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Brief Review

Attachment and Personality Disorders

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Personality disorders (PDs) arise from core psychopathology of interpersonal relationships and understanding of self and others.[1] The distorted representations of self and others, as well as unhealthy relationships that characterize persons with various PDs, indicate the possibility that persons with PDs have insecure attachment.

Attachment

John Bowlby postulated that human beings are under pressures of natural selection to evolve behavioural patterns since early in life, such as proximity seeking, smiling, and clinging, that evoke reciprocal caretaking behaviour in adults, such as touching, holding, and soothing.[2-4] These behaviours promote the development of an enduring, emotional tone between infant and caregiver, which constitutes attachment. From these parental responses, the infant develops internal models of the self and others that function as templates for later relationships and beliefs including expectations of acceptance and rejection. A secure attachment should engender a positive, coherent, and consistent self-image combined with a sense of trust on others and a positive expectation of acceptance and response.

The empirical assessment of patterns of attachment behaviours began with Ainsworth and colleagues' typology of infant attachment behaviours toward their mothers when under stress.[5] Under this typology, there were three organizations: secure, avoidant, and ambivalent attachment. The 'avoidant' typology is seen in children whose caregivers are consistently inaccessible or rejecting. These children tend to develop a strategy of minimizing the output of attachment behaviors, and appear to have little need for the attachment figure and show little overt distress, although they are angered and made anxious by rejection. Children of inconsistently available caretakers develop a strategy of maximizing attachment behaviors, because they are fearful of the caregiver's potential inaccessibility. Efforts by the caregiver to soothe these 'ambivalent' children are not always welcomed. In high-risk or psychiatric samples, a fourth behavioural pattern of attachment labelled 'disorganized/disoriented' was described by Main and Solomon.[6] These children have no coherent strategy to respond to separation or reunion. Lyons-Ruth and Jacobvitz distinguished normal processes of separation-individuation in early development from the disorganized conflict behaviours displayed toward attachment figures by toddlers at risk for later psychopathology.[7] They argued that these toddlers are never able to integrate positive and negative aspects of self and object representations and to internalize images of mother for object constancy.

Although Bowlby was primarily interested in young children, he maintained that the core functions of the attachment system continue throughout the life span. Longitudinal studies have reported a remarkable stability of attachment classification although this stability is open to revision by later life experiences.[8-10] The adult strategies of attachment parallel to infant strategies were described by Main and Goldwyn.[11] Flexible and coherent discourse

around both positive and negative attachment experiences was termed autonomous (the equivalent of secure in childhood); deactivating strategies were termed dismissing (the equivalent of avoidant); and hyperactivating strategies were termed preoccupied (the equivalent of ambivalent). The disorganized attachment behaviours of infants was paralleled by a fourth category of adult attachment behaviour labelled unresolved (with respect to loss or trauma). Unresolved attachment patterns are also given a secondary sub-classification (namely, unresolved/autonomous, unresolved/dismissing, or unresolved/preoccupied) that indicates which organized attachment classification is the best-fitting alternative classification. Bartholomew and Horowitz defined secure/autonomous individuals as having a positive model of self and a positive model of others.[12] They defined two sub-types of avoidant attachment style - fearful (avoidant attachment style described by Hazan and Shaver),[13] and dismissing (avoidant attachment style described by Main, Kaplan, & Cassidy),[14] besides the anxious/preoccupied attachment style. Individuals with anxious/ambivalent or preoccupied attachment styles were defined as having a negative model of self, combined with a positive model of others. Individuals with fearful attachment style were viewed as having a negative model of self with a negative model of others, and those with dismissing attachment style as having a positive model of self with a negative model of others. According to them, fearful avoidants scored lower in self-esteem compared to dismissing avoidants. In addition, based on self- and peer reports, dismissing individuals appeared "cold," and were described as "competitive," "autocratic," and "introverted." Fearful avoidants, in contrast, appeared "submissive," and were described by themselves and peers as "sub-assertive," "introverted," and "exploitable." In a sample of 277 college students aged 18-21years from Bangalore, Narayanan et al found that secure individuals had greater scores on extraversion, friendliness, sociability and openness to new experiences dimensions. Preoccupied participants had higher scores on neuroticism and lower scores on openness to new experiences dimensions. The fearful group had higher scores on performance anxiety and lower scores on sociability dimensions while, the dismissive group had low scores on both performance anxiety and sociability dimensions.

