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Disorganised attachment and borderline personality disorder: a clinical perspective

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Summary

The aim of this paper is to explore the links between the attachment-theory derived concept of disorganised attachment, and the psychiatric diagnosis of Borderline Personality Disorder (BPD). Disorganised attachment can be understood in terms of an approach-avoidance dilemma for infants for whom stressed or traumatised/traumatising caregivers are simultaneously a source of threat and a secure base. Interpersonal relationships in BPD including those with care givers is similarly seen in terms of approach-avoidance dilemmas, which manifests themselves in disturbed transference/countertransference interactions between therapists and BPD sufferers. Possible ways of handling these phenomena are suggested, based on Main's (1995) notion of 'meta-cognitive monitoring', in the hope of re-instating meaning and more stable self-structures, in these patients' lives.

Key words: disorganised attachment, borderline personality disorder

Introduction

The relationship between sub-optimal attachment patterns in infancy and adulthood and psychopathology is a focus for much contemporary debate within the Attachment field. It is clear that the standard 'insecure' attachment patterns originally described by Ainsworth are not in themselves pathological, although they are perhaps factors, which, taken with other adversity, including genetic vulnerability, can lead to psychopathology.

The delineation of disorganised attachment as a third variant of insecure attachment has lead to quite a different perspective. The links between disorganised attachment and psychopathology are much more striking, and, in contrast to hypo- and hyper-activation of the attachment system which can been seen as adaptive responses to sub-optimal care-giving, disorganised attachment is, by definition, non-adaptive, and therefore a potentially pathological response to inadequate care-giving.

The aim of this paper is to connect the evidence about disorganised attachment with the clinical problems presented by BPD patients. I shall look at the ways in which

individuals whose attachment patterns are disorganised attempt to create some sort of security for themselves, however degraded, simplistic, distorted, or self-defeating this may be. I shall also draw on attachment theory's capacity to discover meaning in the detailed analysis of minute segments of behaviour and to make interpersonal sense out of them.

My purpose is primarily clinical. I shall use Attachment Theory to consider some of the difficult states of mind that are characteristic of the BPD patient. I start by a very brief review of the literature on disorganised attachment, especially as it might pertain to adult psychopathology, and borderline personality disorder in particular, and go on to consider its clinical implications for treatment methods and service arrangements for such patients.

Disorganised attachment (D)

'D' was first described by Main and Solomon [7] after reviewing a series of Strange Situation tapes of a group of infants previously categorised as 'unclassifiable' [8].

The D category appeared to be stable over time, to be unrelated to temperamental factors, and to appear not infrequently in relation to one parent but not the other. The prevalence was relatively low in middle-class samples (14%) but Van Ijzendoorn found much higher figures in low socio-economic status groups, generally (24%), and in maltreating samples the figure reaches 60–70% [9].

Cortisol levels are higher in D infants than in controls, and they show decreased mental development compared with controls even when maternal IQ is controlled for [10]. All this suggests we are looking here at a stressed and potentially disadvantaged group of children. It will be recalled that the D classification coexists with the other three attachment categories. The largest proportion of D infants showed ambivalent attachment (46%) – see case report below – only 14% are secure and 34% avoidant [8]. It is important to note that Crittenden [11] sees in D features of mixed avoidant and ambivalent characteristics.

If D is a valid entity, as it appears to be, two immediate questions occur: under what circumstances does the D pattern arise, and what are the long-term implications for the child of D classification? Main's fundamental theory about D is that it represents an *approach-avoidance dilemma*, intrinsic to the very nature of attachment [12]. Attachment theory postulates that a threatened or frightened child will turn to an attachment figure for comfort, security, or reassurance. But if that attachment figure is itself the very source of the threat the child is presented with an insoluble problem. No consistent behavioural strategy will relieve the threat. There is no equilibrium point comparable to the situation in avoidant attachment in which the child gets close to the mildly rebuffing secure base – but not too close; or in ambivalent attachment where the child clings to an inconsistent attachment figure. It is worth noting, in passing, that there is more than a superficial similarity between the Main's D hypothesis and Bateson's 'double bind' theory of schizophrenia [13], in which it was postulated that psychotic behaviour was the result of an individual confronted by two contradictory messages in a field from which he could not escape.

