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Contextual Role Theory and Its Use as an Approach in Counseling Adults

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Introduction

The purpose of this report is to attempt to define an approach to therapy based on theory learned in EPS 601, Theories of Counseling. To serve that end, it is presented as a complete and workable theory. In reality, it is a work in progress. It represents the author's incomplete knowledge and a healthy absence of further training and experience. Although, it is presented otherwise, I hope the reader keeps this in mind.

Most sections are merely smatterings of the information that is available on each subject. The section of brain development, for example, hardly touches the surface of this interesting subject. Attachment theory and its implications and relationship to cognitive schema is a very exciting area and not given justice here in this report. Family systems and role theory also only brushed by in order to support and explain the theory presented here. Again, this report is a work in progress and it represents more of an outline for future work.

One subject was used throughout EPS 601 as a subject of the many techniques in this report. That subject wishes to remain anonymous. Any printing or distribution of the Appendix material dealing with worksheets or dialogue requires the author's permission. The session in Appendix E was recorded verbatim with the subject's permission with the knowledge it would be used only in this report. It was conducted to replicate a therapeutic setting, without notes, and was completed in one hour to conform to the realities of that time constraint. The purpose was to demonstrate a therapeutic dialogue that we connect current irrational thoughts to attachment schema. Because this was one of the first sessions by the author, any constructive feedback would be greatly appreciated.

Contextual Role Theory

The starting point of Contextual Role Theory (CRT) begins with the postnatal development of the brain, expressed eloquently by Allan N. Schore in “Affect Regulation and the Origin of the Self.” (Schore, 1994) CRT assumes that the psychobiological regulation of the infant by the primary caregiver and the resulting stimulation and influence of the structural development of the infant’s brain lays the foundation for the formation of unconscious cognitive working models and later attachment behavior. These working models are the imprinted patterns of reciprocal, interpersonal behavior and affect regulation developed by the nonverbal, coordinated interactions of the caregiver/infant dyad. These patterns create the earliest relationship paradigms. This psychobiological attunement begins in early infancy and develops a cognitive ontogeny that becomes observable between 10 months and 18 months corresponding with Piaget’s (Piaget, 1954) fifth stage of sensorimotor development and the period when Bolby’s (Bowlby, 1969/1982) attachment patterns are measured. In fact, the subcortical limbic and cerebral cortex anatomical areas show maturation at 15 months paralleling Piaget’s and Bolby’s development theories. These corticolimbic structural developments in the brain are the sources of emotional and memory functional development (Shore, 1994, p: 30).

The Development of the Brain

The cortical system in the brain modulates the lower limbic structures. This area, specifically the prefrontal cortex in an area known as the orbitofrontal cortex (located behind and above the right eye), regulates arousal and inhibits drive (Shore, 1994, p 34). This area of the brain is unique because it is the location of convergence of the visual, auditory, and other sensory

mechanisms. The orbitofrontal cortex is positioned between the cortex and subcortex and processes information between the external world and the lower more primitive structures associated with the limbic (emotion) and viscerosomatic systems (fight or flight). The catecholamines, dopamine, and noradrenaline, acting as neuromodulators in the nervous system, biochemically mediate states of arousal and integrate metabolism. (Shore, 1994, p. 45). This paralimbic structure acts as a system that is specialized to regulate autonomic responses to affective cues, according to the prevailing mental state.

The development of the orbitofrontal cortex occurs in two phases. The first phase produces nerve growth associated with arousal. The second phase develops nerve growth associated with inhibition. The first phase begins at around 8 weeks and continues until locomotion around 12- 18 months culminating in high arousal. The development of these arousal patterns activate the later developing parasympathetic or inhibition nerve development. The second phase continues until around 2 years old and is associated with the infant-caregiver dyad's reunion patterns.

The First Phase of Development

The first structural system associated with brain development is the ventral tegmental dopaminergic system (Shore, 1994: p. 91). In layman's terms, it is the neurobiological pathway between the brain stem area and the orbitofrontal cortex. This pathway is stimulated by visuo-affective face-to-face interaction between the mother and infant. These interactions or positive affects neurochemically stimulate the endogenous opioids, which create nerve structures (axon collaterals) and functions in the prefrontal cortex (Shore, 1994: p.46). In other words, the gaze transactions patterns between the caregiver and infant stimulate the growth of

the arousal mechanisms in the infant's brain. This prefrontal dopamine system is associated with the cerebral circuitries of reward and emotionality (Shore, 1994: p. 48).

Shore demonstrates that this initial period of high levels of positive affect promote further structural growth and shape developing neural networks. Kagan (Tulkin & Kagan, 1972) reports that at 10 months, approximately 90 percent of the mother's interactions with the infant are involved in play. This period culminates at around 12 months with the onset of locomotion where the infant demonstrates a high level of excitability. Shore indicates that the increased activity of the mesocortical dopamine system also supports locomotion and investigatory behavior. Thus, the manner (pattern) in which this important section of the brain develops in response to the caregiver/infant dyad stimulation impacts directly on the resulting patterns in which the mature brain interprets latter socioaffective stimulation. Shore states:

“...the postnatal emergence of anterior cortical neuronal systems mediating affective processing also requires adequate caregiver-provided intensity and variety of affective stimulation during a time-window of plasticity in early postnatal development. In other words, the mother's role as a self-object, as a provider of modulated affect, is essential to the development of the child's internal affect regulating system.”(p.60)

Kohut (1977) states that as a result of the dyad-produced internal affect system in the infant the child experiences the feeling states of the mother as if they were his/her own.

