Attachment Theory in Adult Mental Health

A GUIDE TO CLINICAL PRACTICE

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Chapter 7

Attachment theory and personality disorders

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Introduction

Bowlby (1977) contended that internal working models of attachment help explain 'the many forms of emotional distress and personality disturbances, including anxiety, anger, depression, and emotional detachment, to which unwilling separations and loss give rise' (p. 201). Bowlby postulated that insecure attachment lies at the centre of disordered personality traits, and he tied the overt expression of felt insecurity to specific characterological disorders. Given that personality disorders are highly prevalent, chronic and debilitating to those who suffer from them, it is imperative to identify etiological factors contributing to the development and maintenance of these disorders. As will be discussed, attachment theory and research provide a comprehensive framework within which personality pathology can be understood. In this chapter we will review the empirical literature on attachment theory, with a focus on assessment and intervention for personality disorders (PDs). Further, we will demonstrate the clinical utility of attachment theory and research for conceptualising personality pathology.

Theory and assessment of attachment

Bowlby (1977) held that childhood attachment underlies the 'later capacity to make affectional bonds as well as a whole range of adult dysfunctions' including 'marital problems and trouble with children, as well as . . . neurotic symptoms and personality disorders' (p. 206). Thus Bowlby (1973, 1982) postulated that early attachment experiences have long-lasting effects that persist across the lifespan, are among the major determinants of personality organisation, and have specific clinical relevance. Longitudinal studies have confirmed the predictability of later functioning and adaptation from infant attachment styles, with considerable, although variable, stability of attachment classification from infancy to adulthood (Hamilton 2000; Waters *et al.* 2000; Weinfield, Sroufe, and Egeland 2000), which is dependent on intervening experiences in relationships (Fraley 2002; Grossmann, Grossmann and Waters 2005; Lewis, Feiring and Rosenthal 2000; Waters *et al.* 2000).

From the seminal work of Bowlby, attachment theory and research have evolved into two traditions (interview and self-report), each with its own methodology for assessing attachment patterns.

Interview

Main and her colleagues developed the Adult Attachment Interview (AAI: George, Kaplan and Main 1985), which evaluates the interviewee's conception of how early attachment relationships have influenced adult personality by probing for specific memories that both corroborate and contradict how the attachment history has been conceptualised. Secure attachment on the AAI is characterised by a well-organised, undefended discourse style in which emotions are freely expressed, and by a high degree of coherence exhibited in the discussion of attachment relationships, regardless of how positively or negatively these experiences are portrayed. These individuals maintain a balanced and realistic-seeming view of early relationships, value attachment relationships, and view attachment-related experiences as influential to their development.

In contrast, dismissive attachment is characterised by a devaluation of the importance of attachment relationships on the AAI, or relationships are portrayed in an idealised fashion with few corroborating examples. These individuals are judged to have low 'coherence of mind' because of the vagueness and sparseness of their descriptions, as well as the inconsistency between the vaguely positive generalisations and 'leaked' evidence to the contrary. Preoccupied attachment is characterised by parental relationships on the AAI described with pervasive anger, passivity and attempts to please parents, even when the relationship is described as positive. These individuals have a tendency towards incoherence in their descriptions, with excessively long, grammatically entangled sentences, reversion to childlike speech, and confusion regarding past and present relationships.

The Unresolved/disorganised classification is assigned when an individual displays lapses in the monitoring of reasoning or discourse when discussing experiences of loss and abuse. These lapses include highly implausible statements regarding the causes and consequences of traumatic attachment-related events, loss of memory for attachment-related traumas, and confusion and silence around discussion of trauma or loss. Cannot Classify is assigned when an individual displays a combination of contradictory or incompatible attachment patterns, or when no single state of mind with respect to attachment is predominant. This occurs when the individual shifts attachment patterns in mid-interview, when the individual demonstrates different attachment patterns with different attachment figures, or when the individual shows a mixture of different attachment patterns within the same transcript or passage.

