Rethinking the relationship between attachment and personality disorder

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Abstract

Attachment approaches have played a crucial role in furthering our understanding of individuals with personality disorders (PDs) and their treatment. Yet, recent years have witnessed the emergence of a number of findings that urge us to reconsider the role of attachment in PDs. Besides the overlap between conceptualizations of attachment and core features of PD, there is increasing evidence that the link between childrearing environments, including attachment contexts, and later outcomes is less substantial than often assumed. Here, we summarize these findings and propose a novel approach to the role of attachment in PDs by situating attachment within a broader socio-communicative approach to PDs. This approach involves a reconceptualizing of attachment as an adaptation strategy to a given environment, with attachment contexts being only one, albeit important, context to learn about the social environment. Evidence for these assumptions is reviewed, and clinical implications discussed.

Introduction

Attachment approaches have played a seminal role in both our theoretical understanding and in the treatment of individuals with personality disorder; particularly those with antisocial and borderline level of functioning [1-4]. Attachment theory has been of great importance in helping us to understand some of the key features of individuals with PD, and particularly their often severe problems in relating to others, including mental health professionals. Interpersonal problems typical of individuals with PD often fit unerringly and eerily well with descriptions of insecure patterns of attachment. Consistent with these assumptions, studies have shown the high prevalence of preoccupied and disorganized attachment (characterized by marked oscillation between hyperactivating and deactivating attachment strategies exaggerating and minimizing need respectively) in individuals with BPD [5-7]. Other studies have provided evidence for the excessive use of attachment deactivating strategies in higher functioning individuals with PD [8]. Furthermore, attachment approaches have played a major role in the development of several effective interventions for individuals with PD [9-11].

Yet, recent years have pointed to important limitations related to core assumptions of attachment theory. In this paper, we first briefly review these challenges and their relevance for our thinking about the nature and treatment of PD. Next, we discuss how these newly emerging research findings have led to a major reformulation of our thinking about the ways in which atypical parenting and attachment disruptions in particular are implicated in the development of PDs [12,13].

Challenges to traditional attachment theory

Over the past decades, a number of research findings have called basic assumptions of attachment theory into question. Current challenges to attachment theory are at least six-fold.

First, the relationship between attachment in childhood and developmental outcomes in adulthood is less strong than may be expected based on key assumptions of attachment theory. Associations between childhood attachment and psychopathology and socio-developmental outcomes more generally in later life typically are not that strong and typically represent only small effect sizes [14-16].

Second, meta-analyses suggest that the stability of attachment from childhood to adulthood is equally modest, typically hovering around *r*=.40 [17,18]. If early attachment experiences lay the foundation for relatively stable internal working models of self and others, a core assumption of attachment approaches, greater stability over time and larger associations with later developmental outcomes are expected. Moreover, importantly, risk status (eg abuse, family instability) has been associated with *less* stability in security of attachment, which again seems to contradict an important assumption of traditional attachment theory. Attachment approaches characteristically assume that insecure attachment contexts lead to more rigid and thus les flexible use of attachment strategies, and thus greater stability of attachment over time. The opposite seems to be true. Although in adolescence and in adulthood, the stability of attachment appears to increase (with r's ranging from r=.54 to r=.72) [17,19], this effect seems to be largely due to the greater stability of the environment as demonstrated by simulation studies [20]. Without stability of the context, attachment style becomes highly unstable over time.

Third, research is increasingly pointing to the importance of broader historical, socio-cultural and environmental factors in determining the role and function of attachment. Bowlby [21] considered attachment an innate behavioural system that serves to seek proximity to

attachment figures in response to threat, thus enhancing survival. This response is assumed to be universal. Yet, historical research has shown that attachment should also be considered to be a contextual response [22, p.540,see also 23,24]. For example, mothers living in highly deprived areas seem to invest little in their new-born babies, but once they are ascertained that their child may survive under these harsh conditions, they become protective and loving parents [25]. Hence, these findings are consistent with the research findings cited above, suggesting that stability of attachment, or the lack thereof, is highly contingent on stability of the context. From this perspective, attachment is best seen not as a stable characteristic of the individual but as an adaptation strategy to a particular environment at a particular moment in time, a notion to which we will return in more detail below.