The Second Phase of Development

The second structural system associated with brain development is the lateral tegmental limbic circuits. At about 14 months, the relationship with the primary caregiver changes from participation in maximizing excitation to inhibition of behavior. This is seen in the brain by the

lateral tegmental noradrenergic innervations of sites in the orbital limbic cortex. This structure is associated with the inhibitory functional mechanisms of the limbic system. Up until this point, the structure of the brain has created a sympathetic system that culminates in a highly aroused, narcissistic infant enjoying new found locomotion.

Now the caregiver must begin to regulate the infant's excited behavior. This is done through gaze transactions as the child looks to the caregiver for assurance. Negative gazes and interruptions to the excited behavior induce hormonal and neurohormonal alterations in the infant's developing brain. These affect mediating socializing transactions deactivate the ventral tegmental dopaminergic and activate the lateral tegmental noradrenergic limbic circuits. Lowered levels of endorphin and high levels of corticosteroids in the orbitofrontal subplate facilitate the growth of ascending catecholaminergic axons of the noradrenalline neurons.

The sprouting of these parasympathetic terminals into the overlying cortex allows for delivery of noradrenaline, and this bioamine acts to induce a further maturation of the orbitofrontal regions. Thus, the caregiver's interventions are stored in shame imprinted interactive representations that are distributed along the lateral tegmental limbic circuit

The fact that the orbitofrontal cortex regulates both arousal and inhibits drive is important to both the maturation of the brain structure in this area and the development of the transaction patterns in early infancy. This initial development of the arousal mechanisms (sympathetic), followed by the development of the structures creating inhibition (parasympathetic), mature in concert with behavioral observations showing attachment patterns created beginning around 12 months and the socialization experiences in the second year associated with shame transactions (Schoore, 1994: p. 259).

Implications of Brain Development on CRT

Piaget makes it clear that the child does not truly identify an object, and thus himself as a discreet egocentric object until into his sixth stage of development between 18 months and 2 years of age (Piaget, 1954). Piaget makes a defining statement regarding the child's understanding of the world and its objects (including mother): "In short, intersensory coordinations contribute to solidifying the universe by organizing actions but they do not at all suffice to render that universe external to those actions." (Piaget, 1954, p.8) What he is saying is that until between 18 months and 2 years of age all circumstances experienced by the child are experienced only as his own actions--himself. Now, the child still cannot self-experience until he/she has an ego identity, however, the important point is that the developing brain, because there is no object identification, imprints all relational patterns of arousal and inhibition as the original self. There is no distinction between the relational working models and the self. In other words, these experiences of reality were not developed as some object of self-interpretation or conclusion of a subjective relationship encounter or experience. The working models are our pre-cognitive self. CRT assumes, therefore, that those aspects of reality that originate from the first 18 months of relational imprinted patterns are unavailable for introspection and therefore change. CRT also assumes that some attachment behavior originating from these working models are also unavailable for change.

Steven A. Mitchell in his summary of the theories and thoughts of Hans Loewald in *Relationality From Attachment to Intersubjectivity* (Mitchell, 2000) when referring to this same issue states that "...such early experiences are not stored as images of a clearly delineated external other, but as kinaesthetic memories of experiences in which self and other are undifferentiated." (Mitchell, 2000, p. 22) These kinaesthetic memories of patterned transactions

are activated in transference when the client's "...unconscious tastes the blood of recognition in feelings toward the analyst, so that old ghosts may reawaken to life" (Mitchell, 2000, p. 24).

These unconscious patterns were formed through relationships and they emerge in relationships. Mitchell points out that object development is the result of drawing a boundary around a piece of experience. In early childhood, this is a primal process. Secondary processes are developed linguistically later. Mitchell also indicates that this primary process exists in parallel with secondary processes. Object identification in secondary processes is like furniture in a house. You can move them around and organize them by the boundaries you draw. Primary objects are adhesive because the object and self are inseparable. These primary affective states are transpersonal and are prereflective (Mitchell, 2000, p. 60).

CRT recognizes, therefore, that these unconscious primary affective states, developed through infant relational experiences, exist in the present along with secondary affective states. The latter organize our reflective schema. The former provide existential sludge from which these secondary schemas emerge. Thus, attachment patterns and schema are like sleepwalkers emerging from a dense fog. They are coming from somewhere, but you just can't see where. CRT accepts the logical conclusion that simply changing reflective schema does little to change the nature of the fog, which influence new schema. When the client "tastes the blood of recognition", the new schema will be influenced and molded by the underlying, pre-reflective, internal, relational models.

