“It’s about broken hearts, not broken brains”: The possibility of personality reconstruction through focus on universal mechanisms of attachment and relating

Ken Critchfield, Ph.D.
Goals

- Illustrate how transformation of self in psychotherapy can occur through addressing internalized attachment relationships, the same ones in which an individual’s values, ideologies, and identities are often first formed.

- Show that deep and lasting change is possible even among “severe,” “non-responder,” “personality disordered” patients since their “stuckness” is a function of normative attachment processes.
The Interpersonal Tradition

• Harry Stack Sullivan
  – Interaction and relatedness as fundamental; Introjection

• Object-Relations Psychoanalysis
  – esp. Fairbairn, Winnicott

• John Bowlby
  – Attachment Theory; impacts of loss; internal working models

• Harry Harlow
  – Importance of attachment demonstrated in primates
  – Relatedness as evolutionarily adaptive “a lone monkey is a dead monkey”

• Timothy Leary
  – Interpersonal circumplex measurement model
  – Based in part on Henry Murray’s list of needs
A circumplex is a specific psychometric structure involving a ‘circulant matrix’ of associations, which has the specific geometric arrangement shown here in an idealized form; articulated by Guttman (1954).
Freedman, Leary, Ossorio, & Coffey, 1951
Behavioral focus

Control

Affiliation

Dominate

Teach

Give

Support

Love

Cooperate

Admire

Trust

Submit

Condemn Self

Distrust

Complain

Punish

Reject

Boast

Freedman, Leary, Ossorio, & Coffey, 1951
Behavioral focus

Control

Affiliation

Dominate

Teach

Give

Support

Love

Cooperate

Admire

Trust

Submit

Condemn Self

Distrust

Complain

Punish

Reject

Boast
Leary, 1957
Trait focus

Managerial
(Autocratic)

Competitive
(Narcissistic)

Responsible
(Hypernormal)

Aggressive
(Sadistic)

Cooperative
(Overconventional)

Rebellious
(Distrustful)

Docile
(Independent)

Self-Effacing
(Masochistic)

Affiliation

Control

Leary, 1957
Trait focus
An Alternative from Parent/Child Research

Schaefer, 1959; 1965
Parental Behavior
(Similar to Parker’s Parental Bonding Inventory)
Two “opposites” of Control Integrated in SASB

Schaefer

Free

Control

SASB

Free

“Be yourself”

Control

Separate

“Do as I say”

Submit

“I give in”

Leary/IPC

Submit

Control

Transitive:
Focus on other

Intransitive:
Focus on self

“I beg all those who love me to love my solitude too” - Rilke
High level of specificity in full model (Benjamin, 1979)
In addition to the dimensions “Focus” is introduced

<table>
<thead>
<tr>
<th>Focus on Other</th>
<th>Focus on Self</th>
<th>Introject</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior to, for, or about another person</td>
<td>Behavior to, for, or about the self in relation to another</td>
<td>Behavior directed at the self by the self</td>
</tr>
</tbody>
</table>
SASB Quadrant Model (Benjamin, 1979)

**Surface 1:** Focus on Other

Invoke Hostile Autonomy

Encourage Friendly Autonomy

Take Hostile Autonomy

Enjoy Friendly Autonomy

Hostile Power

Friendly Influence

**Surface 2:** Focus on Self

Take Hostile Autonomy

Enjoy Friendly Autonomy

Hostile Comply

Friendly Accept

**Surface 3:** Introject

Reject Self

Accept, Enjoy Self

Oppress Self

Manage, Cultivate Self
SASB Cluster Model
(1987 [numeric] and 1993 [one-word labels] versions combined)
Behavioral evidence of internalization

Copy processes

- **Identification**: be like the early attachment figure
- **Recapitulation**: act like the figure is still present & in charge
- **Introjection**: treat myself as I was treated

• Note: “**Opposites**” also exist, and can be precisely defined.
Example using Intrex questionnaire [Case 320]

Copy process example from clinic: Abusive early figure mirrors auditory hallucination on questionnaire ratings
IDENTIFICATION WITH FATHER [case 308]
Significant similarity identified for Rater behavior in current relationship at WORST and Father’s behavior to rater in childhood

A. Raw pattern data: Rater focuses on Sig. Oth., Father focused on Rater:

B. Raw pattern data: Rater reacts to Sig. Oth., Father reacted to Rater:

A. Best fit pattern descriptors:
Rater Acts: “Attacking” (r=.82) [attack=.82; control=-.46; conflict=.19] Father Acted: “Attacking” (r=.82) [attack=.82; control=-.56; conflict=-.09]
Similarity: Strong Similarity (r=.92)

