

Every Psychopathology is Still a Gift of Love

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In 1993, I wrote “Every psychopathology is a gift of love (GOL; Benjamin, 1993), and GOL was described this way: “I believe that the primary attachment to early objects (parents, siblings, or others) is an important basis of psychopathology. The effect interacts with given temperament, but beyond that, is transmitted by simple learning: the patient either maintains the early childhood position, or identifies with the parent. The wishes and fears that arise from these old patterns organize the problem patterns of adulthood. To achieve reconstructive change, psychosocial therapy must therefore strike effectively at the destructive aspects of this bond. “

During the nearly two decades that have followed, the concept of GOL has been defined more precisely, presented as the foundation of Interpersonal Reconstructive Therapy (IRT, Benjamin, 2003/2006), and supported and enriched by ongoing experience in private practice, supervision of trainees and pilot research studies of effectiveness. There have been two publications using normal, inpatient and outpatient samples that support the concept of copy processes, a central mechanism in the theory of GOL (Critchfield and Benjamin, 2008; 2010). My current book (Benjamin, draft) adds a “natural biology” that describes mechanisms that define “normal”¹ and explains how those mechanisms can go awry to create symptoms of mental disorder. The theory also informs corrective interventions during psychotherapy.

¹ Standard practice defines normal as close enough to average. That means normal is not “not normal.” It is conceptually preferable to define normal in terms of functioning mechanisms, as one would define it in a machine that is running as designed.

GOLs are seen in everyone, whether in people who are functioning normally; functioning superbly as professionals while privately suffering from suicidality; or severely disabled as in our CORDS patients (Comorbid, Often Rehospitalized, Dysfunctional and Suicidal) in the IRT clinic at the University of Utah Neuropsychiatric Institute. Instead of trying to explain copy process, GOLs and natural biology in much detail, I will give a brief, illustrative example at the end of this paper. In the meanwhile, I will concentrate on the editors' invitation to update the content of the talk, comment on state of the art and offer thoughts about the future of psychotherapy research.

Since 1993, psychotherapy research has expanded the collection of randomized control trials (RCT) of various therapy models, and continued to study variables related to therapy process and outcome. Back then, I cited Beutler's list of relevant variables: "...therapy contract, role, interpretation, confrontation, support, affective arousal, therapeutic bond, patient motivation, therapist expressiveness, empathy, and focus." These have been called "general factors" because they are shared by many therapy approaches. Along with others, Beutler suggested a need for a "guiding model" that would consolidate what is known about such effective components of therapy. I cited extant guiding models including: Luborsky's Core Conflictual Relational Themes; Weiss and Sampson's Plan formulations; M. Horowitz's Conflictual analysis of States of Mind; Strupp and Binder's Cyclical Maladaptive Patterns; and Greenberg's Task Analysis. I added my own version, which later was presented in a book on Interpersonal Reconstructive Therapy (IRT; Benjamin 2003/2006). Based on numbers of publications and confirmations by the RCT method for establishing effectiveness, I believe the most robust of that particular group of suggestions would be the CCRT as further developed and applied by Crits-Cristoph and colleagues, and Greenberg's task analysis.

Overall, research on effectiveness of therapy continues to support the Dodo Bird's strategy: "all have won and all must have prizes" (Luborsky, Singer & Luborsky, 1975). That refers to the finding that most therapies are better than no treatment but not better than each other. Despite publications that one treatment technique is better than another, in general, meta-analyses do not confirm that technique matters. In a carefully designed meta-analysis, Wampold et al, 2011 concluded "the effect for EBT (empirically based treatments) vs. TAUs (treatments as usual) that were psychotherapeutic interventions was not statistically different from zero. " Further, there is evidence that placebo can be as effective as a treatment (Wampold et al, 2005; Hougaard, 2010). Meanwhile, it is agreed that the effect of the therapy relationship in many contexts is large (Norcross, 2002; Beutler, 2005). Interest in what makes the therapy relationship (and therapy alliance) so important is intense. For example, a current issue of *Psychotherapy* (December, 2011) is devoted entirely to "Evidence-based psychotherapy relationships-II."

What is it in the therapy relationship that does the work? Is it common factors, and if so, how do they work? What else might contribute to outcome and how? Calls for answers often appear under the heading of "psychotherapy integration" (e.g. Magnavita, 2008). Within SPR, Castonguay (2010) proposed a method for discovery: have a meeting in which: "many experts espousing diverse epistemological orientations (e.g., logical positivism, hermeneutic, phenomenological), across and within theoretical approaches, were to meet....to design and then implement a major investigation of a core process of change (such as insight and corrective experience)...p. 136."