Self-report

In contrast to Main's focus on relationships with parents, Hazan and Shaver (1987) and colleagues (Shaver, Hazan and Bradshaw 1988), using a social psychological perspective, evaluate romantic love as an attachment process. They translated Ainsworth's descriptions of the three infant attachment types (Ainsworth *et al.* 1978) into a single-item, vignette-based measure in which individuals

characterised themselves as secure, avoidant, or anxious-ambivalent in romantic relationships. In subsequent research, Bartholomew (1990, 1994) and Bartholomew and Horowitz (1991) developed a four-category classification of adult attachment that corresponds to a two-dimensional model of anxiety and avoidance: secure (low anxiety/low avoidance); preoccupied (high anxiety/low avoidance); dismissing-avoidant (low anxiety/high avoidance); and fearful-avoidant (high anxiety/high avoidance). Although categorical comparisons between the AAI and self-report measures have typically failed to correspond with each other (Bartholomew and Shaver 1998; Crowell, Fraley and Shaver 1999), studies that have related the dimensional coding scales from the AAI to the self-report measures have found that they are significantly related, even if the two categorical typologies were not significantly related (Shaver, Belsky and Brennan 2000).

Formulations of personality disorders from an attachment perspective

Bowlby (1973) believed that attachment difficulties increase vulnerability to personality pathology and can help identify the specific types of difficulties that arise. For instance, Bowlby connected anxious ambivalent attachment to 'a tendency to make excessive demands on others and to be anxious and clingy when they are not met', and linked this presentation to that seen with dependent and hysterical personalities. Bowlby also described how avoidant attachment in childhood – postulated to be a product of caretakers' rebuffing a child's bids for comfort or protection – may be related to later diagnoses of narcissistic personality or 'affectionless and psychopathic personalities' (1973: 14). Thus Bowlby postulated that early attachment experiences have long-lasting effects across the lifespan, and these experiences are among the major determinates of personality organisation and pathology.

Further, virtually all PDs are characterised by persistent difficulties in interpersonal relations (Levy 2005). For example, impoverished relationships are a cardinal feature of both schizoid and avoidant PDs. Those with schizoid pathology appear defensively devoid of any interest in human interaction, whereas the avoidant pathology is typically characterised by a simultaneous desire for, and fear of, close relationships (Sheldon and West 1990). Those with borderline personality disorder (BPD) and dependent PD struggle to be alone and are preoccupied by fears of abandonment and the dissolution of close relationships (Gunderson and Lyons-Ruth 2008). Further, intense and stormy relationships are one of the central features of BPD (Clarkin *et al.* 1983; McGlashan 1986; Modestin 1987). Those with dependent pathology appear incapable of functioning without the aid of others (Bornstein and O'Neill 1992; Livesley, Schroeder and Jackson 1990).

Integrating Blatt's (1995) cognitive-developmental psychoanalytic theory with attachment theory, Levy and Blatt proposed that within each attachment pattern, there may exist more and less adaptive forms of dismissing and preoccupied attachment (Blatt and Levy 2003; Levy and Blatt 1999). These developmental

levels are based on the degree of differentiation and integration of representational or working models that underlie attachment patterns.

In terms of PDs, Levy and Blatt (1999) noted that several PDs (i.e. histrionic, dependent, BPD) appear to be focused in different ways, and possibly at different developmental levels, on issues of interpersonal relatedness. They proposed that preoccupied attachment would run along a relatedness continuum from non-personality disordered individuals to those with BPD. Those without PDs would generally value attachment, intimacy and closeness. Those at the next level would be more gregarious and exaggerate their emphasis on relatedness. At another level below are those with a hysterical style, who not only exaggerate closeness and overly value others but may defend against ideas inconsistent with their desires, and more histrionic individuals who are overly dependent and easily show anger in attachment relationships. Finally, at the lowest level of functioning are those with BPD for whom strong desires for closeness and intimacy coupled with strong interpersonal sensitivity lead to the most chaotic and disrupted patterns of relating to others.

