Using Theory & Clinical Observation to Generate Testable Hypotheses

A New Perspective on Personality Disorders

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I. THEORY

Dynamic-Maturational Model of Attachment & Adaptation
Central unique feature of the DMM

The organizing function of exposure to danger to:

- Regulate attention
- Organize the mind
- Organize behaviour
The DMM as a comprehensive theory of development & adaptation

<table>
<thead>
<tr>
<th>From Bowlby</th>
<th>DMM additions</th>
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<tbody>
<tr>
<td>- Psychoanalytic</td>
<td>- Epigenetics</td>
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<tr>
<td>- General systems theory</td>
<td>- Neurobiology</td>
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<td>- Evolutionary biology</td>
<td>- Temperament</td>
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<td>- Cognitive information processing</td>
<td>- Sociobiology</td>
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<td>- Cognitive neurosciences</td>
<td>- Developmental psychology</td>
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<td>- On-going integration of theories</td>
<td>- Behavioral learning theory</td>
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From Ainsworth

- Naturalistic observation
- The Strange Situation as a standardized assessment
- The ABC patterns of attachment
- Empirical grounding of attachment theory
- On-going expansion of the model

DMM additions

- Eriksonian development
- Social learning theory
- Theory of mind
- Cognitive psychology (Behavioral, Constructivist)
- Vygotsky - ZPD
- Transactional theory
- Family systems theory
- Vygotsky/Bronfenbrenner: Social ecology
DMM understanding of behavior as a complex interactive process
Two sources of information

- **COGNITION**
  - Temporal order → causal attributions
  - Learning theory & contingencies

- **AFFECT**
  - Intensity → arousal
  - Anger, fear, desire for comfort
  - Fight, flight, or freeze

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1 Genetic & epigenetic information constitute internal sources of information.
Cognitive information

- Inhibit that which leads predictably to punitive consequences (danger)
  - Doing what you want
  - Showing negative affect (anger, fear, desire for comfort)

- Exhibit that which leads predictably to desirable consequences (safety)
  - Doing what adults want
  - Showing positive affect
Affect

- Arousal, i.e., changed body state (feelings), motivates action
  - Comfort → continuing activity
  - Anger → approach with aggression
  - Fear → escape
  - Desire for comfort → affectionate approach
  - Tiredness → no action
  - Sadness → no action
Intensity, Arousal, & Affect

- Death
- Mania & Pain
- Fear
- Anger
- Desire for comfort
- Alert & comfortable
- Bored
- Tired
- Sleep
- Depressed
- Unconscious
- Death
Intensity, Arousal, & Affect: Normative

- Anger
- Desire for comfort
- Alert & comfortable
- Bored
- Tired
Intensity, Arousal, & Affect: Severe Pathology

- Mania & Pain
- Fear
- Sleep
- Depressed
- Unconscious
Two Basic DMM Self-protective Strategies

- **Type A**: Very COGNITIVE; little affect

- **Type C**: Little cognition; intense AFFECT
DMM Strategies in Adulthood

Integrated True Information

True Cognition

Distorted Cognition & Omitted Negative Affect

False Positive Affect

Denied Negative Affect

Delusional Cognition

Integrated Transformed Information

True Negative Affect

Distorted Negative Affect & Omitted Cognition

False Cognition

Denied True Cognition

Delusional Affect

AC Psychopathy

Psychopathy
Types A & C are psychological opposites

- Type A: Reduce limbic arousal, increase repetition of sensorimotor sequences
- Type C: Increase limbic arousal, create unpredicted consequences
Strathearn, et al.

DMM-AAI & fMRI data


Mothers’ brain responses to own vs. unknown baby: Prefrontal cortex

**Type B**

- COR
- $q(FDR) < 0.050$
- $t(1130)$
- $p < 0.001149$

**Type A**

- COR
- $q(FDR) < 0.150$
- $t(1122)$
- $p < 0.001982$
Maternal Brain Response to Own Baby’s Crying Face

![Chart showing brain activity response to Secure and Dismissing conditions for various brain regions such as R Nuc Acc, L Lingual Gyrus, L Inf Frontal Gyrus, R Insula, R Middle Frontal Gyrus, and L Postcentral Gyrus. The y-axis represents % BOLD signal change, and the x-axis shows different brain regions. The chart indicates that Secure conditions have a higher BOLD signal change compared to Dismissing conditions for most of the regions.](image-url)
Types A & C behave differently when faced with danger

- Type A:
  - Inhibits feelings
  - Does what others want
  - Blames self
  - Feels shame
  - Sometimes explodes with anger or fear
  - Has no explanation for explosive behaviour

- Type C:
  - Exaggerates anger and fear
  - Behaves vengefully and deceptively
  - Blames others
  - Considers the self innocent
  - Offers elaborate false reasoning
II. Clinical Observation

From uncertainty to irrationality
**Type C**¹

- **Eliciting conditions**: Unpredictable, intermittent positive reinforcement of negative affect

- **Cognition**: Inability to predict effects

- **Affect**: High, alarming arousal

- **Strategy**: Intensify affective display to:
  - Attract attention
  - Elicit a response that can be shaped behaviourally

¹ The Type C strategy is too complex & variable to be fully articulated here.
C1-2: Threatening/Disarming

- **Condition:**
  - Little or no danger,
  - Lack of comfort,
  - Unpredictable attention.

