangers can have different outcomes and why genetically identical individuals exposed to different threats have different outcomes. The representational process, rather than genes or experience directly, organizes individuals' behavior. This suggests the need to differentiate between contributing, necessary, and sufficient conditions for psychopathology. There is little evidence that genes alone are sufficient to cause mental illness, nor is it evident that they are an essential condition. To the contrary, genetic influence more often functions as a contributing factor. Neither, however, does experience determine outcomes. Attachment theory, through its emphasis on individual representation of events, suggests a process by which similar circumstances could yield different outcomes.

Developmental pathways

The dynamic-maturational model of attachment theory addresses the process by which normal development differentiates into a wide range of human displays, including those considered psychopathological. A particular advantage of this perspective is that the most serious disorders of adolescence and adulthood, the personality disorders and psychoses, can be seen as the cumulative effect of a series of developmental transformations, each of which adds distortion to previously distorted functioning. That is, given numerous branching points in development, the cumulative effect of always selecting the distorted pathway leading away from balance and normality will be an array of serious disorders that, when viewed only in adulthood, appear incomprehensible. Following the behavior forward from infancy renders the accretion of distortion comprehensible, albeit, in a person-specific manner.

Development and changing risk

Maturation combined with experience enables children to develop new strategies that better represent the relation of self to context. Until adulthood, however, children cannot account adequately for all the information, past and present, that is available. Moreover, the context keeps changing as children mature, i.e., past challenges are not static. Consequently, each developmental step forward contains both the opportunity to correct past error and generate more adaptive behavior and also the risk that the new challenges of that age will pose insurmountable problems. In infancy, the problems are to (1) find contingencies of self with others, (2) share affective states with others (e.g., attunement), and (3) regulate arousal to maintain, for increasingly long periods of time, a state of moderate and attentive arousal. Failure to accomplish these with attachment figures leads to inhibition or exaggeration of affective displays (i.e., Types A or C strategies). If these don't function to change the probabilities on parental behavior, the infant may become non-strategic (i.e., depressed with low arousal, disoriented with high arousal, or disorganized with intrusions of high arousal in an inhibitory strategy). In infancy, these three states appear as (1) sad, withdrawn passivity, (2) aimless agitation without interpersonal focus and, sometimes, with self-stimulation (e.g., autistic spectrum symptoms), and (3) brief seizure-like losses of control at moments of intense stress from which there is quick recovery.

In the preschool years, the risks are that some children will fail to establish relations with non-familial adults and children and that those who choose a strategy of escalation of affect may harm themselves while trying to provoke a response from parents. That is, the extreme

Type C patterns carry more immediate and obvious risks than the Type A inhibitory strategies. In addition, preschool-aged children make the transition from action to language. The risk is that Type A children will learn that their true negative feelings cannot be communicated in words to parents, i.e., they are not “politically correct” from the parents’ perspective. Thus the children learn to use language to please the listener rather than to express the self. Type C children are more likely to learn that language can be used to deceive them, especially about future contingencies. The risk is that they will continue to use action to communicate.

During the school years, the cortex matures in ways that, for the first time, permit children to reflect on their own behavior. Children who are not helped to do this by their attachment figures will find it increasingly difficult to regulate their own behavior; this will affect both their inner experience of themselves and their outer experience of relationships with peers (in both best friend peer attachments and affiliative networks). Usually, this failure occurs when (1) the costs of failing to be good are so great that the child relies too heavily on adults’ perspectives or (2) the consequences so unpredictable that the child relies too heavily on his or her own perspective. The former satisfies adults (and goes unnoticed or even praised) whereas the latter upsets adults and results in punishment and referrals to mental health or correction services. To avoid the latter outcomes, some Type C children begin to use language to deceive others.