In contrast, another set of PDs (i.e. avoidant, obsessive-compulsive, narcissistic, antisocial) appear to express a preoccupation with establishing, preserving and maintaining a sense of self, possibly in different ways and at different developmental levels. Levy and Blatt (1999) proposed that avoidant attachment would run along a self-definitional continuum from non-personality disordered individuals who are striving for personal development, to those who are more obsessive, to those with avoidant PD, to those with narcissistic PD, and finally – at the lowest developmental levels – to those with BPD and antisocial PD. Levy and Blatt (1999) proposed that BPD would be related to both preoccupied and avoidant attachment, which is now backed up by a host of studies (see Levy 2005 for a review).

Association between attachment and personality disorders

Research has largely supported theoretical assertions of an overlap between PDs and insecure attachment. Much attention in the literature has been given to insecure attachment and BPD (see the Liotti chapter in this volume) and to a lesser extent antisocial personality. There is much less data on attachment variables and other PDs, and what is available tends to compare dimensions of self-reported adult romantic attachment to self-reported PD symptoms (see Rosenstein *et al.* 1996). Within that literature, while there has been consistency in finding a negative relationship overall between attachment security and personality pathology (Meyer *et al.* 2001; Meyer and Pilkonis 2005), the relationships between specific PDs and insecure attachment types are less consistent.

Meyer and Pilkonis (2005) evaluated the relationship between adult romantic attachment (using the Experiences in Close Relationships scale) and PD symptoms (using the SCID-II questionnaire) in a sample of 176 college students. Their results indicated that attachment security was associated with an absence of PD features, while a dismissive style was strongly associated with schizoid PD

features. A preoccupied style was associated with histrionic, BPD and dependent PD features; and a fearful style was associated with avoidant PD features. Those with paranoid, obsessive-compulsive, narcissistic and schizotypal features fell between the preoccupied and fearful styles.

Meyer and Pilkonis (2005) report similar data in a clinical sample of 152 inpatients and outpatients diagnosed with DSM-III consensus ratings (Meyer *et al.* 2001). In line with the non-clinical study, dismissive style was associated with schizoid PD diagnosis, a fearful style was associated with avoidant PD diagnosis, and a preoccupied style was strongly associated with histrionic, borderline and dependent PD features. However, those with paranoid, obsessive-compulsive, narcissistic and schizotypal features fell more between the dismissive and fearful styles in the clinical sample.

Levy (1993) examined the relationship between attachment patterns and PDs in a sample of 217 college students using Hazan and Shaver's Adult Attachment Questionnaire (AAQ), Bartholomew's Relationship Questionnaire (RQ) and the Millon Multiaxial Clinical Inventory (MCMI). Attachment security was negatively related to the schizoid, avoidant, schizotypal, passive-aggressive and borderline scales. Dismissive attachment was positively associated with paranoid, antisocial and narcissistic personality scales; fearful avoidance was associated with schizoid, avoidant, and schizotypal scales; and preoccupied attachment was associated with schizotypal, avoidant, dependent and BPD scales.

Alexander (1993) examined the relationship between trauma, attachment and PDs in a sample of 112 adult female incest survivors. She assessed attachment using the RQ and assessed PDs using the MCMI-II (Millon 1992). Only 14 per cent of the sample rated themselves as secure, 13 per cent rated themselves as preoccupied, 16 per cent as dismissing and 58 per cent as fearfully avoidant. Preoccupied attachment was associated with dependent, avoidant, self-defeating and borderline PDs. Fearful avoidance was correlated with avoidant, self-defeating and borderline PDs and high scores on the SCL-90-R. Dismissing individuals reported the least distress, most likely due to their proclivity to suppress negative affect (Kobak and Sceery 1988).

Brennan and Shaver (1998) examined the connections between adult romantic attachment patterns (using the RQ) and PDs (using the Personality Diagnostic Questionnaire) in a non-clinical sample of 1,407 adolescents and young adults. Their results indicated that those rated secure with respect to attachment were half as likely to self-rate having a PD, whereas those rated as fearful were four times more likely, those rated as preoccupied were three times more likely, and those rated as dismissive were 1.3 times more likely to self-rate the presence of a PD. Discriminant function analysis was used to predict attachment dimensions based on PD symptoms. Three functions emerged, which differentially predicted attachment ratings on the basis of PD features. The first function, from secure to fearful, was characterised by paranoid, schizotypal, avoidant, self-defeating, BPD, narcissistic, and obsessive-compulsive PDs on the fearful side of the dimension. The second function, from dismissive to preoccupied, was characterised

by dependent and histrionic PDs on the preoccupied side of the dimension and schizoid PD on the dismissive side of the dimension. Finally, the third function, characterised by passive-aggressive, sadistic and antisocial PDs, did not correspond to attachment dimensions.