Philip M. Bromberg in *Standing in the Spaces* (Bromberg, 1998) states that Harry S. Sullivan's opinion of the nature of the arousal and inhibition limbic working models was therapeutically inaccessible because they remained at an autistic and incommunicable level. He states that the me-you experience of the therapeutic relationship (and all relationships)

synchronize with the precognitive need tension level developed in infancy by the mother's responsive patterns (Bromberg, 1998, p.46). He states: "What keeps preconceptual or unsymbolized experience so rigidly unyielding is that the "me-you" representation is organized around elements which are more powerful than the evidence of reason." (p. 49).

It seems conclusive, therefore, that these patterns formed in infancy are not deep, dark Freudian drives or urges that are better off ignored in favor of developing some more contemporary rational belief rehearsals as a vehicle of cognitive or relational change. These patterns exist in the present, as an undertow to our conscious cognitive thought patterns and must be accommodated in the therapeutic process. CRT will suggest a method of dealing with them.

Attachment Theory--A Bridge from Brain Development to Cognitive Schema

This paper is not organized to provide a full summary of attachment theory. I do agree, nonetheless, with Lopez and Brennan (Lopez, 2000) that attachment theory represents an approach with potential to advance counseling psychology by linking developmental themes with personality development. CRT finds attachment theory important because it provides a logical explanation for the development of roles in the family, which are simply an accommodative abstraction of attachment behaviors.

John Bowlby (Bowlby, 1969/1982) proposed the replacement of Freud's discharge of psychic energy with a more structured control system of information and feedback creating a behavioral form of homeostasis. Bowlby compares his theory to modern machines, which regulate feedback and modulate performance toward a specified goal. He also described it to a room thermostat which regulates a heating system based on differences between the room temperature and the temperature set in the system, a subject later, 1979, eloquently used by

Batson to explain the relationship between structure and process and their correlation to higher logical types (Batson, 1979).

Bowlby's attachment theory states that early interactions with the infant's primary caregiver form a "goal corrected" partnership that calibrates the infant's coordination of proximity-seeking and proximity-avoidance behaviors (Lopez, 2000, p 284). Secure attachment arises from a predictable and responsive relational context that provides a "secure base" that, like any homeostatic system manages insecurity. Insecure attachment, that is, unpredictable or unreliable caregiving, leads to the development of secondary strategies to manage relational events that result in either excessive preoccupation with maintaining proximity or excessive preoccupation with avoiding proximity. These led to two classifications of insecure patterns of behavior: insecure anxious and insecure avoidant. CRT agrees that Bowlby's attachment patterns are, in effect, the observed result of the brain's limbic system's monitoring and modulation of emotional stimuli, a neurological pattern developed through early infant-caregiver dyad interactions. Allan Schore stated this point in his forward to Bowlby's 1982 edition of *Attachment*: "The activity of this frontolimbic system is therefore critical to the modulation of social and emotional behaviors and the homeostatic regulation of body and motivational states, affect-regulating functions that are centrally involved in attachment processes."

Attachment patterns become cognitive working models that generalize expectation of self and others exhibiting such components as styles of environmental vigilance, emotional arousal, and response to discrepant relational information that shapes the nature and meaning of the individual's internal and social context. CRT believes that these attachment-related working models are created in modulation to an existing family context of interrelated behaviors, which

effect and contribute to a specific pattern of infant-caregiver interactions. The child, therefore, develops complimentary roles within that system.

The Relationship Between Attachment Theory and Cognitive Schema

Cognitive therapy embraces the approach that mental disorder is characterized by underlying cognitive distortions and that the goal of therapy is to identify and correct errors in information-processing systems and correct them (Seligman, 2001). CRT believes that this approach is incomplete because it focuses only on the cognitive structures that arose epigenetically from the unconscious affect regulating patterns developed prior to linguistic and object development. Cognitive structures and schema are simply a higher level of interpretation of patterns the child had lived with his/her entire life. These higher-level skills emerge during Piaget's sixth stage around 18 months of age. CRT asserts that any treatment strategy that ignores the underlying affect regulating patterns can only be partially successful in accomplishing long-lasting change. Any serious trauma or regression would cause the underlying patterns to reassert dominance in the cognitive interpretations of the stress.

In recommending an approach to connect cognitive schema to attachment patterns, CRT points out that there are structural barriers to both approaches that make this difficult. First, attachment categories are too narrowly defined. There essentially only three, secure, insecure anxious, and insecure withdrawn. There is a more recently developed category called "disorganized" (Solomon, 1999). Other behavioral classifications have been developed including the Cassidy-Marvin preschool model and the P. Crittenden Preschool Assessment of Attachment (Solomon, 1999, pp. 216-226). These classifications typically only explain sub-classifications of observed behavior. Nonetheless, attempting to link diverse cognitive schema patterns to only three classifications of attachment behavior eliminates the possibility of

considering gradients of symptom development. For example, a client may display an irrational cognitive belief that might be rooted in a withdrawal pattern, but simply concluding that the belief is caused by an insecure-avoidant attachment pattern is too simplistic. Attachment patterns should be equally diverse to allow for more logical causal connections to cognitive patterns. Second, attachment patterns are identified through behavior and cognitive patterns through thought patterns and beliefs. While there may be a correlation between thought and behavior, the classifications were abstracted separately and therefore the results are mutually exclusive. This connection requires research, however, CRT's therapeutic approach to bridging this connection, described later, does not depend on a connection between cognitive beliefs and attachment patterns. The following discussion on the relationship between cognitive schema and attachment patterns is intended to provide support to CRT's therapeutic approach rather than propose a causal connection.