Theoretically, environmental threats should provoke withdrawal, freezing, or escape behavior. In a well-functioning goal-corrected partnership between child and parent, such escape usually entails escaping to an attachment figure. Distress may result from either perceived threats from the environment or perceived lack of support from one's caregivers.[16] According to Bowlby, the combination of both, experienced often enough throughout the course of development is likely to produce the most acute forms of psychopathology. A growing body of research indicates that attachment provides a diathesis for various forms of psychopathology in adulthood.[17-20] Insecure attachment in adults may also have negative consequences[21].

Attachment and evolving personality disorder in adolescence

Adolescents are also affected by attachment problems.[22,23] Allen et al examined two distinct roles (direct predictor, moderator) of attachment organization in 117 moderately at-risk adolescents at ages 16 and 18, in relation to developing social skills and delinquency.[24] Adolescent attachment security predicted relative increases in social skills from age 16 to 18 whereas an insecure–preoccupied attachment organization predicted increasing delinquency during this period especially with highly autonomous mothers. Insecure adolescents were more likely to misperceive or defensively exclude information about attachment experiences. This may lead to distorted judgments and negative expectations about others, that may lead to problems in social functioning. For insecure dismissing adolescents, delinquency may result

from rejection of the norms of attachment figures (i.e., parents) and of their efforts at behavioral control, given their tendency to minimize the importance of attachment relationships.[23] For insecure-preoccupied adolescents who are unsettled by autonomy within the parent–teen relationship, delinquent behavior may both express their anxiety and frustration and also serve as an attempt, albeit dysfunctional, to maintain the intensity of the parent–teen bond.[25]

In a small study on hospitalized adolescents with psychiatric disorders (n=60), Rosenstein and Horowitz found that adolescents classified as dismissing were at elevated risk for narcissistic and antisocial PDs (as well as conduct disorder and substance use).[26] Those showing a preoccupied attachment organization were more likely to have an obsessive-compulsive, histrionic, borderline or schizotypal PD. Nakash-Eisikovits et al asked 294 randomly selected psychiatrists and psychologists to provide data in relation to attachment and personality on an adolescent patient (aged 14–18 years) in treatment for maladaptive personality patterns.[27] Secure attachment was negatively correlated with every PD. Conversely, disorganized/unresolved attachment was positively correlated with every PD except for antisocial and histrionic PDs, and was most strongly correlated with avoidant and borderline PDs. Avoidant attachment was most strongly associated with Axis II cluster A PDs (paranoid, schizoid, and schizotypal), which are characterized by social withdrawal and nonconsensual reactions. Notably, avoidant attachment was not associated with avoidant PD, which includes criteria specifying that the person consciously wishes for more contact with people but fears and hence avoids it. Anxious/ambivalent attachment was associated with PDs characterized by neediness and dependency in relationships, including borderline, histrionic, and dependent PD and with measures of withdrawal and internalizing symptoms.

The association between attachment and personality styles in adolescence suggests a role for the attachment styles (which stabilize earlier) in the development of PDs.

Attachment and personality disorders in adults

All PDs

A study by Brennan and Shaver on a non clinical sample of 1407 individuals (mostly adolescents and young adults) showed that individuals with fearful and preoccupied attachment style were three to four times as likely to have at least one DSM-III PD in comparison to those with secure attachment style.[16] Principal component analyses of attachment and personality disorder variables showed that the first attachment-related factor could be conceptualized as ‘insecurity’ (distinguishing secure versus fearful attachment style) and the second attachment-related factor as ‘defensive emotional style’ (distinguishing dismissing versus preoccupied attachment style). The first personality-disorder factor, named ‘general pathology,’ consisting of 6 of the 13 PD scales (avoidant, schizotypal, paranoid, self-defeating, obsessive-compulsive, and borderline), was similar to the first attachment factor. The second personality-disorder factor (named counter-dependence) consisting of 3 personality-disorder scales (schizoid, histrionic, and dependent) was similar to the second attachment factor. Four remaining personality-disorder scales (antisocial, sadistic, passive-aggressive, and narcissistic) formed a third factor (named psychopathy), which was modestly correlated with the first attachment factor, but not with the second. On discriminant function analysis, the fearful group appeared the most troubled, scoring highest on variables that correlated with PDs involving some sort of distortion of reality and negativity about others (paranoid, schizotypal, avoidant, self-defeating, borderline, narcissistic, and obsessive-compulsive). The preoccupied and dismissing groups appeared to suffer from diametrically opposed personality problems as evidenced by the pattern of scores on the second function,

which was about dependent and histrionic versus schizoid personality characteristics. The third personality-disorder function (passive-aggressive, sadistic, and antisocial) accounted for negligible variance among attachment categories.