What parental characteristics might lead to this approach-avoidance bind? The adult analogue of D is the 'unresolved' category on the Adult Attachment Interview. Unresolved is coded when the respondent shows 'signs of disoriented disorganisation when discussing potentially traumatic events' together with 'lost awareness of the discourse context'. Main's idea [12] is that the care-giver of a potentially D child is herself the subject to unresolved loss or trauma. This disrupts her capacity to focus on her care-giving role, which triggers painful memories from her own childhood. Thus the caregiver is not just frightening, but frightened. She cannot maintain affective continuity in her own inner world, and so lacks the capacity to provide buffering for her infant's affective peaks and troughs. Main emphasises the 'dissociative' aspect of D in both child and care-giver. They see the child as dissociated from the immediate environment and the insoluble fright/flight dilemma itself. They also see the care-giver as triggered into a frightened state herself by the child's distress, dealing with this again by dissociation, thereby making herself all the less available to the child as a secure base.

Studying parents of D infants with the AAI, a meta-analysis of 9 studies involving 548 subjects showed high correlation/effect size between parental unresolved status and child D [8]. Lyons-Ruth and her co-workers agree with Main that D arises in very specific circumstances and cannot merely be seen as a manifestation of care-giver insensitivity (which will give rise to insecure attachment, but not specifically D). However they specify a range of care-giving behaviours likely to be associated with D including role confusion (parent uses child as surrogate parent), negativity, intrusive-ness, disorientation, asynchronous mother-infant exchanges ('not being able to get on the same wavelength'), and apparently unmotivated emotional withdrawal.

The next piece of the jigsaw comes from follow-up studies of children classified as D at one year. Two such prospective studies have shown that there is a strong link between D and *controllingness* of children with their mothers and peers at age 6/7 [14]. These children insist on a kind of role reversal with their care-givers, in which they make executive decisions, and are unable to engage in 'democratic' play but have to be in charge. George and Solomon have further studied these children using picture completion methods and found that the controlling children, often with helpless parents, are unable to resolve frightening scenarios – they respond with total silence, or stories illustrating passivity or catastrophe.

Much more research needs to be done in this area, but we can begin to build up a picture of links between D and adult psychopathology which starts with:

1. parental unresolved/traumatised states of mind
2. moves to the D infant caught in an approach-avoidance bind, with no secure base refuge when threatened either from without, or by her own unmodulated feelings
3. then shifts to the controlling 6 year old who has eventually found a security strategy based on role reversal and providing pseudo-secure base for herself
4. includes repressed terror and inability to repair interpersonal discontinuities and loss as revealed by picture completion studies
5. and then moves to adolescence and early adulthood in which the individual is controlling, aggressive, unable to self-soothe when faced with emotional turmoil

and loss, liable to dissociation, and cannot extricate herself from pain-producing relationships

The latter list mirrors the criteria for Borderline Personality Disorder, and it comes as no surprise that Hobson and colleagues found that a group of patients suffering from BPD (as opposed to Major Depressive Disorder) were almost entirely classified as unresolved/preoccupied on the AAI [15].

Clinical material

The term 'Borderline Personality Disorder' has its origins in psychoanalytic thinking about patients who do not fit neatly either into the category of psychotic or neurotic, but have characteristics of both. It is now, via the US Diagnostic and Statistical Manual, firmly established within the descriptive, and supposedly atheoretical diagnostic system of worldwide psychiatry. This has the advantage of conferring a certain respectability on the difficulties of patients who form the bulk of psychotherapeutic work, but the drawback that it divorces such patients from their social and psychological context.