B. Best fit pattern descriptors:
Rater Reacts: “Walling Off” (r=.87) [attack=.58; control=-.87; conflict=-.39] Father Reacted: “Walling Off” (r=.86) [attack=.60; control=-.86; conflict=-.42]
Similarity: Strong Similarity (r=1.0)

A. Description of central tendency for Significant Other focuses, rater reacts:
Rater Acts: Attack (-166º) [affiliation=-144; autonomy=-37] Father Acted: Attack (-175º) [affiliation=-126; autonomy=-11]

B. Description of central tendency for Rater focuses, Significant Other reacts:
Rater Reacts: Wall Off (132º) [affiliation=-127; autonomy=143] Father Reacted: Wall Off (134º) [affiliation=-140; autonomy=145]
Internalized Representations of Early Interpersonal Experience and Adult Relationships: A Test of Copy Process Theory in Clinical and Non–Clinical Settings

Kenneth L. Critchfield and Lorna Smith Benjamin

Studies connecting childhood experience and adult psychopathology often focus on consequences of abuse and neglect. Copy process theory (Benjamin, 2003) states that constructive as well as destructive experiences shape adult behavior with surprising interpersonal specificity. Childhood perceptions and social learning are encoded in memory and then “copied” in 3 basic ways in subsequent relationships: Identification (behaving as he or she behaved), Recapitulation (behaving as one behaved when with him or her), and Introjection (treating oneself as he or she was treated). The first step in evaluating copy process theory is to verify that the predicted correspondence between adult relational patterns and internal representa-
Assessment of Repeated Relational Patterns for Individual Cases Using the SASB-Based Intrex Questionnaire

KENNETH L. CRITCHFIELD\textsuperscript{1,2} AND LORNA SMITH BENJAMIN\textsuperscript{1,2}

\textsuperscript{1}University Neuropsychiatric Institute, University of Utah  
\textsuperscript{2}Department of Psychology, University of Utah

Repeated interpersonal patterns are central to case conceptualization and treatment planning in interpersonal and attachment-based approaches to therapy. In this study, raters (133 college students, 165 inpatients) provided data on the Intrex questionnaire (Benjamin, 2000) about self-treatment, relationship with a significant other, and remembered interactions with parents in childhood. Within-subject profiles were inspected for precise behavioral matches conforming to 3 “copy process” (CP) patterns: identification (behaving like an important other), recapitulation (behaving as if the other person is still present and in charge), and introjection (treating the self the way another did). We observed CP evidence in most individual ratings. Consistent with expectation, nonclinical raters tended to copy a securely attached pattern of affiliation, low hostility, and moderate degrees of enmeshment and differentiation. Only patients copied maladaptive behavior at greater than base rate expectation. We discuss implications and provide recommendations for use of Intrex in individual assessment of CP.
RELIABILITY, SENSITIVITY, AND SPECIFICITY OF CASE FORMULATIONS FOR COMORBID PROFILES IN INTERPERSONAL RECONSTRUCTIVE THERAPY: ADDRESSING MECHANISMS OF PSYCHOPATHOLOGY

Kenneth L. Critchfield, PhD, Lorna Smith Benjamin, PhD, and Kathleen Levenick, MD

Interpersonal Reconstructive Therapy (IRT) case formulations describe psychosocial mechanisms of affective and personality pathology in ways that enhance the effectiveness of psychotherapy for individuals. With a valid and reliable IRT case formulation, a clinician is in a better position to draw upon effective techniques to maximize treatment effects. The case formulation and treatment models for IRT were described in depth along with the IRT treatment model by Benjamin (2003/2006). Data in this report from 93 adult inpatients with complex and comorbid presentations suggest that the case formulation is highly reliable and unique to individuals, and that symptoms reflect current interpersonal stresses linked to early interactions involving forms of hostility in relation with attachment figures and corresponding to three basic patterns in adulthood: identification (be like him or her), recapitulation (act as you did with him or her), and introversion (try to self-manage your introversion).
Copy process research

- CPs occurs very frequently in both normal and clinical samples, and involve all measured behaviors. Degree and type of copying may be moderated by gender, gender of attachment figure, patient status (Critchfield & Benjamin, 2008, 2010; Woehrle, 2012).