Pilkonis tried to define attachment styles in relation to various PDs after reviewing 88 descriptors of excessively autonomous and excessively dependent individuals from clinical literature.[28] He labelled excessive autonomy or avoidant attachment as a) defensive separation, b) lack of interpersonal sensitivity or anti-social features, c) obsessive-compulsive features. For excessive pre-occupation or anxious attachment, two subtypes emerged: a) excessive dependency, and b) borderline features. A prototype labelled compulsive care-giving (as another facet for preoccupation) was later added. A prototype for secure attachment, labelled distinguished was also included.[29] Plikonis' prototype methodology was used by Meyer et al to assess seven styles of secure and insecure attachment in 149 patients shortly after they entered treatment for non-psychotic Axis I disorders and again at 6 and 12 months.[30] As hypothesised, secure attachment correlated inversely with each PD scale. The excessive dependency prototype correlated strongly with dependent PD and moderately with avoidant and histrionic PDs. There was also robust correlation between borderline, obsessive-compulsive and emotional detachment or antisocial prototypes and their corresponding PDs. Compulsive care-giving tended to be unrelated to PD scales. The above mentioned inter-correlations were maintained at 6 and 12 months.

Some studies have failed to show any significant pattern of relationship between attachment and PDs. Fossati and colleagues compared 44 subjects with borderline PD to two other PD groups (98 subjects with cluster B [other than borderline] PDs and 39 subjects with mixed cluster A and C PDs) and to two groups with no PD (70 mentally ill subjects and 206 not ill community members) and found that both the borderline PD and other PD groups exhibited insecure attachment but they did not differ significantly on any of the attachment style dimension scores. The non-PD groups exhibited secure attachment.[31]

The above mentioned studies suggest that attachment difficulties continue to influence personality (mal)adjustment in adulthood. Broadly, Cluster 'A' personality disorders are associated with dismissing avoidant and fearful avoidant attachment pattern, while Cluster 'B' personality disorders are associated with preoccupied and dismissing avoidant pattern.

Specific PDs

Schizoid PD: It is hypothesized that the apparent lack of concern of schizoid individuals springs from considerable confusion about and deep longing for relatedness. Meyer et al state that schizoid individuals emotional needs were not adequately met by others in childhood and so they try to be self-sufficient to avoid pain of further rejections.[32] An association between the schizoid diagnosis and the attachment-related dimension of 'compulsive self-reliance,' which is most closely associated with dismissing avoidance has also been reported.[33] On the other hand, individuals of the dismissing avoidant type describe themselves as "unsociable" and appear to derogate the importance of close relationships they are descriptively similar to schizoid persons. Both dismissing and schizoid individuals are likely to stress self-sufficiency and downplay attachment needs.[16]

Borderline PD: Individuals with borderline PD demonstrate a diminished capacity to form representations of their caretgivers' inner thoughts and feelings and that of self. According to Fonagy and co workers this accounts for many core symptoms of borderline PD, including an unstable sense of self, impulsivity, and chronic feelings of emptiness.[34] Several clinical theorists have posited intolerance of aloneness as a defining characteristic of borderline PD. Gunderson has suggested that this intolerance reflects early attachment failures, noting that descriptions of certain insecure patterns of attachment - specifically,

pleas for attention and help, clinging, and checking for proximity that often alternate with a denial of, and fearfulness about, dependency needs - closely parallel the behaviour of borderline patients.[35] In a review of 13 studies on attachment and borderline PD, Agrawal et al concluded that there was a strong association between insecure forms of attachment and borderline PD.[36] Borderline PD attachments seemed best characterized as unresolved with preoccupied (ambivalent) features in relation to their parents and fearful or, secondarily, preoccupied (ambivalent) in their romantic relationships. Preoccupied (or ambivalent) attachment is close to what Meyer and colleagues defined as the prototypic borderline form of attachment - that is, "ambivalent and erratic feelings in close relationships."[30] The characterization as fearful also entails a longing for intimacy, but fearful individuals are concerned about rejection rather than excessive dependence. Levy and colleagues showed that individuals with preoccupied pattern demonstrated more concern and behavioural reaction to real or imagined abandonment, whereas the avoidant group had higher ratings of inappropriate anger.[37] The fearfully preoccupied group had higher ratings on identity disturbance, although only at the trend level. Aaronson et al found that patients with borderline PD were more likely to exhibit (vacillate between) angry withdrawal and compulsive care-seeking.[38] Patients with borderline PD also scored higher on the dimensions of lack of availability of the attachment figure, feared loss of the attachment figure, lack of use of the attachment figure, and separation protest. Other studies have demonstrated similar findings.[39,40]