Borderline Personality Disorder is best seen as a social/psychological construct, in that it assumes a confluence of certain psychological dispositions with distinct forms of social disruption – abrasive interpersonal relationships, maladaptive contact with professionals etc. Ultimately the ability of care-givers to provide security for their infants connects with the capacity – or lack of it – of society to care for its members. Thus for example social configurations such as endemic racism creates fear in victimised minorities, and that fear transmits itself via attachment relationships to oppressed peoples' children. Similarly the salience of absent or abusive fathers in the life-histories of people diagnosed as suffering from BPD cannot, and should not, be seen merely at the level of individual psychology. The social seedbed for these negative male roles – colonialism and consequent immigration, educational disadvantage, the move from manufacturing to a service economy – needs also to be acknowledged, and, ultimately, worked with in increasing reflexive function of BPD sufferers not just in relation to their own psychology, but consciousness of the choices and dilemmas faced by their progenitors in previous generations.

Deidre is a twice divorced woman in her middle forties. She has lived with her third main partner, Geoff, for the past 11 years. She has four children; the eldest, a daughter from her first marriage, with whom she has no contact; a boy and a girl in their late teens from her second; and a 9 year-old daughter by Geoff. She has been employed in the past as a care assistant, but is currently unable to work because of depression and anxiety. She was referred to our personality disorder clinic by her community care worker because of worrying outbursts of rage and violence, and in particular an episode in which she attacked her husband with a brass candle stick, causing quite extensive scalp injuries.

She arrived at the clinic with Geoff, and clearly found it hard to separate herself from him in the waiting area when invited to come to the consulting room. He is a large reassuring man, obviously younger than his partner. I perceive her as petite, slightly overweight, with dyed black hair. She asks immediately for a glass of water before she

is able to start. With some encouragement, she then tells her story: a dismal childhood, her (according to her mother) violent and useless father having disappeared when she was two, leaving her with a mother who quickly remarried, and had two further children. Deidre felt *de trop* from the start, and more so when her stepfather began to abuse her – physically in public, and sexually in private. She left home as soon as she could, married the first man who would have her, who promptly got her pregnant and left her. She then met her second husband which led to ten years of beatings and rape before she found the courage to leave him.

I shall focus on two key moments in the assessment interview. The first came after about half an hour. Diedre was describing the fact that she found it hard to go out of the house. Asked why, she let slip (or so it seemed) "I keep catching glimpses of myself in shop windows – I hate mirrors". At this point her bottom lip begins to quiver. "What is it about that you find so difficult?" I ask. Silence. I let the silence hang for a few moments. She looked terrified, glanced at the door, and imploringly at me. She wants to be let off the hook, released from some nameless horror. I try to keep her on track. "When you look in the mirror you see something frightening, something difficult to put into words" I suggested. "I...don't…recognise…myself...who…am…I?" the words came falteringly. We had established earlier in the interview that she looks like her father – when she asked her mother what her father was like, the only reply she could extract was "look in the mirror – you're his spitting image". "So what you see reflected is a terrifying part of you that in your mind is like your father" I suggest. She nods, with what looks like a mixture of relief and despair.

The conversation then moves into less threatening territory and after a few minutes I suggest we bring in her husband, whom I then go to collect, leaving Deidre with my colleague who is the supervisor and observer in the interview. The moment I return with Geoff she leaps to her feet, and buries herself in his arms, sobbing furiously. They leave the room for a few minutes to hug and cuddle until she is calm enough to resume.

How can we understand – make meaning out of – this story? Some of it is relatively straightforward. Bowlby [16] maintained that the need for a secure base was not something we outgrow – he saw development in terms of a move from immature to mature dependence. At times of extreme stress we turn to our secure base whatever our age. Geoff is Deidre's secure base. The stress of the interview activates attachment behaviour in them and, like a child in the Strange Situation, she needs physical comfort and reassurance from him before she is able to face the threat posed by the PD team. She has in fact already signalled from the start, via her request for a drink of water, her vulnerability and bid for nurturance.