One presentation of cognitive schema organization proposed by Jeffery E. Young (Young, 1990) identifies eighteen schema organized into five categories: (1) Disconnection and rejection; (2) Impaired autonomy and performance; (3) Impaired limits; (4) Other Directedness; and (5) over vigilance and inhibition. Appendix A identifies the 18 schema. Let's look at both attachment patterns and schema and determine if there are logical relationships.

M. Lynne Cooper, et al, (Cooper, 1998) provide a somewhat detailed description of Bowlby's attachment categories. Becker and Billings (1997) as well as Collins and Read (1990) have developed attachment scales for categorizing attachment styles. When taken together, they consistently use similar measures. For the category insecure anxious they describe the following characteristics:

- Lack self confidence
- Worry about rejection.
- Prone to bouts of jealousy and anger at relationship partners who are perceived as untrustworthy.
- Eager to become involved in romantic relationships despite their perils.
- Likely to engage in inappropriately intimate self-disclosure.
- Caregivers were inconsistent in their responding inducing anxiety, vigilance, and anger.
- Caregivers were cool, rejecting, and unsupportive inducing premature self-reliance and suppression of neediness and vulnerability.
- Find it difficult to depend on others.
- Not sure if their partner really loves them.

For the category insecure avoidant they describe the following characteristics:

- They are uncomfortable with closeness.
- Disinclined to become involved in long-term romantic relationships.
- Are uncomfortable with self-disclosure.
- Relatively inhibited and socially unskilled.
- Find it difficult to depend on others.
- People are never there when you need them.
- Repress negative emotions that stem from rejection.
- Respond intensely to negative emotional input.

Although research is required to confirm any connections between cognitive schema and attachment patterns, CRT has listed 18 schema identified by Jeffrey E. Young (Young, 1990) in

Appendix A and organized the schema into attachment patterns in Attachment B. In addition, the attachment categories are assigned into two categories according to the two stages of development of the brain: the sympathetic (arousal) and parasympathetic (inhibition). The implications of the merging of cognitive schema with attachment patterns organized in accordance with brain development are important to CRT's counseling theory and approach.

Discussion of Organization of Schema and Attachment Patterns

By way of illustration, refer to the section in Appendix B in the block corresponding to "1st Stage of Brain Development - Arousal" and the block below, "Anxious." Note that "Vulnerability to Error/Negativity" has been assigned to that block. This schema, according to Young, means "exaggerated expectation that things will go seriously wrong." Remember, with the development of the brain, this initial period of development is effected by the quality of reciprocal response patterns between the caregiver and the infant. According to Bowlby (Bowlby, 1988, p.124), this category of attachment pattern is one "in which the individual is uncertain whether his parent will be available or responsive or helpful when called upon." Both Bowlby (Bowlby, 1988) and Schore (Schore, 1994) identify gaze transactions, crying, and the social smile as mechanisms for need and emotional communications. When these communications are erratic and unpredictable, it would be understandable that the arousal patterns incorporate a certain level of unpredictability into their wiring. Now, there is no self-object or cognitive development at this period of infancy and, as a result, the limbic pattern: "need - no response; need - response; need - no response" might give rise to a cognitive translation of this limbic response to environmental stimuli later in development as an expectation that things could go seriously wrong. This would be understandable because that is precisely what happened during early infancy. Because the mother was the infant's self-object,

these reactions are not only unconscious, but also are experienced as a universal truth about the nature of self and the environment. From the infant's, and later adult, point of view, they are not some self-reflective opinion or belief. They are the truth about the nature of life. As a result, CRT believes they are immune from cognitive change.

This limbic pattern sets the stage for those developed during the second stage of brain development. Under "Anxious" in that area of Appendix B you will notice the assignment of "'Mistrust/Abuse", "Vulnerability to Danger", and "Overcontrol/Inhibition of Action." One can see referring to the description of these schema in Appendix A that the expectation that other will hurt, that a random catastrophe could strike, and an inhibition of action to avoid mistakes would be a natural reaction to this period of development. This period of development occurs when the child is exploring his/her world and engaged with the caregiver in patterns of inhibition of arousal and shame transactions. During these high arousal states of exploration, the belief that the caregiver may punish, that random catastrophes do occur, and inhibition of action is a logical outcome of learning is understandable. As mentioned previously, CRT believes that since the self-object has not been formed, much of these experiences are limbic patterns and that cognitive translations of these limbic signals precipitated by the "blood of recognition" are developed later in childhood. As a result, these "feelings", which give rise to cognitive schema are also unconscious and unavailable for self-reflection.

From these patterns, higher levels of cognitive schema develop. In appendix B the assignment of "Failure", and "Unrelenting Standards" are more complex schema developed by later cognitive development and life experiences.