- Copying of maladaptive patterns (hostility, extreme enmeshment or differentiation) is especially linked to patient status (Critchfield & Benjamin, 2010; 2015) and maps on to definitions of disordered personality. The patterns themselves (copied or not) have been associated with a wide variety of problems involving anger, anxiety, depression, relational problems, physical/heart health and so on.

- Interestingly: “Normals” in our research sample show reduced odds of copying maladaptive patterns, even when they are present in the history, suggesting resilience and internalization of a healthy, secure base of attachment to characterize and guide functioning of “the self-in-relation”.
Copy Process (one form: Identification)
IRT

- Interpersonal Reconstructive Therapy, Benjamin (2003/2006)
- Symptoms reflect attempts to adapt using problematic rules/values learned with caregivers (Critchfield & Benjamin, 2008; 2010).
- Maladaptive patterns resist change because they maintain proximity and attachment to internalized loved ones.
- Love, protection, and approval are sought by copying the old ways. Psychopathology is thus "attachment gone awry." The attempts to finally "make it" with caregivers are "gifts of love" (GOL).
- Principles-based treatment: Techniques can come from any school or orientation so long as they are consistent with the case formulation and move close to therapy goals.
Maladaptive interpersonal patterns, views of self and others

Goal “in the world”: Develop adaptive ways, views, patterns (friendly, flexible, contextually-appropriate relating with self and others).

Goal “in the head”: Differentiation from rules, values, ways of problematic internalizations so that freedom to choose healthy adaptation is no longer blocked or compromised.
Defining therapy goals behaviorally

The base rate of normative (i.e., healthy, securely attached) relating

Data from Intrex manual (Benjamin, 2000), long form norms
symptoms and problems

(often reflect or derive from)
problematic relational patterns with self and others

(when copied, these patterns suggest internalization of)
specific, key attachment figures

(GOL hypothesis is that patterns are maintained by)
wishes for psychic proximity, love and acceptance from internalized representations

(general treatment implications)

enhance awareness of patterns; differentiate from internalizations sufficient to choose differently; block problem patterns; establish new, adaptive ways to be, feel, and think about self and others in the present

from Critchfield, Panizo, & Benjamin (2018)
Sample case [Jenn]: DSM-IV summary

Axis I: Bipolar II
   PTSD

Axis II: Paranoid, Schizotypal, Borderline

Axis III: Fibromyalgia, MS, Osteoporosis, Hx of DVT, hypothyroidism, migraines.

suicide attempts: 1
   (initially disputed this was an attempt, but endorses long-standing suicidal ideation with specific plans, panic attacks - numerous additional attempts were revealed in course of treatment)

hospitalizations: 3

GAF on admit: 20
Sample case [Jenn]: psychosocial learning history

- Abused horribly (physically, sexually, secretly and backed up by threats if she told or sought help) by brothers for many years in childhood.
- Father mocked and humiliated any sign of weakness in all the children, endorsed sexual abuse of patient (in a different context than with brothers).
- Mother withdrew love and attention “to protect” the patient from angry jealousy of the brothers (implies she knew at least some of what was happening).
- She reports learning to “be strong” “hold it in” “not show weakness” as the only ways to be accepted by her family. She also believes it “protected mother’s feelings” and the family from intervention by social services.
- Adjusted by devoting her life to serving others and keeping focus away from herself, becoming very successful as an entrepreneur in a caregiving field.
- Symptoms escalated dramatically when, in her 50s, her parents died and brothers fought over the estate, effectively pushing the patient out of the process, maligned her character to other family members.
- After loss of her parents, she told her husband of 12 yrs she may need help from him as she gets older and has to deal with MS, a big shift from her way of being prior to this. In response he left a note on the counter saying he was leaving her.
Sample case [Jenn]: Current impact of learning history

- Current self-concept: believes she deserves, and should expect, horrible abuse, loss, humiliation, and abandonment no matter her efforts.
- **Believes she is “strong and good”** when she “holds” and doesn’t show signs of weakness. Presents as calm and controlled in sessions despite severe anxiety, depression, dissociation and more. Thus, past suicide attempts were experienced by care providers as coming “out of the blue.”
- Equates functionality with being exploited and humiliated. Expressing feelings in therapy is seen as a betrayal of her family. Father’s voice mocked her as she drove home after sessions. Expects to be humiliated by her therapist, exploited by research procedures.
- Conscious experience of suicidality is desire to be close to mother in the afterlife, where maybe now she might safely receive love from her. Mother’s voice says come away from suffering and stress. She wants apparent accident, or medical problem to produce death so her daughter can benefit from the insurance money.
IRT Clinic: Our patients