How would we characterise Deidre's attachment style? Her need for physical proximity to Geoff and difficulty in calming suggest an ambivalent pattern, and this is consistent with her narrative style in the interview which is rambling, discursive and overwhelmingly affect laden. How then would we understand the story of the mirror and her difficulty in talking about it. I suggest we are seeing here the coexistence of disorganised/incoherent pattern with ambivalent insecurity. Her thoughts are confused. She finds it difficult to stay on track. She is in a state of extreme terror out of proportion to the context, and she describes quasi-psychotic and dissociated feelings – she

doesn't recognise who she is and wonders if she is seeing her father rather that herself in the shop-windows.

We can speculate that 'behind' this incoherent (in the technical sense) speech pattern there may lie unprocessed trauma (her mother's aggression, her father and second husband's abuse) which my insistence on keeping her on track (which in my counter-transference felt quite abusive and bullying) may have activated. In order to avoid the eruption of this potentially disorganising constellation of thoughts and feelings, she narrows her behavioural repertoire and seeks the physical proximity of Geoff to provide the external secure base which she lacks internally.

How then do we understand the outbursts of uncontrollable rage towards Geoff which are what have brought her for help? There are perhaps three aspects to this. First, like Harry Harlow's Feli [17], a goose deliberately reared without attachments and who also showed inexplicable episodes of aggressive behaviour when faced with fellow-geese, they represent 'displacement activity' in someone who lacks a consistent behavioural strategy for dealing with problematic intimacy. She wants to be close to Geoff, but she is terrified of doing so, and attack is a way of escaping from that dilemma. Second, in a more straightforward way she is punishing him for not being with her at all times – a standard attachment-influenced interpretation of interpersonal aggression, similar to our understanding of deliberate self-harm when faced with an 'attachment crisis'. Aggression here is essentially a negative reinforcement schedule designed to re-establish a compromised attachment bond.

A third aspect concerns the characteristics of spouses of people suffering from Borderline PD. Many or most BPD sufferers manage to drive partners away, and instability of relationships is of course typical of this diagnostic group. Those whose relationships do survive often are married to people who are phlegmatic in the extreme, and usually highly emotionally avoidant. The attack on Geoff was both a desperate attempt to elicit an emotional response, and at the same time an attempt to reassure herself that however outrageous her behaviour, he would stand by her.

These socio-biological accounts are deliberately non-teleological. Psychoanalytically, one could argue that when Dierdre attacks Geoff the unconscious meaning of these actions is to be found in rage at the step-father who abused her, the father who abandoned her, the terrifying mother who failed to assuage her fears. Her outbursts could be seen as the desperate attempts of an exploited, ignored overlooked woman to communicate her need to be seen, acknowledged, given due attention. An attachment perspective sees such explanations as post-hoc, narrativised accounts of semi-automatic psychobiological responses to threats of separation or disconnection.

A final point I want to draw from this example returns to Deidre's emotional 'collapse' when talking about the shop-windows. Her tears and quivering lip here were quite different to what happens for instance when someone is talking about a bereavement or loss in their life. There was an incongruity and suddenness with which the overwhelming feelings erupted.

Compare the sudden change of mood that might be seen in a two-year old, happily playing 'alone in the presence of the mother' [18], when the care-giver goes out of

the room without warning – to attend to a chore for instance or go to the lavatory. The child may suddenly dissolve into tears and the narrative envelope of her play collapses no less instantly that it might for the audience if a fire-alarm went off in the middle of a theatrical performance. In Diedre's case and that of the child there is no sustaining internal care-giving presence that can soothe and smooth affective fluctuations. These un-buffered emotional states or failures of self-soothing are part of the core diagnostic profile of Borderline conditions.

Psychotherapeutic implications

Psychotherapeutic work with patients suffering from BPD is notoriously difficult [19]. Over and above 'non-specific factors', the therapeutic effectiveness of dynamic psychotherapy is based on two main clinical tools. First is the therapist's counter-transferential capacity to use her own emotional reactions in the service of the sufferer. Second, the ability to put those feelings into words – in the terms of this article to create a language-game of shared meaning with the patient. In the light of the foregoing discussion we can begin to understand how both of these can be compromised when working with Borderline patients.

