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Necessary and Sufficient: Examining the Role of Attachment Trauma and Psychological Maltreatment as Primary Etiological Factors in the Development of Borderline Personality Disorder

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Abstract

Current widely-accepted conceptualizations regarding borderline personality disorder (BPD) profess that trauma is not required in the etiology of BPD and place a significant focus on biological predispositions. This review sought to evaluate the current paradigms regarding BPD and examine whether trauma may be the most significant contributing factor in the development of BPD. Studies on developmental trauma (including psychological maltreatment) and attachment were examined. These studies appear to strongly support the idea that when disrupted attachment and psychological maltreatment are taken into consideration, trauma does appear to be both necessary and sufficient as primary etiological factors in the development of BPD. As such, a reconceptualization of BPD as a trauma disorder may be beneficial in both destigmatizing BPD and for more effective treatments.

NECESSARY AND SUFFICIENT: EXAMINING THE ROLE OF ATTACHMENT TRAUMA AND PSYCHOLOGICAL MALTREATMENT AS PRIMARY ETIOLOGICAL FACTORS IN THE DEVELOPMENT OF BORDERLINE PERSONALITY DISORDER

DEDICATION

For all the kids who did not receive their full coat of armor.

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CHAPTER I: OVERVIEW OF TRAUMA

Trauma and psychology have a long and complicated history. From hysteria to the modern-day diagnosis of borderline personality disorder (BPD), reactions to trauma, particularly in females, have been marginalized, minimalized, and stigmatized. Merriam-Webster currently defines hysteria as a "psychoneurosis marked by emotional excitability and disturbances of the psychogenic, sensory, vasomotor, and visceral functions" (2018). Theories of hysteria's etiology have ranged from a wandering uterus to sexual trauma. For example, Freud (1896) posited that "at the bottom of every case of hysteria, there are one or more occurrences of premature sexual experience," a theory which was abandoned by Freud quickly following a cold reception by his colleagues (p. 203). Freud's later disavowal of his theory (1925), and his revised claim that it was women's repressed sexual longings and fantasies regarding their fathers, not actual incest or sexual exploitation, was a blow to the field of traumatic psychology, again discrediting and pathologizing women.

"Hysteria" as a diagnosis, fell out of fashion in the mid-twentieth century. Other diagnoses, such as personality disorders, became predominant for women who had experienced trauma, particularly BPD. According to the *Diagnostic and Statistical Manual, Fifth Edition* (*DSM-5*; American Psychological Association, 2013, p. 663), BPD is characterized by "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts." Those diagnosed with BPD have significant comorbidity with posttraumatic stress disorder (PTSD) (Cloitre et al., 2014; Courtois, 2004; Grant et al., 2008; Herman, 1992; van der Kolk, 2014). They also tend to be women who have experienced abuse, specifically sexual and emotional abuse as children (Cloitre et al., 2014; Courtois, 2004; Crowell, Beauchaine, & Linehan, 2009; Latzman et al.,

2004; Gratz, Tull, Reynolds, & Lejuez, 2011; Herman, Perry, & van der Kolk, 1989; Razek, 1992; van der Kolk, 2014).

In 1992, Judith Herman, a renowned researcher and author in the field of trauma, posited that that three diagnoses-somatization, borderline personality disorder, and multiple personality disorder (now known as Dissociative Identity Disorder or DID) were frequently given to female survivors of childhood abuse. She stated that the three diagnoses "are charged with pejorative meaning" and bring into question the individual's credibility and integrity, causing further damage to an already traumatized population'' (Herman, 1992, p.123).

Reconceptualizing the experience of repeated, interpersonal trauma, Herman proposed a new diagnosis, Complex Post-Traumatic Stress Disorder (CPTSD), which captured the essential symptomology of somatic disorders, BPD, and DID (Herman, 1992). PTSD did not cover the plethora of additional difficulties those exposed to repeated interpersonal trauma exhibited, such as problems with identity, interpersonal relationships, and personality disorganization (Herman, 1992). Now, nearly 30 years later, while considered for inclusion in the ICD-11, at the time of this writing, CPTSD is still not available as a diagnosis. However, Herman's work remains well-respected, and CPTSD is commonly used as a framework for those working with victims of chronic interpersonal trauma.