Using the AAI, Rosenstein and Horowitz (1996) found in an adolescent inpatient sample that preoccupied attachment was uniquely associated with avoidant PD, whereas dismissing attachment was uniquely associated with narcissistic, antisocial and paranoid PDs. Similarly, van IJzendoorn and colleagues (1997), in a criminal offender group, found that preoccupied attachment tended to be associated with anxiety related personality disorders (cluster C) and that dismissing attachment was associated with antisocial PD. These findings were confirmed in a meta-analysis examining AAI distributions in clinical samples (Bakermans-Kranenburg and van IJzendoorn 2009).

Despite some differences across studies, for the most part, across both interview and self-report measures and various age groups and samples, the findings converge. Both preoccupied and dismissing attachment are associated with BPD. Generally preoccupied attachment is uniquely associated with the anxiety based PDs such as dependent and histrionic PD, whereas dismissing attachment is associated with antisocial, narcissistic and some of the cluster A PDs, in particular schizoid and paranoid PDs. Fearful avoidance has sometimes been associated with cluster A PDs and sometimes with cluster C PDs.

Clinical features of attachment types in personality disorders

Based on the delineation of Levy and Blatt (1999), and refined by the aforementioned research, the clinical characteristics of several PDs will be discussed in terms of their predominant attachment styles. While some disorders have most often been found to correspond to a preoccupied style (i.e. dependent and histrionic PD), a dismissive style (i.e. schizoid and antisocial PD) and a fearful style (i.e. avoidant PD), others have a less distinctive attachment style (i.e. narcissistic and paranoid PD) but are nonetheless notable for characteristic attachment-related features.

Personality pathology with preoccupied styles

Levy and Blatt (1999) note that PDs characterised by the preoccupied style (i.e. histrionic, dependent, BPD) tend to focus in different ways on issues of interpersonal relatedness. Because such individuals often have a negative model of themselves but a positive model of others (Bartholomew 1990), they are likely to look to the therapist to meet needs that they feel unable to address within themselves. Thus preoccupied individuals are often likely to seek treatment (Levy *et al*. 2012). Such individuals are likely to disclose a great deal of information to the therapist, with evocative descriptions of themselves and others that engage the therapist's

attention. However, their discourse often lacks the narrative coherence that would aid in working through the experience or would allow for others to fully join with their experience.

Further, preoccupied individuals with personality pathology are likely to assume that the therapist has more knowledge about them than can be realistically expected, and as a result not explain and contextualise their thinking for the therapist. At best, the therapist may often feel that she is working hard to make links within her own mind between disparate pieces of information, since the patient has not provided such narrative bridges. At worst, the therapist may feel lost in a chaotic, entangled narrative that leads to confusion and frustration. Thus even though the preoccupied patient may eagerly attend and appear to be working very hard in treatment, such work may not translate into a productive dialogue that allows for shifts in the patient's representations of self and others.

Ms. D, diagnosed with histrionic PD, often began her sessions breathlessly reporting an entangled series of events during the week, with little sequence or structure. Narratives were often pressured and organised around her subjective affective experience, with only cursory anchors in objective events, which prohibited the therapist from following the progression that led to a particular feeling. 'What happened on Monday? I was freaking out, that's what happened on Monday. Why? Because it felt like my guts were being torn out, that's why.' Like the therapist, Ms. D would become lost in her own narratives in ways that she too found destabilising, as she would begin to feel herself drowning in the affect with no structure to grasp on to. Further, efforts on the therapist's part to slow her down and fill in some of the gaps in her narrative would be met with frustration. Given that Ms. D's preoccupation was embedded in pervasive anger at the inconsistent care of attachment figures, this style of expression was also understood to reflect a desire for the therapist to be a completely reliable and omniscient attachment figure who could finally fill her deep well of unmet need states. As a result, the therapist would remark, 'You want me to be completely in sync with you, to know what you are thinking without having to say it. This is why it must be so frustrating for you to be seeing what you are in my face – that I am quite lost in this story and too confused to respond in the way you wish I would'. Over time Ms. D became increasingly aware of the relational impact of her preoccupying anger, as well as the function it served in relation to underlying longings for connection.