The eliciting of powerful counter-transference is in itself almost diagnostic of Borderline states. Anyone who has worked with such patients will recognise feelings of rage, anger, exasperation, murderousness, intense pity, desire to rescue, erotic arousal, wish to extricate themselves from the relationship and many other intense emotional reactions in themselves. These feelings are usually understood in terms of projective identification, and in the Klein-Bion model represent the projection of the patient's primitive un-modulated feelings which have failed to be metabolised by care-givers and therefore cannot be re-introjected by the individual in a transmuted form.

Adding to this an attachment framework, we can postulate that an interpersonal situation akin to infancy is recreated in the consulting room in which the supposed care-giver (the therapist) is potentially distracted from her secure base function by powerful, preoccupying and potentially terrifying emotions. *Thus the trauma of non-mirroring care-giver is reproduced as the therapist is in the thrall of strong feelings and so unable to reflect accurately the patient's state of mind* – despite the fact that those feelings were evoked precisely by the patient. The pressure on the therapist to 'act out' – to enact her controlling, angry, loving, rejecting or all-embracing feelings in some way — is insistent. Like the D care-giver, we become frightened by our own fear and seek to evacuate it through action. We become subject to role-reversal pressures and try to use the patient as a receptacle for our own unbearable feelings. We try impose a pseudo-organisation on a chaotic situation, thereby deepening the split in the patient's inner world between control and pseudo-order on the one hand and the un-modulated terror which lies beneath.

A similar dilemma confronts with the use of words in working with BPD patients. Clearly words are fundamental to organisation and resolution of painful feelings. The human voice in itself can be soothing, a bedtime story sends us to sleep safely until morning, telling the history of a life provides objectification and verification, imposing

meaning on seemingly inchoate events and feelings. *But for the BPD patient words are also a threat, arousing painful memories, counteracting defensive strategies, and threatening to lay bare naked fear and panic.* This can be understood in terms of the BPD patient's operating within 'equivalence' as opposed to 'pretend' mode [2]. According to this theory, in equivalence mode a word directly evokes an experience rather than being a representation of it, and therefore is associated with overwhelming affect, rather helping to process and master feelings.

A further vignette serves to illustrate this point. The patient was a middle aged woman referred for psychotherapy after she had had a series of fits for which no neurological basis could be found. She told me that the fits were very worrying to her because she believed she was having some sort of stroke, and that the right side of her body was becoming weaker and weaker, and that she would be unable to carry out her role as carer for her disabled husband. She then told me about his progressive rheumatological condition, and about their son who had had a very bad motor bike accident recently and her daughter who was involved with an unsuitable man. She made it clear that she and her husband never rowed and that it was important to her to have a placed family life since her childhood had been so dominate by conflict.

When I then asked her about her family and especially her parents there was the typical change in breathing patterns and eye-glazing of the unresolved patient. She then blurted out the story of how her father had murdered her mother, had been in jail for 10 years, that she had been ostracised by her siblings because she refused to believe that he had done it, and then after his release from jail how he had threatened her on one occasion, so that in the end she was so frightened that she had decided to have nothing further to do with him either.

At this point I tried to summarise the situation by saying that I thought she had suffered a huge amount of trauma and loss in her life and that it was entirely possible that this was what underlay her 'turns', since the body has strange ways of making its feelings known. No sooner had I delivered this salvo (as I think she experienced it) than she began to 'fit'. Her eyes because glazed, she started to shake, especially on the right side of her body, her lip curled upwards, and she appeared inaccessible. The episode lasted for about a minute, after which she seemed drowsy and slow in her movements.