- Referred for repeat hospitalizations, failure to respond to previous treatments, suspected “Axis II involvement”

- Clinic research data suggest “CORDS” acronym
  - Comorbidity: 2.2 Axis I disorders; 1.8 Axis II
  - Often Rehospitalized: 4 lifetime hospitalizations on average
  - Dysfunctional: GAF = 24; 2 sd over norms for depression, anxiety
  - Suicidal: 2.2 lifetime attempts; 90% hospitalized for suicidal ideation or an attempt when referred
The Five Steps


2. Learning about patterns, where from, and what for.


4. Enabling the will to change.

5. Learning new patterns.

Self-discovery

- Tell the stories and be heard. Discover.
- Reexperience feelings safely.
- See it differently and react differently.
- Befriend, value self.
- Grieve for the losses.
- Unmask and give up old loyalties, rules, fantasies.
- Accept what was and is. Move forward.
- Make mindful and benevolent choices.

Self-management

- Engage Growth Collaborator.
- Be honest about thoughts, acts, and feelings.
- Change self-talk and behavior.
- Invoke new internal models.
- Construct new goals, ways that feel right.
- Allow compassion for, and tolerance of, self.
- Seek and practice new, constructive patterns.
- Resist the wish to go back to old ways.

from Benjamin (2003/2006)
 Collaborate

Learn about patterns

Block maladaptive patterns

Learn new patterns

Dare to change & Let go of old wishes

GC  "Green"

RL  "Red"

Cling to old wishes

IRT View of Interventions and Change

Important People and their Internalized Representations (IPIRs). i.e., “family in the head”

- Learning
- Loyalty
- Love

Depth of attachment mechanism invoked

<table>
<thead>
<tr>
<th>Maladaptive Messages / Input: Red Self</th>
<th>Adaptive Messages / Input: Green Self</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Problem Patterns”</td>
<td>“Healthy Patterns”</td>
</tr>
<tr>
<td>“Regressive Loyalist”</td>
<td>“Growth Collaborator”</td>
</tr>
<tr>
<td>“Yearning Self”</td>
<td>“Birthright Self”</td>
</tr>
</tbody>
</table>
IRT: research challenges

• Operationalizing the case formulation method

• Operationalizing adherence/fidelity

• Application with patient population referred for severity, complexity, and lack of change

• Theory and setting require something other than an RCT approach
Adherence (Fidelity) in IRT

**Optimal** interventions use the following **principles**
(formally rated on scale -10 to +10 for whole session)

- **Core algorithm (Th only)**
  - Accurate empathy
  - Support ‘green’ over ‘red’
  - Use of case formulation
  - Elicit interpersonal detail
  - Track affect, behavior, cognition

- **Five Steps (Th & Pt)**
  - Collaboration in service of Green
  - Learning about patterns
  - Blocking maladaptive patterns
  - Enabling will to change
  - Learning new patterns
Reliability of session-level adherence measure (before and after revision of coding manual)

Tabled values are ICC[1,2]

Adherence Ratings range from -10 to +10

+10 defines “optimal” given overall context (i.e., not frequency-based)