The work of Dozier and colleagues (2001) suggests a seemingly contradictory stance on the part of the therapist: to remain securely present with the patient while simultaneously maintaining sufficient distance from becoming entangled in the patient's production. This secure detachment allows the therapist sufficient

distance to clarify and confront breaks and omissions in the patient's discourse (Clarkin, Yeomans and Kernberg 2006). Slade suggests that progress is slow-moving with preoccupied patients, and that it is gained through the therapist's 'emotional availability and tolerance for fragmentation and chaos' as they aid the patient in forming less distorted and/or chaotic representations of self and others (Slade 1999: 588).

Personality pathology with dismissive styles

Many with dismissive attachment appear valuing of attachment in their idealisation of caregivers, and yet they are often unable to remember specific events that would corroborate their general event representations. Others can recall negative events with caregivers, but by restricting affect may remain disconnected to the feelings such experiences normally evoke. Finally, many with dismissive attachment are openly derogating of others and the need for relationships that have any dependency attached to them.

Levy and Blatt (1999) note that PDs organised around avoidance (i.e. avoidant, obsessive-compulsive, narcissistic and antisocial PDs) are characterised by a preoccupation with establishing, preserving and maintaining a sense of self. Because individuals with dismissive avoidance often have a positive model of themselves and a negative model of others (Bartholomew 1990), they are unlikely to expect that help from and dependency on others will lead to change. Therefore dismissive patients are less likely to seek treatment of their own accord (Levy *et al.* 2012). When these individuals enter therapy it is often at the behest of another: a significant other who makes it a condition of staying together; an ultimatum from a boss in order to keep a job; a mandate from a court in order to stay out of jail; or a recommendation from a lawyer in order to provide the appearance of remorse. Early in treatment, such individuals often maintain a distance from the therapist, disclose little and express scepticism about the treatment. Though they may appear compliant in relaying personal information, their discourse will often lack the details needed to create vivid, complex and multifaceted images of self and others in the mind of the therapist. At best, the therapist may often feel that she is 'going through the motions' of a treatment with a distant and superficially compliant patient. At worst the therapist may repeatedly feel she has to answer to the criticisms of an individual who continually has 'one foot out the door'.

Therefore the early phases of treatment with dismissive patients often focus on the high threat of drop-out. As with preoccupied patients, this challenges the therapist to balance two seemingly contradictory demands. On one hand, dismissive patients often become more distressed and confused when confronted with difficult issues in treatment (Dozier *et al.* 2001). At the same time, not directly confronting threats to treatment creates an increased risk of drop-out (Clarkin, Yeomans and Kernberg 2006). The capacity of the therapist to emotionally engage herself in a narrative that may not be engaging to begin with, and to bring direct emotional expression to a narrative that often omits complex

affects, may provide an optimal space for intervening with such patients. Despite these challenges in engaging and retaining dismissive patients in treatment, when they follow through with treatment they do seem to fare better in terms of outcome (Fonagy *et al*. 1996).

Dismissive attachment tends to be at its most extreme in individuals with malignant narcissism, antisocial PD, and/or sociopathy/psychopathy (Blatt and Levy 2003; Levy and Blatt 1999). These individuals are competitive, aggressive, preoccupied with power and exploitation, and tend to aggress against others or use them for instrumental means. Similarly, Karen Horney (1945, 1950) described a pattern that she characterised as 'moving against people'. The following clinical example illustrates such dynamics.