CRT is based on the assumption that when confronted with a schema, for example, of "Unrelenting Standards", that is the belief that one must strive to meet very high internalized

standards, it is unproductive to attempt to confront that specific belief as irrational and attempt to replace it with a more rational belief. The underlying limbic patterns would negate the logic of the new rational belief. It would be experienced as intuitively illogical and threatening. In attempting to address the illogical belief, the therapist, in effect, would replicate the original transactions that led to the formation of the limbic patterns and confirm the threat of hurt and catastrophe by attacking the defense mechanisms or, in effect, the person him/herself. If the client was borderline personality or a victim of sexual abuse or there were other unidentified issues, the results could be disastrous.

In summary, CRT is founded on the belief that current cognitive beliefs are developed unconsciously in response to reciprocal patterns during development of the brain and contribute to, or define, later attachment behavior. Many cognitive beliefs are self-reflective, but they arise from unconscious limbic patterns that are activated by environmental stimuli. When activated, they elicit beliefs that have been learned to explain these unconscious feelings. Re-framing the learned behaviors in no way changes the underlying feelings. In fact, that process leaves the unconscious feelings that still arise unexplained and therefore threatening.

The Development of Roles - Creating a Context for Cognitive Beliefs

CRT believes that ecosystems, including the family and the children who participate in them, remain in equilibrium. Thus, cognitive beliefs that arise from attachment patterns are themselves part of, and in equilibrium with, the larger family system. Mom's cognitive beliefs and behaviors compliment dad's and the entire family harmonizes to maintain a status quo as a functional or dysfunctional system. The family system creates a specific context, which modulates and defines meaning for each role in the family. Gregory Bateson stressed the

importance of context in Mind and Nature: "Without context, words and actions have no meaning at all." (Bateson, 1979).

A child adapts his/her specific attachment pattern to the family system. This is the horizontal adaptation to the vertical intergenerational attachment patterns. In other words, mom's schema and attachment patterns were influenced by her parents and grandparents and mom marries someone who complements her patterns. Now the child is influenced by mom's attachment behavior and must adapt to a role horizontally within the family system.

This paper does not intend to introduce the dynamics of social fields or the theory of logical types both of which are relevant and very interesting support to the influence and dynamics of groups on behavior and cognitive schema. For the purposes of introducing an approach to therapy, I will simply state that the role the child develops to adapt to the original family is typically carried into adult relationships. CRT asserts that the maladapted childhood role carried into current relationships also has a powerful influence on behavior and cognitive beliefs and cannot be ignored when developing an approach to therapy.

One can see that the challenge of therapy has become even more difficult. We are faced with unconscious limbic relational patterns, which develop into pre-conscious attachment patterns, and now the behaviors and cognitive beliefs that define these patterns are structured by family systems that create a powerful context, which regulates behavior to maintain equilibrium. However, CRT believes the solution lies in the problem itself and the power of these early roles can be used to support new more functional behaviors and beliefs. In fact, CRT believes that attempting to change behavior or cognitive beliefs *without* changing context is like going on a diet: they work wonders, but don't last.

With this background, let's look at how one might utilize CRT as an approach to therapy.

The Approach to Contextual Role Theory

Contextual Role Theory is an eclectic approach that utilizes a relational/psychodynamic framework with cognitive-behavioral treatment strategies. Emphasis is placed on the transactional aspects of the approach because individual functioning is continuously reciprocal and thus dysfunctional relationship patterns can be detected and adjusted in the therapeutic relationship.

The overall approach of CRT is to (1) establish a trusting therapeutic relationship, (2) recognize the psychodynamics of the relationship and the client's patterns of resistance, etc, (3) clearly map the irrational cognitive beliefs and behaviors and corresponding schema, (4) identify the connections, or similarities, between present and past patterns, (5) determine the interface of self-reflective schema and more primitive limbic patterns, (6) identify family roles and adults roles and their connections, (7) establish a new personal role or context to support change, (8) re-write the cognitive/behavioral patterns in the present, and (9) develop/encourage short and long-term life goals based on the new role and CB patterns.

CRT is designed for brief therapy. More time to spend on each area is certainly welcomed, however, I believe that the first cycle through the seven steps is important for the client in order to understand the change model. Thus, the therapist might concentrate on one presenting cognitive/behavioral symptom and work it through the steps. Once adjusted, the others are easier because you are working more as a team and the therapist is more of an inspirational coach/mentor. Once the client has been through one cycle, it is then much easier to

spend more time in any one area, for example, family roles, because there won't be a tendency to become stuck in any step too long.

CRT is not designed for persons with psychotic disorders or those who cannot think abstractly. However, it could serve as a structural template within an approach designed for that classification of disorders. For example, CRT would not work for a client with borderline personality disorder. The approach itself would be perceived as invalidating the client's reality, which is the underlying problem with this disorder. In other words, it would make the client's situation worse and since this population is prone to suicidal behavior, it could be construed to be dangerous. However, once the therapist has completed the validation phase of treatment, taught emotion observation and labeling skills, taught behavior/cognitive observation and labeling skills, and begins to get into the problem-solving phase of treatment, CRT could be useful. It might, in fact, be beneficial because the technique used to identify the interface between limbic/attachment fits beautifully into the reality of the client with more serious disorders. Although not in sequence, now is a good time to explain the approach to the limbic/attachment interface.