At puberty, the reproductive system becomes functional and the challenges are to (1) integrate sexual desire with the previously existing affects of both comfort and joy and also desire for comfort, anger, fear, and pain and (2) engage in an intimate heterosexual relationship that can become the foundation for selecting a life-long reproductive partner. Failure to integrate the onset of sexuality with attachment can lead to isolation, promiscuity, or dangerous sexual entanglements. In addition, failure to integrate different sources of information will interfere with the adolescent’s ability to differentiate appearance from reality. In such cases, the adolescent will be unprepared to select a partner wisely in early adulthood.

Cortical maturation is complete somewhere in the early 30's. Consequently, the transition to adulthood presents unique risks. For those adolescents who have not learned to use reflective, integrative processes to guide their behavior, becoming responsible for their own livelihood, choosing a partner, and having children present very difficult challenges. Among the young adults using the compulsive A strategies, the risk is that they will fulfill these tasks to the satisfaction of others without themselves having input or finding satisfaction; depression, psychosomatic distress, and failure in family or work may lie ahead. In extreme cases when it is not possible to leave the family physically, psychotic breaks in which the forbidden negative affect and behavior are suddenly displayed in extreme form may reflect the battle between attachment figures’ perspectives and the inhibited perspective of the inner self. Among the obsessive C’s, the risks are a stuck form of struggle that itself obscures causality; in the common diagnostic terms, these are the eating and personality disorders. In both cases, decisions that will affect the self and one’s partner and children for decades are being made. The costs of uncorrected and severely distorted DRs can be very great and enduring.

Assessment

Attachment researchers have developed a series of age-specific assessments to permit researchers and clinicians to assess individuals' representations and behavior. All differentiate Types A, B, and C (including subclassifications) and the discourse-based assessments also permit evaluation of integrative capacity. The *CARE-Index* (Crittenden, 1981, 1988, 2005) can be used from birth to 3 years, the *Ainsworth Strange Situation* (Ainsworth, Blehar, Waters, & Wall, 1979) from 11-15 months, the *Preschool Assessment of Attachment (PAA)* (Crittenden, 1992, 2004) from 18 months to five years. Each of these assesses child behavior in the context of the attachment figure, but relies on only those psychological and behavioral processes that are available to children of that age. Thus, integrative processes are not assessed by the tools. Instead, when substantial problems are identified on these assessments, the attachment figure(s) should be assessed for integrative capacity.

The discourse-based assessments include the *School-aged Assessment of Attachment (SAA)*, the *Adult Attachment Interview (AAI)* adapted for adolescents, and the *Adult Attachment Interview (AAI)* as originally devised for adults (George, Kaplan, & Main, 1986). The *AAI* has been modified to fit the DMM (Crittenden, 1999, 2004). These tools permit assignment of both a strategy and also the form of integration (i.e., integrated, reorganizing, disrupted by unresolved trauma or loss, disoriented, disorganized, and depressed).

Symptoms, strategy, and treatment

Current diagnostic procedures rely on symptoms clusters and tend not to address the etiology of the disorder, the context of its display, or its treatment. The approach offered here addresses functional formulation of the problem with both hypotheses about developmental pathways and also implications for treatment. In the DMM, symptoms are seen as actually serving a function or being thought preconsciously to serve a function which, in fact, they do not serve (i.e., superstitious behavior based on erroneous information). Underlying the symptoms (and change in symptoms) are the dispositional representations. Determining which DR regulates behavior, i.e., which constitutes the behavioral strategy, is crucial to identifying where to direct treatment (and thus selecting methods/tools).

Identifying the process by which layers of distortion are added, in a developmental sequence tied to brain maturation, has several advantages. Because it makes maladaptive behavior meaningful, it can help therapists to communicate with patients (Crittenden, in press). Further it suggests developmentally earlier points that might be open to intervention and prevention. Lastly, it suggests new approaches to treatment, particularly treatments that address the strategic function of the distorted process.