<table>
<thead>
<tr>
<th>Adherence component (alpha in parentheses)</th>
<th>Before (n = 17)</th>
<th>After (n = 20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Algorithm (.98)</td>
<td>.66</td>
<td>.92*</td>
</tr>
<tr>
<td>Empathy</td>
<td>.87</td>
<td>.88</td>
</tr>
<tr>
<td>Supports Green more than Red</td>
<td>.70</td>
<td>.86</td>
</tr>
<tr>
<td>Use of the CF</td>
<td>.70</td>
<td>.86</td>
</tr>
<tr>
<td>Elicits interpersonal detail</td>
<td>.35</td>
<td>.86*</td>
</tr>
<tr>
<td>Elicits info on Affect, Behavior, Cognition</td>
<td>.10</td>
<td>.92*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Five Steps of IRT</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Collaboration (.97)</td>
<td>.83</td>
<td>.82</td>
</tr>
<tr>
<td>Therapist</td>
<td>.80</td>
<td>.87</td>
</tr>
<tr>
<td>Patient</td>
<td>.78</td>
<td>.71</td>
</tr>
<tr>
<td>2. Learning about Patterns (.89)</td>
<td>.82</td>
<td>.87</td>
</tr>
<tr>
<td>Therapist</td>
<td>.79</td>
<td>.83</td>
</tr>
<tr>
<td>Patient</td>
<td>.83</td>
<td>.82</td>
</tr>
<tr>
<td>3. Blocking Maladaptive Patterns (.92)</td>
<td>.77</td>
<td>.90</td>
</tr>
<tr>
<td>Therapist</td>
<td>.75</td>
<td>.91*</td>
</tr>
<tr>
<td>Patient</td>
<td>.71</td>
<td>.78</td>
</tr>
<tr>
<td>4. Enabling the Will to Change (.92)</td>
<td>.91</td>
<td>.78</td>
</tr>
<tr>
<td>Therapist</td>
<td>.77</td>
<td>.79</td>
</tr>
<tr>
<td>Patient</td>
<td>.84</td>
<td>.69</td>
</tr>
<tr>
<td>5. Learning New Patterns (.89)</td>
<td>.25</td>
<td>.68*</td>
</tr>
<tr>
<td>Therapist</td>
<td>.53</td>
<td>.72</td>
</tr>
<tr>
<td>Patient</td>
<td>-.11</td>
<td>.55*</td>
</tr>
</tbody>
</table>

| Patient use of 5 steps (.98)                | .69            | .89            |
| Therapist use of 5 steps (.98)              | .78            | .80            |
| Therapist total (.99)                       | .77            | .92            |
| Total Session Adherence (.99)               | .81            | .91            |

Context rating:
Gift of Love Awareness & Choice scale .51 .88*
High Adherence Example

- Case formulation (among other things) includes: blaming herself, taking responsibility for chaotic and violent men.
- A copy process which replicates history with violent, adopted older brother. Mother supported brother. Patient’s assignment to was to “be the peacemaker” and manage him. Punished severely when she failed.
Session transcript

T: How are you?
P: Not good, had a long day..(Pushes hair aside and looks at floor.)..today. So.
T: So, tell me about it.
P: Well, I just, I had to work at 5 this morning, so got up at 4 (T: Ouch!), and I hadn’t slept in 2 nights (T: Mm), not on purpose, just I can’t get control of it. So anyway, so I went to work until 10 and I left work, and then tried to go to bed but I can’t sleep. But I didn’t want to get out of bed because I would do something stupid. (Smiles, looks down and laughs) So I stayed in bed. So that’s my day. (big head nod and looks down) Not a good day.
T: Do you know what got it kicked off? What was happening?
P: I don’t know (upset starting to cry) I’m trying to think of things. (grabs a tissue)
T: Maybe I’m not on the same page as you right now, as to where you’re at.
P: I don’t know. (wipes tears)
T: You said you didn’t want to get out of bed or you would do something stupid?
P: Um-Hum. ( makes eye  contact)
T: What was the something stupid?
P: Cutting. (short pause)
T: You wanted to cut yourself?
P: Um-hum. (looks at floor)
T: But you stayed in bed, and you didn’t.
P: Mm mm. But I didn’t sleep either, I wish I could do that.
T: What happens when you try?
P: Just, my thoughts are racing, I can’t sleep.
T: Ok, your thoughts are racing. You catch any of them as they went by?
P: Um. I don’t know. I just, got really angry. I was on my dinner break at work and I went over to Wal-Mart, and these two guys in a truck pulled up really close to me and they were like, making like obscene gestures with like their tongues and their hands and stuff and asking me to, like, come in the truck; and I flipped open my phone, and I think they thought I was calling the cops cause then they drove off as soon as I flipped open my phone. … a lot of people in the Wal-Mart parking lot, why’d they pick me?

T: So you were feeling good about yourself before that?
P: Mm hmm (nods)
T: And it was okay to be pretty again?
P: Yeah. But right now it’s not. (sniffles) (pause)
T: And now when you try to sleep you’re angry.
P: mm hmm (nods)
T: So it feels like you’re a target?
P: (nods)
T: Makes sense to be panicked and anxious if you’re a target.
P: Yeah. (sigh, sniffle, long pause).
T: Can you help me understand how that turns to wanting to cut yourself?
Low Adherence Example

- Case formulation includes pronounced passivity, failure of self-care/reckless self-neglect, self-criticism, harsh/rigid interactions with his children; pattern of attempting to prevail, deferring, and then withdrawing (variously reflecting history with father, mother, brother).