Childhood Trauma and BPD

BPD is defined in the *DSM-5* as "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts" (APA, 2013, p. 663). The diagnosis requires five of nine criteria be met that include impulsivity, suicidal ideation, fear of abandonment, and unstable self-image (APA, 2013). The *DSM-5* (APA, 2013) also noted that BPD is primarily diagnosed in females

(75%). Other features associated with BPD include patterns of self-destructive behavior, "psychotic-like" symptoms, suicide, job losses, and divorce (APA, 2013, p. 665). The *DSM-5* notes that "physical and sexual abuse, neglect, hostile conflict, and early parental loss" are frequently found in the histories of those diagnosed with BPD (APA, 2013, p. 665).

Childhood abuse has repeatedly been significantly correlated with BPD, as studies have indicated that between 60 to 81% of adult females with BPD report some form of abuse in childhood (Cloitre et al., 2014; Courtois, 2004; Crowell, et al., 2009; Gratz et al., 2011; Battle, et al., 2004; Herman et al., 1989; Razek, 1992; van der Kolk, 2014), yet with differences depending on the type of abuse experienced such as with physical, emotional/ psychological, sexual, or neglect. It has been well-established and accepted that there is a significant correlation between childhood sexual abuse (CSA) and BPD (Lobbestael, Arntz, & Bernstein, 2010; Ross-Gower, Waller, Tyson, & Elliot, 1998). Physical abuse is the form of abuse least correlated to BPD (Battle et al., 2004; Lobbestael et al., 2010; Ross-Gower et al., 1998). Childhood emotional abuse and neglect, which are encompassed by the term psychological treatment (PM), have been found to be the type of abuse most significantly correlated with BPD. (Affif et al., 2011; Kuo, Khoury, Metcalfe, Fitzpatrick & Goodwill, 2015; Lobbestael et al., 2010; Park et al., 1992; Raczek, 1992). This correlation between BPD and emotional abuse or neglect is important, as the definitions of psychological abuse can vary significantly, be difficult to measure, and may be underreported.

In a study by Gratz, Latzman, Tull, Reynolds, and Lejuez (2011), the relationship between childhood trauma and childhood borderline traits was examined. Results indicated that emotional abuse was correlated with BPD traits in children even when other variables such as trait vulnerabilities and pathology expression (externalizing versus internalizing) were

controlled. Their results demonstrated a strong association between borderline personality pathology in childhood and a history of emotional abuse (Gratz et al., 2011).

Rates of co-occurring PTSD are also high among people with BPD. PTSD, as defined by the *DSM-5,* is a disorder that is diagnosed when an individual struggles to cope with a traumatic event, defined as experiencing multiple psychiatric symptoms for over six months following the event (APA, 2013). According to one study, 31.2 % of people with BPD in the past year also had PTSD in that year, whereas 39.2 % of those with a lifetime diagnosis of BPD also had PTSD at some point (Grant et al., 2008). However, because of the overlap in symptoms, such as dissociation, hyperreactivity, hypervigilance, and paranoia between the two disorders, as well as the high rates of early trauma among those with BPD, there is also an ongoing debate as to whether BPD may, in fact, be a traumatic stress reaction (Herman, 1992; Lewis & Grenyer, 2009; van der Kolk, 2014).

Additionally, the role of attachment, specifically disrupted or poor attachment, is considered to be a significant and central feature in the etiology of borderline pathology. John Bowlby (1969, p. 194) defined attachment as a "lasting psychological connectedness between human beings." He posited that children formed either secure or insecure attachments with their primary caregiver. Currently, there are four well-recognized categories of attachment: Secure, avoidant, ambivalent, and disorganized (Ainsworth, Blehar, Waters, & Wall, 1978; Main & Soloman, 1990).