Psychological opposites

In the DMM of attachment, Types A and C are psychological opposites. The transformations that lead to the Type A strategy are based on a different characteristic of the incoming signal and are processed through different parts of the brain than are the transformations associated with Type C. Because they result from opposite processes, they are likely to be corrected by opposite forms of treatment. For example, a Type A individual might benefit from techniques that focused on feeling and somatic representation of feeling, whereas this treatment might increase somatic symptoms of distress in a Type C individual. Similarly, a Type C individual might benefit from a behavioral approach emphasizing self-relevant contingencies, whereas

this might expand the repertoire of compulsive behavior of a Type A person. If this were shown to be true, it implies that clustering patients by symptom-based diagnoses would usually lead to mixtures of individuals using different psychological and behavioral strategies. Treating all the members of mixed-strategy groups with the same technique(s) would be helpful to some and harmful to others. Most therapists know that they are unable to help some patients. But do they imagine that faulty diagnosis might result in harmful treatment?

Treatment goals and processes

Psychological treatment has variously focused on treating symptoms or deep structural change in personality. More recently attachment has fostered a focus on achieving secure (Type B) attachment. The DDM of attachment theory suggests a somewhat different approach that combines elements of the other approaches. From psychoanalytic theory, the DMM approach borrows the ideas of (1) deep change, in this case, change in how the individual processes information regarding safety versus danger and sexual opportunity, (2) the power of feelings to motivate behavior, (3) the notion that symptoms can serve different functions and that it is the function, and not the symptom, that requires attention, and (4) use of the patient-therapist relationship as a part of the treatment. Behavioral treatment has contributed awareness of the importance of (a) temporal order and (b) reinforcement schedules, especially as uncertainty of reinforcement affects organization of the Type C strategy. Indeed, the power of reinforcement schedules implicitly confirms (c) the importance of interpersonal processes for behavioral change. From family systems theory, the DMM borrows the ideas of (1) the familial context providing the primary occasion for employing and maintaining self-protective strategies, (2) family change being an important means of changing individuals' strategies, and (3) conscious recognition of preconscious procedural enactments during therapy sessions being crucial to change. Cognitive therapy contributes its focus on (a) procedural behavior and (b) semantic representations as well as the importance of (c) specifying and testing the effectiveness of psychotherapy.

The central treatment issue becomes enabling the individual to generate and apply self-protective strategies at the right time and in the right context. That is, the goal is psychological balance and not security. Psychological balance is possible for everyone whereas security is partially dependent upon external circumstances beyond the control of individuals. The focus on protection clarifies the importance of creating in treatment an environment of safety in which new strategies can be learned without fear or threat. As opposed to symptom reduction, a DMM approach presumes that the patient's existing strategy is useful in some context and needs to be (1) repaired (if it is in a depressed, disoriented, or disorganized form), (2) freed of erroneous, distorted, and false information, and (3) applied with greater specificity. The combination of using existing strategies appropriately and developing a wider repertoire of strategies for other occasions should go a long way to making the individual's behavior adaptive in the present. Managing future challenges, however, means that the patient must learn to use reflective integration before the therapy can be considered complete and stable.

The process by which this is accomplished implies that the therapists function as a transitional attachment figures for patients, both accompanying them and sometimes guiding them from patients' reality of threat to therapists' understanding of the possibility of safety

and comfort. In this context of relationship, the therapy is co-created. That is, therapies cannot be boxed, copyrighted, or manualized before the patient is seen. Crucial in this process is that patients must influence the contingencies in their lives or they cannot feel safe. For children, this implies that the parents must be included in the therapeutic process.

Identifying the patient

As soon as one applies attachment and systemic thinking to psychological disorders, it becomes clear that disorder is not solely an *intra*-personal process. Instead, its roots are always *inter*-personal, as is its display. The issue then becomes identifying the proper focus of treatment. For children who cannot communicate verbally, the focus should always be the parent(s), with or without the child. Whether the focus should be counseling, parent education, parenting intervention, or psychotherapy for the adult(s) is the more important question. The attachment assessments for adults can be helpful. If the parent is relatively balanced and able to integrate (i.e., A1-2, B, and C1-2), counseling might be a good way to enable them to use more effectively skills and information that they already have. Lack of information in the context of satisfactory integrative competence might suggest parent education. Substantial distortion of information and relatively little integration, in the context of few (if any) traumas, point to parenting intervention of a dyad-specific sort. This can be managed in group contexts, but each dyad must be treated uniquely because each parent distorts information differently and the parents lack the integrative skills to select for themselves that which is appropriate. If the parent, however, uses a relatively extreme Type A or C strategy (i.e., 3-4 or higher) and they also display in their daily lives the effects of past exposure to danger (i.e., psychological trauma), it is likely that individual psychotherapy (or marital therapy) should precede or co-occur with parenting work. The attachment assessments can be helpful in making these distinctions.