- Session falls mainly in the neutral area of the adherence scale. Not a bad exchange in usual terms, but isn’t adherent to IRT principles.
Th: How are things going?
Pt: Ok. Looking forward to moving out.
Th: So you are still feeling that way?
Pt: Yea I have gone out and looked at some apartments.

Th: How did that go? How did you feel doing that?
Pt: Um . Just a little overwhelming kind of, kind of reminds me of looking for a job … A lot of them are already filled, or you know, fill out this application and leave it with us and we will call you if, you know, we’re interested, so, um, I have an appointment to go look at a couple more tonight.
Th: Ok. That sounds good. So as you were doing it you were feeling like it was kind of overwhelming?
Pt: Um, I, I just, It just reminds me of looking for a job, and I hate that…and, you know it doesn’t bother me to uh, to buy a home, because the money is going to buy my home. But it just kinda bothers me that, you know, my money's just going into somebody’s else’s pocket.
Th: mhm. You like thinking of it as investing in something.
Pt: Um, I've got you know, heck I’d rather buy a fourplex or a duplex and rent out the other three units, or two units,and you know... I’d probably make enough to make the payment and you know just live there for free.

Th: Well it sounds like some good plans. I mean, I like the way you are thinking because even though you’re feeling like, um, it might not be the best and wisest use of the money that you’re kind of still looking down the road to maybe what you might do differently in the future. Which is good.
Pt: And she'll (wife), she'll just keep saying, uh go to bed, you guys, just go to bed … See if I, if I come upstairs to help her or enforce her, then I’m the bad guy, and if I don’t come upstairs then I’m the bad guy because I don’t help her or enforce it.

Th: Yeah, well we’ve already seen that you don’t, you don’t win with her no matter what. And its, its kind of like with your Dad where you try to stand up for yourself, and that wasn’t even the right thing to do because you didn’t do it good enough. So when you try to step in and lend a hand with her the same thing happens.

Pt: Exactly.

Th: Um, so, uh, when you guys decide how custody is going to be split up and you know if they’re coming to your house a certain time and hers … Because like you said if they are expected to go to school but only when they are at your house, then you’re going to have some difficulty yourself taking on that um, responsibility and being able to have that power that you want.

Pt: I know because that, they'll behave exactly as I expect them to be at my house, and they'll behave the way she expects them to be at her house. … I just really don’t, I’m not hopeful at all about anything changing at home.

Th: Mhm. Well, if, you if we talked about before if it changes at your place, and you have that influence on them … I would think that, if you have this place that you create that’s more peaceful that has more structure for them, that has good boundaries and guidelines for them to follow. …It might take a little time but eventually they are going to see the chaos is not really what they like.

Pt: Mhm.

Th: You know? And even though you think ‘I don’t see anything changing at home with her the way she is’, what, what would she do if they started changing based on the rules and guidelines that you’re putting into place, and you know her seeing that might make her come around a little bit to wanting to do things differently.

Pt: Yeah.
What others do; how they treat me

my actions or responses

Impact on my self-concept, identity, values, goals, or how I treat myself

Strong feeling/s paired with this pattern: ____________________________________________

Does the pattern parallel other important relationships or events in my life?
__________________________________________________________________________

Awareness of ‘how it works’ can sometimes open up the possibility of change through identifying and practicing new responses with self or others (e.g., compassion, kindness, assertion, distance, self-care).

Desired, healthy choice/s going forward: ____________________________________________
______________________________________________________________________________
______________________________________________________________________________
IRT adherence links to outcome

- Global therapist adherence (i.e., rater impression of whole session) is linked in small *n* analyses to:
  - retention in treatment
  - fewer re-hospitalizations
  - symptom reduction (depression, personality disorder)
  - Subsequent patient adherence
  - Adherence elements: Use of the case formulation & Enabling will to change are especially predictive even controlling for empathy and time in treatment. (Karpiak, Critchfield, & Benjamin, 2011)
GOL change in adherent IRT: Therapy course for Case 318
Miriam: good outcome

Treatment reached bilateral termination (sessions = 127)

Th adherence: 8.8
Pt adherence: 7.4
Total adherence: 8.3

“I made a decision I should probably tell you about. I decided it’s time for me to stop being angry with my mother. … I think she did the best she could; she just didn’t do a good job. And that’s not her fault, it’s just, that’s the best she could do. So I need to be more understanding I think. I made that decision and I’m going to work on it. It’s going to take a while … I’ve always blamed her for [abuser], I expected more protection and felt she went out of her way to protect him all of the time … It left me confused. All of us were.”