Securely attached children are likely to see others as supportive and helpful, be resilient, relate well with others, display confidence, and view themselves as deserving of respect (Kennedy & Kennedy, 2004). Children who fall into the avoidant category have more difficulty managing stressful situations, avoid seeking help from others, can be more

aggressive, and may withdraw and remain distant from others in attempts to regulate emotions. Ambivalently attached children lack self-confidence, tend to cling to primary caregivers, and display exaggerated emotional responses. Children with disorganized attachment may view others as threatening and utilize unorganized and ineffective strategies for coping with distress, such as vacillating between socially withdrawing and being defensively aggressive with others (Kennedy & Kennedy, 2004).

Conceptually, among leading researchers in the areas of CPTSD and BPD, there are diagnostic disagreements in regard to where each disorder falls, the etiology of the disorders, and therefore how, specifically, each disorder should be treated (Cloitre et al., 2014; Courtois, 2004; Crowell et al., 2009; Herman, 1992; van der Kolk, 2014). In addition, there is significant overlap and or comorbidity between CPTSD and BPD, which further convolutes the issue of diagnosis and treatment (Cloitre et al., 2014; Crowell et al., 2009). There are multiple factors to consider when examining the causes, differences, and conceptualization of BPD as a personality disorder and BPD as a response to early childhood trauma.

Explaining the Lack of Reported Trauma in the Minority of BPD Patients

Currently, there are several explanations within the existing models of BPD for the lack of reported trauma in approximately 20-40% of those who have received a BPD diagnosis. Perhaps the most widely held belief by those who do not see trauma as a necessary precursor for BPD has been summed up by Linehan's (1993) biosocial model. Linehan posited that interactions with caregivers that fall short of abuse are enough to produce borderline symptomology in biologically predisposed persons.

In 2009, Linehan et al. proffered a new paper, incorporating recent supporting evidence for her theory and a shift in her conceptualization regarding the etiology of BPD. The defining

feature of Linehan's updated theory was that trait impulsivity predisposes individuals to develop BPD. She further posits that attention-deficit/ hyperactivity disorder (ADHD), antisocial personality disorder, substance abuse, and conduct disorder, share "similar biological correlates" and "etiological mechanisms" with BPD (Crowell et al., 2009, p. 496). This addition to Linehan's theory moved her original biosocial model much farther towards the side of biology and placed significantly less importance on social influences.

Linehan has continued to maintain her position that trauma is “neither necessary nor sufficient for the development of the disorder" (Crowell et al., 2009, p. 501). Linehan acknowledged that the association between disrupted attachment and BPD continues to grow, yet it purports not knowing the relationship between the two, citing a lack of longitudinal studies. She stated her belief that "the developmental trajectory or trajectories that lead to BPD in adulthood remain unclear" (Crowell et al., 2009, p. 501). Linehan's model aligns with the current criteria for BPD, which indicates that BPD does not require a traumatic stressor, and PTSD symptoms may or may not be co-morbid (APA, 2013).

Others have concurred with Linehan's biosocial model noting that "the effects of trauma in the personality disorders can be better understood in the context of gene-environment interactions" (Paris, 1997, p. 34). Affective dysfunction, but not impulsivity, was found to play a moderating role in the relationship between emotional abuse and childhood features of BPD, suggesting that particular trait vulnerabilities may play a role in the development of BPD (Gratz et al., 2011). Levy (2005, p. 996) examined BPD and attachment, which led to his more tepid conclusion that while “temperament does not appear to directly influence attachment security, it may interact with attachment security to increase the risk of BPD.”

Neurological differences found in those with BPD may be considered as another reason trauma is not considered a requirement for BPD. Studies have indicated differences in the neural functioning of those with BPD when faced with negative emotional content including a lack of frontolimbic inhibitory function (Silbersweig et al., 2007) and prefrontal and amygdala dysfunction (Buchheim et al., 2007; Buchheim et al., 2016). Those with BPD have been shown to have hyperactivation in neural networks relating to representations of self and others, indicating more complex, but less effective strategies in that domain (Beeny, Hallquist, Ellison, & Levy, 2015). However, there is no definitive way to assess if differences are caused by experiences or are organic in nature.