- **Strategic behaviour:** Heightened signals of feelings to elicit response.

- **Unresolved problem:** set aside and go on, with repetition.

- **Outcome:** Problem is not put in words and resolved.
C3-4: Aggressive/Helpless

Condition:
- Over-solicitous parent who fails to perceive child’s need for limits and protection.
- Under-responsive parent who struggles over who will be the object of attention, i.e., the ‘child.’

Strategic behaviour:
- Provocative behaviour & risk-taking
- Pseudo-resolution through deception of the child.

Irresolvable problem that defines the relationship.

Outcome: child uses extreme behaviour to bring parent toward the norm.
C5-6: Punitive/Seductive

- **Condition:**
  - Feeling of being misunderstood;
  - Lack of predictive generalizations.

- **Strategic behaviour:**
  - Dangerous behaviour
  - Intense battle for recognition.
  - Dismissal of others’ perspectives/feelings.

- **Problem-solving:**
  - Self-deception
  - Deception of others
  - Avoidance of talk; non-verbal communication
  - Rationalizing use of language.
Depression in Type A (depressed)

- Affect: Low arousal, non-motivating affect
- Cognition: Low expectation that one’s behavior will have any effect (i.e., non-contingency between self & outcomes)
- Absence of strategic behavior of either an inhibitory or arousing sort.
Depression in Type C (agitated)

- Affect: Chronic high negative arousal, not tied to changes in circumstances

- Cognition: Low expectation that one’s behavior will have a predictable and desired effect (i.e., lack of predictability).

- Active withdrawal or aggressive behaviour in anticipation of frustration.
Unresolved trauma

- Commonly acknowledged to ‘cause’ an array of disorders.

- Evidence of trauma is sought by both patients and professionals to explain the symptomatic behaviour.

- Such evidence is generally lacking in the personality disorders (excluding borderline and anti-social personality disorder)
Three sets of AAI data

- Eating disorders (N=66)
- Avoidant personality disorder (N=18)
- Borderline personality disorder (N=15)
Adult Attachment Interview (AAI)

- 1 hour, semi-structured, about childhood relationships, particularly threat

- Discourse analysis (not content)

- Yield:
  - Strategy
  - Current psychological trauma
  - Overall states of mind like depression
DMM & Eating Disorders

1. Very short AAIs

2. Wordless, silent, lack of recall, ‘sorry’, very awkward for interviewer

3. No evidence of psychological trauma

4. Inexplicable behaviour/strategy

5. Mother’s AAI clarified the nature of the unspeakable problem.

DMM & Eating Disorders

1. Utr(i) C3-4(5-6) Δ

2. Utr(i) C5-6 & [A]/C5-6 Δ (most)

3. Utr(i) A3-4 Δ (fewest)

4. Wordless triangulation around family secrets

Family secrets

- Secrets
  - Parental discord (triangulation)
  - Parents’ psychological trauma
  - Parental sexual behaviour (adultery, paternity)

- Parent intention to protect child

- Effects in childhood
  - Unpredictable parent behaviour
  - Breaches in interaction.
Effect on adolescent/adult behaviour (EDs)

- Individuals had mixed feelings
  - Angry with parent
  - Desired attention/comfort from parent

- Could not express their feelings because the parent so needed silence and approval

- Felt guilty for feelings

- Sought both a reason (trauma) and predictability
Avoidant Personality Disorder: [A] C5-6 \( \Delta \)