As is common with those with antisocial PD, Mr. M was court-mandated to treatment. During a public argument he was having with his girlfriend he had pummelled an innocent bystander who he believed was about to intervene. He went into what he described as a blind rage and threw punches at the police officers that were responding to the call for help. Initially he failed to share that he was court-mandated to attend sessions; this information came to light after the therapist questioned his motivation for treatment and suggested that they end their work together. Mr. M's attitude in treatment was generally cavalier, and it was difficult to get him to be serious about his situation or his internal experience. He vacillated between treating therapy as a game and as an imposition forced upon him. He oscillated between seeing the therapist as a naïve fool who was dumb to the ways of the world and seeing the therapist as corrupt and going through the motions of therapy with little interest in his improvement. When he viewed the therapist as naïve, he held him in disdain as weak and unable to help. He berated the therapist as someone who 'just doesn't know', who would be eaten alive in the 'real world', and who probably cried at weddings, funerals and even sad movies. When he saw the therapist as corrupt there was a subtle identification with being both powerful and protected against others' manipulations, but in those moments the therapist was also disinterested, uncaring and dishonest. In these moments, he saw the therapist as 'crying fake tears for the dumb saps who believe that he really cares'. As therapy progressed, the vacillation between these two positions gradually entered the patient's awareness; the motivations for and consequences of each position became more salient and resonate. Although such awareness often angered the patient, it also allowed him to see that his views of the therapist were mental representations and not the actual reality of the therapist or others in the world.

Personality pathology on the fearful to dismissive continuum

As previously discussed, Levy and Blatt (1999) note that those with PDs characterised by avoidance are concerned with creating and maintaining a sense of self, which manifests in a number of ways. Because individuals with a fearfully avoidant style have both a negative model of themselves and a negative model of others (Bartholomew 1990), they are unlikely to expect that they can depend on either themselves or anyone else to improve their circumstances. For example, those with avoidant personality pathology tend to desire intimate relationships but fear that their own inadequacies will become a source of humiliation at the hands of critical others. In contrast, patients with narcissistic and paranoid personality pathology tend to lead with a dismissive view of others, but this stance may be taken to belie some level of attachment anxiety and feelings of vulnerability.

Ms. N, who was diagnosed with narcissistic PD, began her treatment by referring to the therapist's office as 'the nicest broom closet I have ever seen', which was quickly followed by reprimands for a series of perceived failures: he had no water cooler in his office, the office was too far from where she had to park, the weather did not suit her. She was hostile, but it seemed that part of her wanted the therapist to care for her – she wanted him to provide nourishment, intimacy and atmospheric comfort. And even before he said anything more than 'Come in', she was angry for wanting these things from him. If in fact she did want these things from him and was sad that he could not provide them, she was also angry that he had evoked such desire in her. It also seemed that she took great pleasure in knowing that the therapist was incapable of making a water cooler appear or moving the parking garage. And, even if he could get her some water and find her a closer parking spot, he could not change the weather. Thus it was the therapist who was incapable, not her.

Fearfully dismissive patients are likely to alternate between aggression and neediness in the early stages of treatment. Such patients may also vacillate quickly between idealisations and devaluations, leaving the therapist feeling confused and deskilled. Therapists have to be on guard not to over-interpret these behaviours, nor to respond defensively or aggressively, or collude with the pathology through passivity. Avoiding these problematic reactions can be facilitated by the therapist's maintaining his or her own reflective and non-defensive stance, as well as through involvement in some form of supervision or consultation.

Attachment and interventions for personality disorders

From its inception, Bowlby believed that attachment theory had particular relevance for psychotherapy. There are a number of ways in which attachment and

psychotherapy may intersect, and many of these connections have been examined empirically (see Borelli and David 2003; Daniel 2006; Levy *et al.* 2011; Obegi and Berant 2009; Steele and Steele 2008 for reviews). Findings from this body of research indicate the clinical importance of accounting for patients' attachment styles and the potential fruitfulness of addressing issues around attachment within treatment. In particular, this work suggests that patient attachment status may be extremely relevant to the course and outcome of psychotherapy for PDs.