Would such a group be able to solve the puzzle? Perhaps, but I am betting that a paradigm shift is needed. If so, then history suggests such a change is more likely to be

developed by an individual or by a very small group concentrating on a shared belief coordinated by a focused leader. There are many examples in the history of modern science. Here is one: In the early 1900s, there was a large data base that showed each element in the periodic table emits a specific frequency of light (color). Nobody could understand why or make much of it until Niels Bohr proposed a shockingly different model of the atom. His model, which built on the work of others, and was elaborated upon later by still others, had huge practical implications and to this day is central to theoretical physics and much of our current understanding about the nature of the universe. Another of many possible examples is Copernicus' interpretation of data about seasonal positions of stars and planets that had existed for over a thousand years before he proposed that instead of thinking that the sun revolves around the earth, the earth actually revolves around the sun. That challenged religious ideas and flew in the face of the "obvious" fact that the sun moves across the sky every day and therefore must be circling the earth! These two examples demonstrate that organizing theory that truly fits the facts can yield tremendous practical predictive power.

Generalizing from natural science to psychotherapy research, it would seem that a useful integrative psychotherapy approach likewise needs to be based on valid theory. To achieve it, we need to work harder to use the methods of natural science. But we usually use different methods, allegedly required by the uniqueness of our subject material. I disagree. We may be able to account for relatively small differences in outcome variance in large samples, but natural science at its best can account for every single case. Our large N results in social science can be meaningful to administrators who make decisions affecting large numbers of people, but they are not so helpful to individual patients in the clinician's office. Why not make more explicit attempts to emulate natural science?

Consider what we would need to change. I think the major difference between us and them is this: the natural scientists try to describe and understand the “nature of nature” while psychotherapy researchers (clinical psychologists and other social scientists) focus primarily on specific procedures or “methods.” We do not ask of our results: what does this have to do with the nature of things, the nature of nature? For example, we show little curiosity about what an observed decrease in depression or anxiety during a treatment tells us about what went wrong, how was it changed by treatment, and what can be done to prevent a recurrence. And if we do have a theory of change, is there a way to prove it wrong? Failing to reject the null hypothesis hardly compares to predicting a specific result that if it fails, destroys our theory. We need to have theories that are so specific we can know if we are wrong; if a mistake has been made. Biological psychiatry, with its descriptions of mechanisms for depression and anxiety comes closer to providing such explanations of symptom change.

Far from informing us about the nature of nature, I am dismayed to see an escalating trend for our journals to offer various forms of multivariate analysis (MVA) as scientific “theory.” A major problem with MVA is that investigator choices have far too much potential to distort the outcome in MVA. Examples of decisions that could bias conclusions include choices of order of entry, of covariates to adjust for, how to identify error variance, and what to choose to represent relevant constructs. Not long ago, I saw a complex MVA model of personality disorder in a prestigious journal that used deviant promoter region of the serotonin transporter gene as a marker of heritability. A search of an on line data base reveals that particular genetic deviation in the 5-HTT gene can be created in chimpanzees by removing them from their mothers at birth (Bennett, Lesch et al., 2002). The point of that study was that conclusions based on statistical models should be checked by laboratory science. In this and most studies in up to date

psychiatry, “genetic” no longer simply means “heritable.” The interaction between environment and genes is powerful. Such errors of interpretation can more easily be averted these days because of the easy access to primary sources on the internet. A natural scientist would worry about being “called out” for such a mistake. We should too.

Another methodological practice that interferes with our progress is our willingness to assign numbers to indeterminate constructs on the basis of rating scales when their components have not been described in precise, objective, testable terms that derive from explicit logic. And, in addition to giving the burden of “quantifying” to judges, we are content with mere tests of reliability as measures of validity (e.g. field tests of DSM5 proposed diagnoses; Frances, 2012).

In addition to the requirements that we (1) describe “the nature of nature” and (2) offer theory with internal logic that is confirmed *and* refutable by data, we also should strive to: (3) make predictions that ultimately are palpable by human senses, even if it is as difficult as investigating the existence of “invisible” dark matter (Cowen, 2010). (4) Our theories should be as parsimonious as possible. (5) Our scientific theories should center on study of interactions to distinguish them from craftsmanship (Goldman, 2007). (6) In the life sciences, our explanations must provide detail to show how the mechanism relates to adaptation (Nowicki, 2004). This list presents significant challenges, but it is not impossible to meet them.