# Mothers with BPD

<table>
<thead>
<tr>
<th>M&amp;G</th>
<th>DMM</th>
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<tbody>
<tr>
<td>Ut Ds1</td>
<td>Dp Ul(dx) Utr(b)pa Ut(p)sibling abuse A7-8/C6 [ina-anger]</td>
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<tr>
<td>Ut Ds1</td>
<td>Dp Ut(ds)aban (ds)PA A6/C5-6</td>
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<tr>
<td>Ut Ds1</td>
<td>dp Ut(ds,p)F's vio, DV (ds)N (I)F vio A7M C6F</td>
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<tr>
<td>Ut Ds1</td>
<td>Dp Ut(dp)PA, CSA A4-(+)C+ [ina]</td>
</tr>
<tr>
<td>Ut Ds1</td>
<td>Dp Ut(b)CSA (ds)PA A4-, (7?)8 C5-6 [ina]h</td>
</tr>
<tr>
<td>Ut Ds3</td>
<td>Dp Ut(p+ds) PA, (b) SA, Ul(p) son, A+ (7GF) C5 [ina pain X2]</td>
</tr>
<tr>
<td>Ut D2</td>
<td>dp Ut(p&amp;i)CSA A7C6</td>
</tr>
<tr>
<td>Ut D2</td>
<td>dp Ut(p,ds) broken arm A/C5</td>
</tr>
<tr>
<td>Ut E1</td>
<td>Dp Ut(p&amp;ds) EN A4-C5-6 [ina]h</td>
</tr>
<tr>
<td>Ut E3</td>
<td>Dp Ut(p,ds)PN (p,ds)aban (dx)PA, PN, l(p)B A8C5 [ina]?</td>
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<tr>
<td>Ut &amp; l E3</td>
<td>Dp Ut(dx)SA, aban tr(dpl)SA l(dx)M A+/C5 ) [ina]</td>
</tr>
<tr>
<td>Ut E3</td>
<td>dp Ut(p&amp;ds)DV, CSA A4 C5-6Δ [ina]?</td>
</tr>
<tr>
<td>Ut E3</td>
<td>Dp Ul(dx)F+many (p)bullied A7C5(7?) [ina]?</td>
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<tr>
<td>Ut E3</td>
<td>dp Ut(p&amp;ds)PA, aban, families l(p &amp; ds) many A3-4,5(8)/C5-6 Δ [ina]h</td>
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<tr>
<td>Ut E3</td>
<td>dp Ul(p)F, GF, teach, t(p &amp; dpl)F sui A+(4)7 C5 [ina]</td>
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(Crittenden & Newman, 2010)
DMM & Borderline Personality Disorder

BPD: Dp Utr A+ C5-6Δ [ina]
DMM & Borderline Personality Disorder

Component patterns:
Psychoses: Dp Utr(ds) A+ [ina]

ED & PD: Utr(i) [A] C5-6 Δ

BPD: Dp Utr A+ C5-6Δ [ina]

BPD reflects the intersection of ‘psychoses’ and ‘personality disorder’ patterns.

III. Developing an Hypothesis

Integrating information from several sources
Eating disorders & avoidant personality disorders (not BPD or APD)

Symptoms

- Resentfulness
- Poor intimate relationships
- Expanding problems: work, social relationships
- Poor response to standard treatments
Eating disorders & avoidant personality disorder

AAI data
- Absence of traumatic events
- Confusion regarding why other people act as they do
- Obsessive strategy that is expected to fail
- Feeling that one has tried everything (pseudo-Type A)
- Intense effort to find causal relations tied to oneself
- Focus ‘speakable’ problems
- Inability to find invisible/unspeakable problems
- Dp Utr(i) C5-6
A Functional Formulation of PD

- Chronic inability to understand interpersonal processes leading to:
  - Mixed negative feelings
  - Unmet expectations
  - Feelings of being insignificant to others
  - Negative expectations
A Functional Formulation of PD

- Resolution requires
  - Current social skills
  - Attention to feelings as information (affect)
  - Understanding of why things happened as they did (cognition) to yield:
    - The opportunity to feel valued by parents
    - The opportunity to find rational explanations to events
    - Confidence in one’s own perceptions
    - Predictable sequences of interaction
    - Perspective-taking
    - Reflective functioning
    - Forgiveness
Integrating Theories of Change

- **Biology**: Genetic, epigenetic Tx
- **Neurology**: Pharmacological
- **Psychology**: Psychotherapies, CBT
- **Relationships**: Family Systems, Parent-infant work
- **Context**: Community Tx, Advocacy
Treatment of PD’s

- Medication
- Long-term psychotherapy
- Day treatment in skill groups (5day/18mo)
- Short-course day treatment (4day/6wk, Dal)
  - Self-report data
  - Short-term data
  - Not psychological processes or strategies
Hypothesis

- Most cases of PD will be associated with a failing C5-6 attachment strategy, with Utr(i)
- Cases of BPD will use an A/C strategy, with serious Utr (Dp Utr A+ C5-6Δ [ina])
- Effective treatment will address:
  - Social skills
  - Interpersonal processes (affect & cognition)
  - Unspeakable information
- Treatment will address
  - Current relationships
  - Past family processes
IV. Testing the Hypothesis

Multi-group, multi-method design
Comparing the DMM & Bartholomew's 4-factor model
Design

- 2 group comparisons (Tx and not)
- Pre-post treatment assessment
- Multi-method, multi-informant
  - Bartholomew self-report
  - Symptom self-report
  - AAI: blind coding & greater differentiation
  - Blind professional symptom report.
For further reading on the DMM:


For other downloads, see

www.patcrittenden.com