Validity and directions for further research

Published studies of infants and preschool-aged children suggest the validity of attachment theory and its relation to risk for psychiatric disorder. Unfortunately, there is little published work using this model with adolescents and adults. There are, however, a number of unpublished dissertations that are consistent with this thinking. Together, these suggest that the attachment strategies and distortions of information processing are associated differentially with several types of psychiatric disorder. In addition, these studies suggest that disorders with different symptoms may sometimes be functionally similar at the levels of distorting transformations and functional self-protective strategy. If this is the case, treatment might be improved by clustering patients on the basis of these similarities rather than symptom-based diagnoses. Certainly, continuing the process of exploring the relation between DSM or ICD diagnoses and the DMM classifications is valuable.

More important, however, might be exploration of the relation between treatment technique, patient attachment strategy, and treatment outcome (success, no effect, and harm). A series of doctoral dissertations could easily define the relation between particular treatment strategies and changes in mental processing of information. Having this information would be a boon the field of psychopathology at large, regardless of what diagnostic model was used.

Conclusions

The dynamic-maturational model of attachment theory focuses on protection and

reproduction as central organizing functions and on the array of ways that these may be realized. Representation is understood as being an intra-personal process derived from the inter-personal context, especially with attachment figures who fulfill the functions of protection and reproduction. Behavioral strategies, on the other hand, are always interpersonal and should be described as something a person does and not as a characteristic of the person, i.e., an individual *using* a Type C strategy as opposed to a Type C person. Both representation and strategic action are treated in attachment theory as being the interactive outcome of universal maturational processes, individual genetic differences, and unique environmental contexts.

Attachment theory's contributions to understanding psychopathology include (a) a model of functional formulations (as opposed to symptom-based diagnoses), (b) development-based hypotheses regarding the relation of childhood experiences to later psychopathology, and (c) an information processing model with implications for treatment. Its contributions to treatment are to (1) suggest that patients can be grouped in new ways that might both facilitate treatment and also reduce harm to patients from misapplied psychotherapy and (2) provide a rationale for assessing the specific effects of treatment strategies on information processing. If patients were grouped in terms of their pattern of transforming information and then treatment techniques were chosen on the basis of how they effect information processing, we might improve the effectiveness of psychotherapy and shorten its duration. Doing so would require, however, that therapists become skilled in all methods of delivering treatment and that they be able to function as transitional attachment figures - who both establish personal relationships with patients and also limit those relationships to the context of therapy.

Determining the relations between psychotherapeutic techniques and information processing and between techniques and different function formulation clusters need not be difficult to accomplish; it requires only systematic research into the process of psychotherapy. Indeed, they could form the basis of a series of doctoral research studies. Encouraging therapists to gain skills outside of their current training might be more difficult as might enabling them to function as transitional attachment relationships with patients. The hope of becoming more effective with patients might be sufficient, however, to encourage psychotherapists to add to their repertoire of strategies - which is precisely what the dynamic-maturational model of attachment theory indicates that patients should do to improve their effectiveness in dealing with life's problems. Bridging the barriers between different approaches to psychotherapy seems almost analogous to psychological integration. Possibly this is the time to embark on a process of integrating the schools of psychotherapy in the hopes of improving the success rate of psychotherapy, reducing the long-term cost of treatment, and increasing the quality of life of endangered, endangering, and vulnerable humans.

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