Narcissistic and Antisocial PD: It is postulated that the primary caregiver of narcissistic and antisocial individuals is unable to empathize in response to child's needs of mirroring and twinship experiences.[41] The child then grows up treating others as though they exist only to gratify his/her narcissistic needs. The dismissing attachment style has been shown to be associated with narcissistic and antisocial PD and preoccupied attachment style with delinquency.[18] However, some studies failed to find any specific association between attachment styles and either of these PDs.[16,27]

Anxious-avoidant and Dependent PD: Those with avoidant PD, like fearful avoidant individuals, appear to desire closeness with others but fear rejection.[34,42] As a consequence, these individuals are likely to avoid the very social interaction that would mitigate their loneliness. Research with adults has found a relationship between avoidant and dependent PDs and preoccupied attachment.[33,43] Brennan and Shaver have suggested that individuals with dependent PD and anxious-Avoidant PD could be differentiated by the correlation of preoccupied attachment with the former and fearful avoidant attachment with the latter.[16]

Obsessive compulsive PD: Brennan and Shaver reported obsessive compulsive PD to be associated with fearful attachment.[16] While, Aronson et al didn't find any significant difference in specific attachment styles scores in obsessive compulsive PD and borderline PD groups. They hypothesized that the self-doubt commonly seen in such individuals is the consequence of absence of reciprocity from their parents during their childhood.[38]

Influence of attachment on psychotherapy of personality disorders

Attachment may affect the outcome of PDs due to its influence on adherence to psychotherapies. Levy suggested that individuals with an avoidant attachment pattern may be at risk for dropping out of treatment because they are not fully committed or attached with the therapist or may perceive that psychotherapy emotionally unravels them.[44] In contrast, individuals with preoccupied attachment may dropout of treatment after perceived abandonment such as emergency cancellations, scheduled vacations, and or even while

waiting for phone calls to be returned. The fearfully preoccupied may be prone to dropout in response to feeling connected, attached, or dependent on the therapist and treatment.

Fonagy et al compared the effectiveness of intensive and non intensive psychoanalytic treatment for severely personality disordered young adults and found attachment styles to be useful in identifying those who dropped out of treatment early.[34] Although the sample size was small, all the patients who prematurely dropped out of treatment were from the preoccupied/enmeshed group. They also noted that individuals rated as dismissing were more likely (93%) to show clinically significant improvements on the Global Assessment of Functioning scale. In contrast, 43% of the preoccupied and 33% of secure subjects showed significant clinical improvement. In contrast, Meyer et al found greater positive changes in functioning and symptoms (anxiety, depression) in individuals with secure prototype.[30]

Bradley et al reported that various dimensions of transference were correlated with adult attachment styles and PD clusters.[41] The cluster A (odd/eccentric) disorders was associated with the avoidant/counterdependent factor; the cluster B (dramatic/erratic) disorders with the angry/entitled and sexualised factors; and the cluster C disorders (anxious/fearful) with anxious/preoccupied transference. These findings suggest that the therapy relationship, as an intimate, emotionally charged, asymmetrical and typically nurturing relationship, is likely to activate many attachment-related patterns of thought, feeling and behaviour, linked with the involved PDs.

Conclusions

Based on the above review, it can be suggested that patterns of insecure attachment overlap with patterns of disordered personality, many of which are moderately related to each other. Insecure attachments in infancy and childhood may serve as markers of risk for development of PD. This group of children and adolescents may require special attention and intervention. There is obviously a need for prospective studies regarding the role of attachment style in personality evolution, especially in disorders other than borderline personality disorder. Evidence of differential response to treatment by patients with various attachment styles, emphasizes the need for research to provide guidance on engaging patients in the therapeutic process.

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