Attachment-based interventions

Most existing psychotherapies implicitly employ techniques and principles that are congruous with attachment theory, particularly those concerning the importance of a healthy therapeutic relationship as well as the exploration and updating of mental representations of significant relationships and the self. Until recently, few psychotherapies were directly based on the principles of attachment theory; however, in recent years, attachment-based interventions have been developed for a number of problems (e.g. Johnson 1996) and recently for personality disordered patients. For example, mentalisation-based therapy (MBT: Bateman and Fonagy 1999, 2001, 2008) was designed as a long-term, psychoanalytically-oriented, partial hospitalisation treatment for BPD. This treatment model is based on the idea that patients were not able to develop the capacity of mentalisation (i.e. the social-cognitive and affective process through which one makes sense of intentional behaviour in the self and others by reflecting on mental states) within the context of an early attachment relationship, and that fostering the development of this capacity in turn leads to more stability in terms of the self and relationships with others. This goal of MBT rests on developing a safe attachment relationship between client and therapist to provide a context in which these mental states can be explored. MBT has been demonstrated to be effective over long-term follow-up with regard to reduction of depressive symptoms, suicidality, parasuicidality and length of inpatient stays, as well as improvement in social functioning (Bateman and Fonagy 2009).

Attachment moderating psychotherapy process and outcome

A number of studies have examined how client attachment relates to the process and outcome of psychotherapies for PDs and other conditions. Generally, secure attachment has been associated with better treatment outcomes across psychotherapies for patients with PDs (Meyer and Pilkonis 2005; Strauss *et al.* 2006). Conversely, these studies suggest that clients who are more anxious with respect to attachment may demonstrate different trajectories of treatment engagement and outcome than do more avoidant clients. Given that variation in these attachment styles differentially characterises patients with PDs (Levy and Blatt 1999), these characteristics are useful to consider when making predictions regarding the course of treatment in these individuals.

As noted earlier, clients with PDs who are more anxious with respect to attachment (particularly preoccupied individuals) may initially present as very engaged and interested in pursuing treatment. Empirical studies in this area have indicated that individuals with high levels of attachment anxiety are more likely to perceive distress and seek help for emotional difficulties (Vogel and Wei 2005). Additionally, preoccupied individuals in particular tend to be more frequent users of medical services in general; for example, preoccupied individuals with cluster B PDs report longer medical hospitalisations than do matched individuals of other attachment classifications (Hoermann *et al.* 2004). Although they may appear more disclosing and dependent on providers, preoccupied clients are not more compliant to treatment recommendations (Dozier 1990; Riggs and Jacobvitz 2002). Additionally, there is evidence that higher attachment anxiety may be especially predictive of poorer treatment outcomes among both preoccupied and fearful-avoidant clients with PDs (Fonagy *et al.* 1996; Strauss *et al.* 2006).

By contrast, more avoidant individuals tend to report less distress and help-seeking behaviours (Vogel and Wei 2005), and they tend to be less compliant to treatment recommendations (although in a more subtle manner than preoccupied patients) and exhibit generally weaker therapeutic alliances than other attachment groups (Eames and Roth 2000; Mallinckrodt, Porter and Kivlighan 2005; Satterfield and Lyddon 1998). However, there is some evidence from a mixed sample that included PDs that they may perform better than their anxious counterparts with respect to outcome. For instance, Fonagy *et al.* (1996) found that dismissive patients were most likely to show improvement during treatment, as compared to patients exhibiting other attachment styles including preoccupied. These findings suggest that while avoidant (particularly dismissing) clients may seem detached, they may be able to effectively utilise treatment; conversely, while preoccupied individuals may seem particularly engaged, they may not be able to use interventions in a helpful way. Of course, these findings may not hold up in PD samples and should be confirmed.