A fourth challenge to traditional attachment theory relates to research findings suggesting that some of the presumed key psychological mechanisms involved in the intergenerational transmission of attachment, such as parental sensitivity and parental reflective functioning, only explain a small proportion of the variance in the transmission of attachment across the generations [26,27]. Other mechanisms, including biological ones, may thus be involved in the intergenerational transmission of attachment.

This also brings us to a fifth challenge to attachment theory, as it traditionally placed great emphasis on the early caregiving environment in the development of attachment-related internal working models. Yet, particularly from adolescence onwards, genetic factors may play an important role in explaining individual differences in attachment [28,29].

Finally, as noted, attachment theory has always been thought of as being particularly relevant to our understanding of process and outcome in psychotherapy. A recent meta-analysis of 36 studies (n=3,158 patients) indeed found that patients with secure attachment showed better outcomes in psychotherapy than those with insecure attachment, yet the estimated effect

size, once again, was relatively small (Cohen's *d*=.35) [30]. Moreover, when controlling for pre-treatment levels of outcome measures, this effect disappeared. Furthermore, there was only a small association between changes in attachment during psychotherapy and better outcome (Cohen's *d*=.32), and such an association was only found for symptoms, but not for personality or general functioning. Attachment also did not predict drop out from psychotherapy.

All is not lost

Finding reviewed above may lead us to question the central role of attachment in our understanding of individuals with PD and perhaps in psychological development altogether. We believe, based on our current knowledge of psychological development, that a more appropriate response to these findings is one that involves a re-evaluation of the role of attachment in normal and disrupted psychological development, leading to a more nuanced understanding of the role of attachment in relation to atypical caregiving contexts [4].

To begin with, we should not overlook the fact that our current methods to assess attachment are far from perfect. If we consider for a moment the SSP, often considered to be the gold standard to measure attachment in early childhood, there are many assumptions underlying this and similar assessment methods. For instance, in the SSP, attachment is typically determined based on interaction between the infant and one caregiver, often the mother, but we have already seen that attachment may be relationship-specific and highly context-specific. Also, the SSP typically leads to a categorical classification of infant attachment, whilst attachment has been shown to be dimensionally distributed [31].

Moreover, studies have convincingly demonstrated the often powerful role that disruptions in attachment relationships may play in the development and course of PD, as well as in the current relationships of individuals with PD, including those with mental health

professionals [4,32,33]. Clinicians are all too familiar with the often very intense nature of attachment relationships typical of individuals with PD.

Finally, findings concerning averages based on studies in the population may overshadow important associations in subgroups of individuals within the broader population. For instance, population-representative studies have demonstrated large and consistent effects of early adverse conditions, and particularly those involving attachment trauma and early caregiving contexts characterized by insecurity of attachment more generally, and a wide array of (mental) health outcomes across the life span [34,35]. Such prospective associations have also been demonstrated in those with PD [36,37].

How then can we explain these paradoxical findings of both limited and strong evidence for an association between early attachment experiences and later psychological functioning? In the next section, we summarize recent theoretical developments that suggest that both sets of findings can be reconciled within a broader, social-communicative approach to psychological development and the development of PD in particular. We also discuss emerging empirical evidence supporting these views.

A new perspective on the role of attachment in PD

As noted, there is now increasing consensus that attachment is best seen as an adaptation strategy to a given environment [38]. Avoidant attachment is best seen as representing an adaptation to an environment in which greater self-reliance and detachment from others might be an advantage, whilst preoccupied and disorganized attachment might be the most 'effective' attachment style in unpredictable and/or inconsistent social environments [39].

Furthermore, in the context of our rethinking of the role of attachment in PD, we suggest that attachment constitutes an important component of learning about the social environment

for the infant, but only one component among many others [13,40]. Specifically, we argue that the attachment strategy of primary caregivers functions for the infant as an important indicator of the social environment. Yet, other indicators of the social environment are found in other relationships (e.g. with peers and teachers) and in the broader socio-cultural environment. Hence, attachment is only one element of the epistemic complex within which the human infant resides.

The view that attachment as an adaptation strategy is best accommodated in a social-communicative approach to psychological development and PD in particular, that centrally emphasizes the role of epistemic trust and salutogenesis in human development and the development of PD in particular. Epistemic trust refers to an evolutionary prewired capacity that enables humans to identify knowledge conveyed by others as significant, personally relevant and generalizable to other contexts [13,40]. This capacity allows for complex forms of communication and collaboration and salutogenesis, that is, the capacity to benefit from positive social influences in one's (social) environment [41].