GOL Awareness/Choice:
4 = Maintenance
3 = Action
2 = Contemplation
1 = Pre-contemplation
0 = Unaware
GOL as a key mechanism governing process of change with “stuck” cases

<table>
<thead>
<tr>
<th>Self-treatment (at best) early in treatment</th>
<th>Miriam with mother in childhood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-treatment (at best) near end of treatment</td>
<td>Miriam with mother &quot;in the head&quot; late in therapy</td>
</tr>
</tbody>
</table>

![Graphs showing self-control and self-emancipation with different emotional states and stages of treatment.](image-url)
Jean: adherence to IRT helps make decision to let go of old patterns

Sessions 1-97:
Th1 adherence: 2.8
Pt1 adherence: 2.6
Total1 adherence: 2.7

Sessions 98 – 170:
Th2 adherence: 7.4
Pt2 adherence: 4.6
Total2 adherence: 6.5

Sessions 171 – (ongoing):
Th3 adherence: 7.9
Pt3 adherence: 7.7
Total3 adherence: 7.8
Jenn: stalled progress related to un-readiness to let go of old attachments

Sessions 1-62:
  Th adherence: 3.1

Sessions 63 – 155 (ongoing):
  Th adherence: 8.1

Describes her suicidality: “she was calling me” (i.e., mother, now deceased, who she wished would rescue her from the abuse). “I know that if I let this go I will feel better, be able to cope and have more peace. But it feels like if I do that, then they [abusers] win. It will just be like ‘whatever.’ I cannot allow that. I have to stay hypervigilant so that justice will be done.”
Unpacking adherence:

- Two contrasting sets of sessions were selected based on observer-rated levels of IRT adherence (high = 9 sessions; low = 10 sessions)
- Available data are 6 high adherence cases compared with 9 low adherence cases. Coding continues for the remaining 4 cases.
- Strategy: Aggregate and sequential analysis of moment-by-moment transcript codes.
- Session segments selected based on mention of key attachment figures in the CF
<table>
<thead>
<tr>
<th>Unit</th>
<th>Spk</th>
<th>A, B, C</th>
<th>P=1/C=2</th>
<th>X</th>
<th>Y</th>
<th>Cluster</th>
<th>Pt Red or</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>359</td>
<td>2A</td>
<td>1</td>
<td>1</td>
<td>21/24</td>
<td>7</td>
<td>R/G?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>B</td>
<td>1</td>
<td>21/24</td>
<td>14</td>
<td>R/G</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>C</td>
<td>1</td>
<td>2</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Th: yeah, I'm remembering

Pt: I get it, I know

Th: haha

Pt: I can, I can get her, I can just give me a chance, and God says go for it, she's good, she's strong, and she can do this and he said go for it and he started taking things away and giving me back my family.

Th: mm-hm

Pt: - - - and then I realized you, you know, you are as good as you think you are.

Th: mm

Pt: and then before IRT, you know, before - - - I started to - - not think of myself as worthy not think of myself as responsible and that's what changes it, it's not a concept - maybe I can make a better one. If I honestly and truly do not think that killing my mom in an earlier stage, if I don't think there is anything wrong with that. Did I and I did when I had my mom, she's past being cognitive and I take her out of her misery, and I do not think that it is anything wrong with that, have I committed a sin?

Th: I think you did what they asked.

Pt: have I committed a sin? Murder is a sin, it's a mortal sin.

Th: well, I don't know. It depends on what you believe.

Pt: ok

Th: I really do.

Pt: Since I know where you are coming from and I know where I am coming from I used to use this analogy.

Th: mm

Pt: I see absolutely nothing wrong with stealing something because it used to belong to me and now it belongs to you.
The two contrasting groups:

- **High IRT adherence (6 cases):**
  - Mean turns at talk (TAT): 682 (range: 468 - 1004)
  - Mean TATs selected for coding: 26% (range: 1 - 47%)
  - Mean TATs coded in relation to CF figures: 9% (range: 0 - 19%)
  - Mean session # chosen: 70 (range: 48 - 97)*
  - GOL stages of change: 3.2 (range: 2.25 – 4.25)* [action phase]