Change in attachment in personality disorders

Some researchers have examined changes in attachment status as a result of treatment for individuals with PDs. Generally, the findings of these studies have suggested that treatment may lead to changes in attachment status for these patients, although this impact may differ depending on the characteristics of treatment (e.g. treatment length). Levy and colleagues (Diamond *et al.* 2003; Levy *et al.* 2006, 2007) have examined changes in attachment status as assessed by the AAI in patients diagnosed with BPD. In a pilot study (Levy *et al.* 2007) of 10 patients in a year-long course of Transference Focused Psychotherapy (TFP) it was found that a third of the patients were classified as secure with respect to attachment post-treatment, and 60 per cent of those previously classified as unresolved with respect to trauma and/or loss were no longer so by the end of treatment. In a randomised controlled trial (Levy *et al.* 2006), the researchers

examined changes in attachment in 90 patients with BPD who were randomised to receive one of three treatments: TFP, dialectical behaviour therapy (DBT), or a modified psychodynamic supportive psychotherapy (PST). After a year of treatment, within the TFP group 7 of 22 patients (31.8 per cent) changed from an insecure to secure attachment classification; this change was not observed within the other two treatment groups. This finding with regard to change in attachment in TFP was recently replicated in an RCT in Munich and Vienna (Buchheim *et al.* 2012). In a chapter publication, Fonagy and colleagues (1995) reported findings from a subset of 35 of the 85 inpatients from the Cassel Hospital inpatient study (described in Fonagy *et al.* 1996). This subset of patients was comprised of individuals from a mixed diagnosis sample, who were mostly characterised as severely disturbed, treatment resistant and personality disordered. All 35 inpatients were classified as insecure during their initial interview; however, 14 (40 per cent) of the 35 inpatients were assigned a secure classification upon discharge, representing a statistically significant increase in the proportion of secure classification. These findings are important because they show that attachment patterns can change as a function of treatment, but neither the specific psychopathology nor the treatment were well specified. Additionally, to date a more detailed description of the changes in AAI status observed in this study has not been published, making reports of these findings difficult to interpret.

Another recent study examined change in attachment following short-term inpatient treatment in a sample of 40 women diagnosed with BPD, avoidant PD, or both disorders. Although patients symptomatically improved over time, there was little evidence of a shift in the proportion of securely attached individuals within this sample. The authors did note that overall ratings for attachment avoidance were higher after treatment, and that a shift from ambivalent to avoidant attachment was associated with better treatment outcomes for patients with BPD. The authors argued that this change was reflective of a de-activation of the attachment system, or a shift away from the enmeshment characteristic of more preoccupied styles. This study suggests that the shifts in attachment that may occur as a result of short-term therapy may be more subtle and that shifts from insecurity to security are less likely in short-term treatment, particularly when compared to the long-term treatments.

Attachment as a process variable in psychotherapy with personality disorders

Some preliminary work has indicated that attachment-related constructs may also be used as a lens through which to examine psychotherapy process. Samstag and colleagues (2008) used the narrative coherence coding system from the AAI to examine psychotherapy process as a predictor of treatment outcome within 48 client–therapist dyads. This sample included clients with primarily cluster C PDs (with comorbid depression and/or anxiety) who were divided into three groups based on outcome: (1) drop-out (termination within first third of treatment);

(2) good outcome (high reliable change); and (3) poor outcome (low reliable change). Coherence was rated for a portion of sessions that were randomly selected from the first third of treatment. Coherence ratings were significantly higher for the good outcome group, as compared with the drop-out and poor outcome groups. These findings suggest that more highly coherent narratives occurring within the context of psychotherapy may be an indication of a particularly fruitful collaboration within the client–therapist dyad. Furthermore, it is possible that patient-level factors, including attachment, may influence the level of narrative coherency, which may in turn influence the course of psychotherapy.

Conclusion

As has been discussed, attachment theory and research provide a robust framework for conceptualising personality disorders. In terms of assessment, evaluating personality disorders in terms of thematic concerns of interpersonal relatedness and self-definition, valence of models of self and others, as well as level of attachment anxiety and avoidance, may inform case conceptualisation and treatment planning. Attachment theory and research also have broad implications for therapeutic interventions with personality-disordered patients. This includes attachment-based treatments for personality disorders such as MBT (Bateman and Fonagy 1999), which specifically target deficits in mentalisation that occur in the context of heightened activation of the attachment system. Change in attachment patterns has also been observed in TFP, a treatment for personality disorders that specifically targets models of self and others. Lastly, attachment research has identified prognostic indicators in psychotherapy as a function of attachment style. Taken together, the clinical utility of attachment theory and research for conceptualising personality pathology is too powerful for clinicians to ignore.

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