The Academy Award winning movie "The Beautiful Mind" is a wonderful example of how CRT approaches this area in treatment. In the movie about the real life of John Nash, who suffered from schizophrenia, the main character had developed people and events that were a complete illusion. They were real to him, but did not exist. He had a roommate in college who introduced him to his niece, a little girl, and he was hired by the FBI to decode foreign plots against the United States. To those on the outside, his behavior was quite bizarre, however, to him everything was completely real. The epiphanitic moment came when, after shock therapy and a very distressed confrontational wife, he suddenly realized that the little girl, his roommate's

niece, who he had known for years, had never aged. From that moment on, he realized that she was an illusion, understood his sickness, and learned to challenge and separate illusion from reality. A great part in the movie came when he was standing by his classroom door and a stranger approach him and introduced himself. He stopped a student and asked her if there was someone standing next to him. When she said yes, he told the stranger it was now safe for him to acknowledge him.

CRT proposes to use the same technique. There are some patterns wired into the brain that cannot be changed. Basic concepts and knowledge of reality that are reality. They are real just like the roommate of John Nash. These were developed during infancy and early childhood before the child was able to self-reflect as a single object. Once schema and beliefs formed later are identified there is a murky region of reality that underlies these schema that are not capable of analysis and self-reflection. These are the patterns that create the "blood of recognition" of early attachment patterns. CRT attempts to identify these limbic impulses by having the client identify the feeling that precedes an already identified irrational cognitive thought/pattern and work through replacing the irrational cognitive thought or behavior with an alternative, more functioning, thought or behavior. This would be very close to the AA approach of "fake it until you make it" approach. But, most importantly, it would re-frame what seems, and is, a real unquestioned recognition of reality that has driven higher-level cognitive interpretations that have lead to problems with adult relationships and personal satisfaction. Like the John Nash in the movie, the client would be able to notice and look humorously on the impulse arising out of old limbic patterns and learn to separate the old dysfunctional reactions from the functional more healthy reactions. They would always be there, albeit now with less impact, but the client would, through practice, prefer the more healthy response. Also, over time, the impulse loses its power

as a justification for reality. Once identified, a cascade of thoughts and behaviors also lose their rationality. But, this is step eight. Let's take a closer look at each step.

Step 1 - Establish trust in the therapeutic relationship

This step is basic to all therapeutic relationships. The client is accepted unconditionally. There are no interventions or challenges to beliefs. This is a time to completely understand the client's current reality. It is characterized by empathetic listening and understanding. The goal is to be able to produce a confirmed summary of the client's current thinking, behavior, and feelings about where they are now. This step is Rogerian. It is undertaken with the understanding that the client is inherently perfectly acceptable the way they are. They already have within them the power and resources to be whoever they want to be. This step is complete when the client clearly acknowledges and confirms that the therapist totally understands the client's issues.

Step 2 - Relational psychodynamics

This step begins with step 1 and is established as a step because of its importance. CRT believes that the most effective insights are those that pertain to the client's behavior as it pertains to the interactions with the therapist. Transference, object relations, and projection are all important to recognize and note. This framework is important not only in the beginning of therapy, but also during and near the end. The client may, at first, clearly relate to the therapist as an authority or parent figure, but later adjust with change his/her relationship with the therapist. Thus, CRT as an approach is based on a relational form of psychotherapy. It underlies the entire process. As a step, it is important because early in the treatment, the therapist can identify these interactional patterns, which will support the work in later steps.

Step 3 - Map the irrational cognitive/behavioral patterns

In this step, the therapist and client begin the work of identifying the irrational thought and behaviors. As mentioned previously, it is important not to try to solve them all. CRT suggests only working on the client's most important presenting problem.

CRT starts with the identification of that presenting problem, and uses the Lifestyle Assessment (LA) as one of the first techniques. This is because it is important to start understanding the bridge between present thoughts and behaviors and their links to early childhood and the LA is a good way to get there quickly. In addition, the LA helps identify a host of patterns and thought associated with irrational beliefs and behaviors.

CRT then uses a variety of CB techniques to assess issues including WDEP, REBT, and the numerous other techniques. It is important to note that CRT only uses these techniques to *identify* the irrational thoughts and behaviors. It is premature at this time to begin changing the thoughts and behaviors, although CRT recognizes that the identification of more rational beliefs are a logical outcome of the identification of irrational thoughts. The emphasis, however, is placed on the identification, not forcing the client to change those irrational thoughts. In other words, the second half of the technique (rational beliefs, etc.) is completed in a later step.

CRT is also developing and will be testing an "Anxiety Map." This is an assessment or identification of areas in the client's life in major role categories such a job, spouse, parent, money, health, and spirituality where the client is experiencing anxiety. It is suspected that these relational areas are undifferentiated relational problems directly connected to the role, cognitive, and behavioral problems. The Anxiety Map will be used later in Step 7 and Step 10 to develop new roles and life plans.

Examples of this step used in the case study, discussed below, are found in Appendix C, D, and E.

Step 4 - Identify the connection between the irrational beliefs in the present with the past.