Attachment contexts probably provide the most fertile ground for the development of epistemic trust, particularly in early childhood [13]. In the context of secure attachment relationships, a 'learning mode' is triggered in the child. Particularly when attachment figures have high levels of reflective functioning, they are able to reflect together with their child about the trustworthiness of knowledge conveyed by others, thus also fostering their child's capacity to generalize that knowledge to other contexts. Moreover, when such secure attachment figures are available, they provide a secure base to which the child can return whenever it has doubts about the trustworthiness of others or social information more generally. Yet, other contextual factors (peers, the broader family and interpersonal context, and broader sociocultural influences) become increasingly important as the child grows up in determining the epistemic

trustworthiness of others [42]. These views are consistent with the bulk of evidence suggesting that broader contextual factors (e.g. peer victimization, social inequality) determine the course of PD (and psychological functioning more generally) [40]. Biological factors such as effortful control or impulsivity may also play an important role in fostering or compromising the development of epistemic trust.

Whereas in the past we largely attributed PD to features in the individual, consistent with the bulk of personality theories [36], we now see PD as a disorder of social communication, as PDs seem to describe the type of interactions the individual with so-called PD features has with others and their social context more generally. Pervasive mistrust of others and epistemic hypervigilance, for instance, represent a reasonable and understandable adaptation to severe childhood adversity. Hence, the PD is in the eye of the beholder, as is the perception that individuals with PD are 'hard-to-reach" or "difficult-to-treat".

This view has also led us to consider attachment not as something that resides in the individual, but rather as something that refers to the type of interaction that an individual has with others and their social contexts more generally. The apparent stability of the strategy has been ascribed to personality as the structure which could explain lack of responsiveness to changing environments. It seems equally plausible that the absence of epistemic trust makes individuals with a PD diagnosis 'unwilling' (unable) to change because they do not absorb and internalize information. They do not lack understanding, but they have (because of personal history) disengaged from social communication: they hear you but they are not listening. Insecure attachment is thus not considered to reflect a 'stable' attachment strategy, but as a communicative strategy that underpins social learning to ensure adequate adaptation to changing social situations. For instance, avoidant attachment, characteristic of many individuals with narcissistic personality disorder, reflects an epistemic stance characterized by

mistrust of social communication, which can be considered a reasonable adaptation to childhood emotional neglect. In individuals growing up in an environment marked by abuse and violence, as is the case for many individuals with antisocial personality disorder or BPD, epistemic hypervigilance to others increases chances of survival and thus similarly reflects an understandable adaptation strategy [43].

From an intervention perspective, these views have important implications, as they suggest that the often profound levels of insecure attachment that we observe in patients with PD, may not be as stable as often assumed. If avoidant attachment, for instance, reflects first and foremost the type of relation the individual has developed with a specific environment (which he or she expects to be harsh and neglectful), this strategy will only remain active as long as the individual feels epistemic vigilance is helpful.

These views provide in our opinion a comprehensive explanation for the observed stability of, as well as variability in, attachment. Importantly, it provides an optimistic view of PD as a clinical entity that is not an inevitable consequence of childhood exigencies, but rather a strategy which acquires stability through a disruption to a key biological mechanism of social adaptation: the capacity to discern trustworthy social communication. By this token the dysfunction may be shifted or even overcome if epistemic trust can be reestablished through therapeutic intervention. As psychotherapy is itself an act of social communication, it is not surprising that examples of failures often outnumber successes. Further research is needed as to factors that may limit flexibility and adaptability in attachment strategies. Typical emotional responses associated with attachment strategies may be more deeply ingrained in some individuals than in others, perhaps because they have become deeply embedded in the basic biobehavioral repertoire over time. Also, research findings suggest that early childhood attachment prototypes may function as ‘attractor states’, with individuals gravitating towards these prototypes throughout their lives [44]. These findings may in part explain why some

individuals with PD show a relatively rapid response to psychosocial interventions, while it takes others many years to develop a solid capacity for epistemic trust and salutogenesis [45].

Discussion and Conclusions

Research findings urge us to rethink the nature and role of attachment disruptions in individuals with PD. If attachment reflects a particular adaptation strategy to a given environment, both stability and variability over time and contexts can be expected. This has important implications for research, prevention and intervention in the domain of PD, as in all three areas we need to pay greater attention to the role of the social environment.

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