- **Low IRT adherence (9 cases):**
  - Mean turns at talk (TAT): 704 (range: 540 - 887)
  - Mean TATs selected for coding: 30% (range: 15 - 53%)
  - Mean TATs coded in relation to CF figures: 13% (range: 0 - 33%)
  - Mean session # chosen: 30 (range: 6 - 91)*
  - GOL stages of change: 0.6 (range: 0 - 0.9)* [unaware]
Therapists by adherence group
No process differences.
$r = 0.99$
Patients by adherence group
$r = 0.99$

One (subtle) process difference:
Low adherence Pts show more **Wall Off**
(Mann-Whitney U, $p < .05$)
Complementarity for even subtle levels of hostility

<table>
<thead>
<tr>
<th>Patient Hostility</th>
<th>Therapist Hostility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absent</td>
<td>Absent</td>
</tr>
<tr>
<td></td>
<td>9</td>
</tr>
</tbody>
</table>
|                  | Present             | 1  
| Present          | Absent              | 1  
|                  | Present             | 4  

Chi-Square = 7.35, p = .006
Significant **aggregate** differences (p's < .05)

<table>
<thead>
<tr>
<th></th>
<th>High Adherence (n = 6)</th>
<th>Low Adherence (n = 9)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Pt speaks in Red state</td>
<td>0.486</td>
<td>0.357</td>
</tr>
<tr>
<td>Pt speaks in Green state</td>
<td>0.716</td>
<td>0.316</td>
</tr>
<tr>
<td>Green Self-Concept described by Pt</td>
<td>0.110</td>
<td>0.092</td>
</tr>
<tr>
<td>Healthy differentiation from a key</td>
<td>0.036</td>
<td>0.042</td>
</tr>
<tr>
<td>attachment figure is focus of Pt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy differentiation from a key</td>
<td>0.029</td>
<td>0.040</td>
</tr>
<tr>
<td>attachment figure is focus of Th</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data shown are proportions (of transcripted ‘turns at talk’)
Significant **sequential** differences (p's < .05)

<table>
<thead>
<tr>
<th></th>
<th>High Adherence</th>
<th></th>
<th></th>
<th>Low Adherence</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>n</td>
<td>Mean</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td>Th Protect after Green self-concept is mentioned by Pt</td>
<td><strong>-0.165</strong></td>
<td>0.101</td>
<td>5</td>
<td>-0.060</td>
<td>0.056</td>
<td>8</td>
</tr>
<tr>
<td>Th Protect after enmeshment with key CF figure is mentioned by Pt</td>
<td><strong>-0.259</strong></td>
<td>0.009</td>
<td>2</td>
<td>-0.107</td>
<td>0.063</td>
<td>6</td>
</tr>
</tbody>
</table>

Interesting by absence is differential Th response to Pt Red or Green states by adherence group.

Data shown are phi coefficients (i.e., correlation computed for binary variables) Negative signs indicate Therapists show **reduced** rates of behavior in the specified context.
Summary of transcript analyses

• A work in progress; VERY preliminary findings
• We are attempting to operationalize and test a complex theory that uses underlying principles to make specific predictions about optimal intervention in context of:
  – An individual’s case formulation
  – specific moment in therapy
  – readiness for change with regard to attachment figures
Conclusions

- Beneficial transformation of self in psychotherapy can occur with “non-responder” patients. However, it may ultimately require coming to terms with internalized loved ones so that yearnings for love and acceptance can no longer determine an individual’s values, ideologies, and identities – in other words: with awareness, choice becomes possible.

- Part of our quest is to conduct empirical research that does justice to the complexity of theory and focuses on the proposed mechanisms and principles of change, to verify whether/when they matter (in contrast to a focus on application of specific sets of techniques).

- To the degree we are successful, the work also seeks to inform clinical training at the level of pairing moment-by-moment process with relational content, similar to the level of analysis engaged through role plays and tape review in many training settings.
Thank you to our sponsors, colleagues, collaborators, and assistants.

- IRT study therapists and patients; Lorna Smith Benjamin
- University of Utah Neuropsychiatric Institute Administration (Tom Woolf, Ross VanVranken)
- Kathleen Levenick, Matt Davis, Christie Karpiak, Ronna Dillinger, Heather Gunn, Justin Mackenzie, Emily Traupman, Sheryl Schindler, Julia Mackaronis, John Tobias, Justin Lukas, Jonathan Broadwell, Julie Black, Karen Stovall.
“It’s about broken hearts, not broken brains”:
The possibility of personality reconstruction through focus on universal mechanisms of attachment and relating

Ken Critchfield, Ph.D.
critchkl@jmu.edu