Up until now, with the discussion in Steps 1-3 as well as the Lifestyle Assessment, the therapist more than likely has a fair understanding of the client's general pattern of childhood. CRT does not support psychoanalyzing the client's childhood. However, now is the time to link the client's present irrational thoughts/beliefs to specific events that occurred in childhood. It is important not to stray from pursuing the connection. Once into childhood issues, the client is tempted to take the therapist "around the block" and show him/her (avoiding the repressed material) the neighborhood. The goal of this step is to directly connect a present day irrational thought/behavior to a specific relationship pattern and events in the past.

Appendix F is an example of how to apply Step 4 techniques. This is a verbatim transcript of a one hours session with the client in the case study. There are some important factors to point out. First, notice how irrational present day beliefs are attached to numerous emotional relational justifications that support them. In session, the therapist (the author) ignores the tangential justifications and constantly brings the client back to the feeling underlying the issue. To complete Step 4, one cannot get lost in the tangential justifications, you may be inadvertently supporting the irrational belief. This can be annoying if trust and confidence is not present in the relationship. Second, the therapist avoids linking the pattern to the client's childhood until the issue or conflict is focused and as understood as possible. This is because if the issue is not focused, the examples found in childhood will be too general. The therapist will get lost there also.

Once the therapist and client find the connection, the connection, the "ah ha", it is time for Step 4.

Step 5 - Determine the interface between schema and limbic patterns

Once Step 4 is complete the client and therapist have a specific issue to begin work on this step. In the case study in this report, the client (Attachment E) had discovered a role she played in childhood was being played out in adult relationships. In effect, the lawyers in her firm had replaced her sisters in keeping the old patterns alive. But, this is not at all close to the interface. If you look at Appendix B, the subject in the case study clearly showed attachment issues centering around "Failure", "Entitlement", and "Unrelenting Standards". The task in Step 5 is to follow these back to, more than likely, "Mistrust" and eventually to "Vulnerability to Error." It is in this tracing that the interface will be found.

Tracing in this step is supplemented with homework. The client will be asked to observe situations documented in Step 4. In the case study, the subject will carefully observe the feeling that immediately precede the feelings of frustration and anger. The therapist would then work the current feelings in with an exploration of childhood feelings much like Step 4. Once this feeling had been pursued as far as possible, the therapist would then use such techniques as Narrative Therapy to name the feeling, externalize it, become very familiar with and begin preparation of attaching new behavior to it. As in the Beautiful Mind, the client would not be asked to try to get rid of it. The feelings may dissipate over time, but surrendering to them is a much better way to begin change than to try to control them. This brings us to the next step.

Step 6 - Identify family roles and adult roles and their connections

CRT avoids trying to coach new behaviors on old feelings without developing a context. The process now lets the client observe his/her reaction to the issue discussed in Step 5. More

than likely, the client will unilaterally barrage the therapist with new insights. In this Step, the therapist discusses the role the client played in the original family and where and how these are still playing in adult life. The Anxiety Map is completed to help identify areas. The focus of this step is not to do family maps and delve into the complexities of role theory. It is intended to identify specific areas for the client to work on. Many of the techniques used by Gestalt therapists will be useful in this step.

It is recognized that if the client has too many issues like the ones described in Step 4, the therapist may have to repeat Step 4 on another issue to provide room for the work on context.

Step 7 - Establish a new personal role or context to support change

This step can almost be viewed as a mini-identity formation. The client visits values, wants, and needs, addresses irrational values and beliefs, and, most importantly, establishes differentiated values--a personal mission statement. . This is constructivist narrative therapy.

The purpose of this step is to define a new personal context--identity--so that the chosen new behaviors can fit the new context. Many techniques in Existential theory would also be useful in this step.

Step 8 - Re-write the cognitive/behavioral patterns in the present

Now that the client has a somewhat clear vision, or context, the therapist begins to use the many behavioral therapy techniques to begin to rewrite the thoughts and behaviors discovered during therapy and with the Anxiety Map. This is the fine-tuning of cognitive/behavioral therapy.

Step 9 - Develop/encourage life goals based on the new role and CB patterns.

This step is the transition to the termination of therapy. It is simply a ceremony that works with the client to establish short-term and longer-term goals.

The Case Study

The case study used in this report is a middle-aged female professional. She has a satisfying marriage. This is her second. She has one child who is married. She is in excellent health. She works in a law firm as a paralegal. She wishes to remain anonymous. Her name is presented as Joan.

Joan's presenting problem was extreme difficulty at work with relationships with lawyers. She complained that she had too much work to do to complete it in a professional manner and the attorneys would not cooperate with her to meet deadlines. Her conflict was that if she got the work done, it would result in severe costs to her health due to overtime or the work would not get done and she would be blamed for the problem. She vacillated between working hard and becoming passive aggressive in avoiding demands to attempt to solve the problem.

The first technique with Joan was administering the Adlerian Therapy Lifestyle Assessment survey. The summary is Attachment C. This highlighted Joan's bias toward intelligence, achievement, and perfection as strong character traits. Also standing out was Joan's role as taking care of everyone in the family and never getting credit. As noted in the Lifestyle Assessment, it was clear at this stage that motivation, rather than behavior change would be suit Joan's style. She would be a great candidate for first establishing goals with their inherent benefits as a context to work on behavior change.