From a medical-psychiatric point of view, this was undoubtedly a 'pseudo-fit'. From an attachment perspective it was a psychosomatic response to what felt like a psychological assault, one which activated, so to speak, a neural network established on the basis of previous trauma. As Van de Kolk puts it 'the body keeps the score'. From the point of view of our discussion it had some of the features of disorganisation described by Main and others in D children in the strange situation – bizarre posturing, stereotypical behaviour, incongruent affective response. The point however is that this bizarre response emerged immediately after a comment from me trying to link together disparate an inexplicable events – an attempt to move towards organisation and meaning. *I suggest that this put the patient in an approach-avoidance dilemma: the move towards meaning has the potential to increase her sense of security and continuity, but at the same time the words themselves arouse terrifying memories of trauma.*

What then is to be done? How can we prevent 'D dilemmas' reproducing themselves in therapy. From an attachment perspective, the answer lies in what Main calls 'meta-cognitive monitoring' [12]. Meta-cognitive monitoring refers to the process of 'thinking about thinking', which entails a clear understanding of 'pretend' or symbolic mode. In the case of overwhelming counter-transference feelings the therapist has to be able to 'contain' them – i.e. to recognise them for what they are without suppressing, dismissing or acting on them. She then has to be able to put them to good use in the session by seeing these feelings and the actions they stimulate, not as 'real, but as symbolising a need or inner state of the patient, and then to be able to put this notion into words.

Let us say a therapist is working with a patient who has been severely sexually abused, and that the patient is able to describe the 'facts' of what has happened, but without attendant feelings, and that the therapist finds herself experiencing disgust and rage and being on the point of offering to accompany the patient to confront her abuser. To do so would, I suggest, simply evoke the typical D response in the patient – panic, embarrassment, dis-empoweredness and a wish to regain control. Instead, the sensitive therapist might say something like "it sounds like these are feelings that it is very difficult for you to face on your own, but that to do so with another person brings up huge feelings of shame – so you are damned if you do, and damned if you don't". The therapist takes her own responses as reflecting, representing, or symbolising the emotional state of the patient. By introducing a conversation about conversation the therapist is initiating the BPD sufferer to the possibility of a shared language of intimacy.

Thus the patient needs to be offered not just words or meanings, but words about words, and meanings of meanings. Rather than in an ex-cathedra way suggesting that the patient's fits represented her unresolved trauma, (or that the weak right side of her represented the dead mother killed by her powerful and out of control father-like left side) it might have been better to have said something along the lines of "we *could* talk about the pain and trauma you have been through, and this might help reduce the frequency of your fits, but it also might increase them because would be approaching such painful topics which you have effectively buried for a long time".

Conclusions

To summarise then, the BPD patient, who may well be a D child grown up, has used various kinds of controlling strategies to maintain a modicum of security and stability. Some of the more extreme and bizarre features of Borderline behaviour can be seen in this light – e.g. self-injury, bingeing and vomiting, and substance abuse all of which produce temporary physiological features associated with secure base experience. I have called these 'pathological secure base phenomena' [3]. Working with such patients produces similar unresolvable dilemmas to those encountered by the D child in the strange situation. Staying with this paradox, and using various 'meta-cognitive' manoeuvres are an integral part of therapy with Borderlines.

Any organised *service* for such patients needs also to take these issues into account. There needs to be an emphasis throughout the team on the notion of *'holding in mind'*. Fonagy & Target [20] suggests that a crucial feature of personality disorders (PD) is lack of 'mentalizing capacity', or 'mind-mindedness' [20]. PD patients find it difficult to sustain a stable sense of the self and other as having beliefs, desires, and intentions. This puts them at grave disadvantage in interpersonal relationships, and may influence their problematic relationships with care-giving institutions. It has been suggested that such people as children lacked a care-giver who could either validate their internal world, and see them as autonomous and sentient. One of the functions of therapy with people suffering from BPD is to offer a 'thinking mind' which can plan, intervene, and take a perspective on them as persons, in which meta-cognitive monitoring is a central component. We hope that this 'holding in mind' function may eventually be internalised by the PD sufferer as self-reflexive capacity which in turn will enhance their interpersonal life.

In the clinic we aim to provide just such a 'thinking mind', held collectively by the members of the team, through the assessment and supervisory functions which they offer to the clients, their carers and their therapists. Essentially what is being offered to these patients is continuity of care in its deepest sense. The nature of BPD is such that it tends to vitiate attempts to create such continuity, and the emphasis on engagement, consistency and long-term commitment is an attempt to mitigate the disruptive features that are so characteristic of the condition.

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