Do I “practice what I preach?” Not entirely, but I try. Structural Analysis of Social Behavior (e.g., Benjamin, 1978, 1996/2003) offers a way to quantify what most people talk about in therapy: relationships with self and others. The language is simple and it has testable, refutable internal logic that relates to the “nature of nature.” For example, the poles of the axes represent “primitive basics” that we share with other mammals: sexuality, aggression, power/submission, separate territory. They define underlying dimensions that can be used to

“unpack” complex human communications (e.g., Humphrey and Benjamin, 1985). SASB relates to adaptation. For example, rather than representing aggression as a given energy that demands expression, aggression is described in behavioral terms and is interpreted in terms of adapting to the environment: Aggression serves control (manage space and supplies) or distance (dispersion so the few can survive and/or leavers find new territory). The dimensional structure of SASB logically and geometrically defines predictive principles (similarity, complementarity, introjection and antithesis) that are useful in many ways. Reviews of research based on SASB appeared in Benjamin, 1996 and Benjamin, Rothweiler and Critchfield, 2006. Although not as well developed as any of the natural sciences, the SASB does attempt to follow the paths they have cut.

IRT theory applies SASB based observations and principles to descriptions of behavioral normality and psychopathology (Benjamin, draft). It describes a way of developing case formulations and making treatment decisions using flow diagrams and tables (Benjamin, 2003/2006). Because of the clarity and specificity, errors can be defined. A case formulation in IRT begins with symptoms, relates them to current stresses (what might you be depressed about?), and connects current patterns to remembered interactions with attachment figures via copy processes that reflect the predictive principles. Copy processes are: be like him or her (identification), act as if he or she is still there and in control (recapitulation) and treat yourself as you have been treated (introjection). Exact opposites (SASB defined) also count as copying. Patients participate actively in developing the case formulation and must affirm its validity before it is accepted by the clinician. Ken Critchfield used the detail in IRT flow diagrams and tables to create reliable rating scales for case formulations and for therapist and patient adherence

to the treatment model. Pilot studies confirm supervisory impressions (Critchfield, 2011), but IRT has not yet had enough research testing to carry the relative certainty associated with SASB.

Both SASB and IRT theory now are accompanied by theory by natural biology, which interprets normalcy and psychopathology in terms of the structure of the nervous system, neurochemistry and neuroanatomy, action of psychoactive medications, brain changes in mental disorder, molecular biology (i.e. genetics at the level of natural science), primatology, developmental psychology and psychopathology, psychotherapy and more. Here are some relevant highlights from Benjamin, draft: Affective symptoms are based in the threat (sympathetic = “fight/flight”) and safety (parasympathetic = “rest/relax”) parts of the autonomic nervous system (ANS). Affects are cued by signals from subcortical affect regulators (e.g., HPA axis, amygdala, hippocampus) and predispose behavioral responses to threat (anger, anxiety and depression predispose fight, flight, freeze, hide, surrender) and safety (positive affectivity predisposes rest, relax, bond, play). The mechanisms linking affects and threat/safety responses release of neurochemicals familiar in psychiatry (cortisol, norepinephrine, epinephrine for threat; dopamine, serotonin, oxytocin, opioids for safety). Recognition of and response to conditions of safety and threat are greatly affected by implicit learning (repetition of temporal, spatial, figural associations) in relation to caregivers. They provide safety (proximity, clingability, nursing, and other reflexes related to attachment). By contagion, what attachment figures do and feel (and perhaps think) is absorbed by the infant and when it comes to safety and threat, their “iron rules” are immutable. One never forgets to avoid drinking when crocodiles are present. What is learned from attachment figures cues affects and behaviors related to safety and threat. However, if the safe base figure also is a threat, as in child abuse, signals for threat and safety are confused. Maladaptive signals from internalized representations of attachment figures frequently release

cortisol and other stress chemicals brain changes associated with mental disorder follow. The maladaptively cued affects and behaviors are symptoms.

For example, suppose a child is rejected and punished as she is told by her caregiver she must constantly to serve others else she is selfish and unlovable (will be abandoned). She will then live in abject servitude and selflessness and likely accept exploitation and abuse in intimate relationships. Her devotion to those “iron rules” in order to receive affirmation from the internalized representation of her caregiver is her GOL. This inspires chronic anxiety because she always strives to serve well enough (anxiety mobilizes coping) and depression because she never succeeds (depression supports surrender). Her treatment by psychotherapy will include encouraging her to resist commands from the “family in the head” and work with the therapist to identify and implement strategies to rewire her lower (subcortical) brain. For example, as homework, she might dare to try a single act of self-care, and learn to tolerate the terror that inspires by practicing meditation, desensitization, EMDR or other such strategies to develop more adaptive subcortical responses to self care. This transformation is frustratingly difficult, and can be dangerous for reasons explained in Benjamin, draft. Trust in the competence and reliability of the therapist is vital to the success of this process. In time, an internalized representation of the therapist can form the kernel of a consistent safe base, the beginning of new, more adaptive GOLs. These need to be enhanced by increased openness to normative interactions with benevolent friends and family. No wonder therapists can carry so much outcome variance! If they are caring and work effectively with a model that helps address GOLs that support symptoms, mechanisms of change are activated to properly recue the release of affects and behaviors, and the “Birthright self,” the self that would have been, had there been secure base conditions during childhood, can emerge.

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