The next technique with Joan was the Gestalt empty chair technique. This was moderately successful with Joan. She did not like Gestaltian techniques, but completed the exercise. She was able to see her conflict more clearly. The personalization of the roles did help her see the distinctions much better. There were no insights however. One important observation was noticed during the exercise. When she was the hard worker, her posture was

upright and stiff with knees together. When she took the other chair as the person who cared about her health and taking care of herself, her posture was very relaxed and cross legged. This was pointed out to Joan.

The next techniques was Albert Ellis's REBT. While it was easy for Joan to identify irrational beliefs, she became very irritated at attempting to develop replacement beliefs. I sensed she wanted to talk more about the irrational beliefs and the attempt to discover disputes and replacements did not work. We did come up with replacement beliefs, but they did not take with Joan. This experience led me to suggest in CRT completing these techniques after there has been some kind of epiphany with regard to the presenting symptom.

Joan also completed the Solution-Based Therapy WDEP form. Although wants, doing, etc. were identified, this also was not productive. Joan responded mechanically to the exercise. After this technique, it was clear that Joan needed to get to the bottom of her symptom before any progress at all was possible. She needed the insight to motivate her to meaningful change.

Joan was also given Jeffrey E. Young's Schema Questionnaire. Joan's results were scores above 90 percent of possible points in three categories: "Unrelenting Standards", "Entitlement", and "Mistrust/Abuse". The results confirmed the Lifestyle Assessment and provided a roadmap to following irrational beliefs and schema back to attachment patterns. This was very helpful. Secondary high scores were in "Subjugation" and "Self-Sacrifice."

The final session (with respect to this report) with Joan was an hour-long session to trace current issues back to the original family patterns. This worked wonderfully and Joan loved doing it. It was very rewarding and the feedback was encouraging. She had tremendous insights as a result as can be seen in Appendix E.

As predicted, Joan, after the session, was automatically identifying prelude behavior to frustration and automatically searching for replacement behavior. This result led to the conclusion that you must follow the motivation of the client. Now is the time that Joan would benefit from the second part of Cognitive/Behavior techniques. They should never be used to identify and clarify symptoms with clients with Joan's personality.

Conclusion

The most important element of CRT is that it is based on Rogerian/Existential/Relational context and uses all the techniques of several disciplines as tools to create change. The techniques are not ends in themselves. The techniques do not define CRT. CRT is founded on the principle that people author their own stories and because they possess all that they need, they can identify a new context and re-write any story.

As one can see with the steps, CRT does not believe anyone is "sick" or has problems, per se. They are not their problems. The client is a noun, their problems verbs. There is nothing wrong with the noun, that doesn't need to be changed. This belief, I feel, creates a very positive therapeutic context for change.

On a personal note, much of this theory is based on 30 years of hands-on experience regulating and changing "sick" organizations. I have found (the hard way) that organizations become worse when leaders concentrate on the problems. They get much worse when someone assumes that the issues are a result of employees not doing the right thing. The minute the focus is on changing behavior, the staff freeze up and the problems get worse. All positive organizational change starts with the clear understanding that there is nothing wrong with the staff, the context is wrong. All you have to do is change the context and the behavior follows. I can't go into the details, but I have personally watched two organizations of over 100 staff that

both have been "dysfunction" for longer than ten years, explode with creative change in less than a year. I personally believe very strongly that the same applies to the therapeutic context. I absolutely believe that a therapist who can walk into the room for the first time with a new client and truly see a wonderful person loaded with potential creative energy is sure to witness the same explosive creative change. The structure, steps, and context of CRT reflect that belief.

References

- Bateson, Gregory, (1979). *Mind and Nature, A Necessary Unity*, New York: Bantam.
- Bowlby, John, (1969/1982). *Attachment*, New York: Basic Books.
- Bromberg, Philip M., (1998). *Standing in Spaces*. Hillsdale, New Jersey: The Analytic Press.
- Cooper, Lynne M, Shaver, Phillip R., Collins, Nancy L., (1998). Attachment Styles, Emotion Regulation, and Adjustment in Adolescence. *Journal of Personality and Social Psychology*, 74, 1380-1397.
- Kohut, H. (1977). *The Restoration of the Self*. New York: International Universities Press.
- Lopez, Frederick G., Brennan, Kelly A., (2000). Dynamic Processes Underlying Adult Attachment Organization: Toward an Attachment Theoretical Perspective on the healthy and Effective Self. *Journal of Counseling Psychology*, 47, 283-300.
- Mitchell, Stephen A., (2000). *Relationality From Attachment to Intersubjectivity*. Hillsdale, N.J.: The Analytic Press.
- Piaget, Jean, (1954). *The Construction of Reality in the Child*. New York: Basic Books.
- Schore, Allan R., (1994). *Affect Regulation and the Origin of the Self*, Hillsdale, New Jersey: Lawrence Erlbaum Associates, Inc.
- Tulkin, S.R., & Kagan, J. (1972). Mother-infant Interaction in the First Year of Life. *Child Development*, 43, 31-42.
- Young, Jeffrey E., (1990). *Cognitive Therapy for Personality Disorders: A Schema-Focused Approach*. Sarasota, Florida: Professional Resource.