Genetics is another area that has been posited to have a role in the development of BPD. Linehan acknowledges that research on heritability and BPD has been varied and divergent (Crowell et al., 2009). However, she favored the research supporting a link between the two. In particular, Linehan noted that the 5-HT candidate genes, which have been tentatively (notably in unreplicated studies), linked to impulsivity, self-injury, and BPD.

The aforementioned biological predispositions, brain differences, and definition of trauma are all utilized by those who do not believe attachment trauma or PM, leads to BPD to explain why trauma is not a necessary requirement for the development of BPD. However, these theories do not appear to incorporate the latest findings regarding attachment trauma and PM. Recent research on attachment and the brain, the impact on development, and the long-lasting repercussions of insecure attachment may explain a portion of those diagnosed with BPD that report no trauma history (Buschheim, et al., 2007; Ensink et al., 2016; Fonagy, et al., 1996; Levy, 2005; van der Kolk, 2003).

Purpose of the Review

The purpose of this clinical research project is to examine if underreported trauma, specifically attachment trauma, precognizant or unacknowledged psychological maltreatment (PM), or a combination of both may explain the 20-40% of those with BPD who do not report a trauma history, utilizing a narrative literature review intended for clinicians.

Significance of the Review

The results may make a significant difference in the way many providers conceptualize and treat clients. Clinicians and patients both could potentially benefit from a more comprehensive and accurate way to provide targeted treatment to populations who have experienced attachment trauma. If upon examination traumatic attachment and unreported psychological maltreatment (PM) are critical factors in BPD that have been overlooked, it could change the dominant paradigm suggested by Linehan (2003) that trauma is not necessary for the development of BPD. If attachment trauma and psychological maltreatment can be used to explain the portion of those with BPD who not report trauma, then BPD would fall solidly on the trauma spectrum. A shift of this magnitude would have a widespread impact on practicing clinicians and how they provide treatment.

CHAPTER II: OVERVIEW OF BPD

In order to consider if attachment trauma and PM may be the etiology to BPD, we must first consider how BPD is defined. There are several well-developed definitions and sets of criteria. A widely accepted current definition in the United States is offered by the American Psychological Association (APA) in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*; APA, 2013) in which BPD is placed in the personality disorder category.

The *DSM-5* states that "a personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence and early adulthood, is stable over time and, and lead to distress or impairment" (APA, 2013, p. 645). In addition, the *DSM-5* states that "the essential feature of borderline personality is a pervasive pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity that begins in early adulthood and is present in a variety of contexts" (APA, 2013, p. 663). These descriptions indicate the chronicity, severity, and pervasiveness associated with BPD.

Definitions for BPD

Criteria for BPD is described in the *DSM-5* (APA, 2013) as:

> A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning in early adulthood and present in a variety of contexts, as indicated by five or more of the following:
>
> 1. Frantic efforts to avoid real or imagined abandonment. (NOTE: Do not include suicidal or self-mutilating behavior covered in Criterion 5).
> 2. A pattern of unstable and intense interpersonal relationships alternating between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self

4. Impulsivity in at least two areas that are self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (NOTE: Do not include suicidal or self-mutilating behavior).

5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behaviors, mood changes, feelings of emptiness, anger, and transient paranoia/dissociation.

6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

7. Chronic feelings of emptiness.

8. Inappropriate, intense anger, or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

9. Transient, stress-related paranoid ideation or severe dissociative symptoms (p. 663).

The *DSM-5* (APA, 2013) also presents an alternative model for diagnosing personality disorders, including BPD. General criteria for a personality disorder utilizing the alternative model include:

A. Moderate or greater impairment in personality (self/interpersonal) functioning.

B. One or more pathological personality traits.

C. The impairments in personality functioning and the individual's personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations.

D. The impairments in personality functioning and the individual's personality trait expression are relatively stable across time, with onsets that can be traced to at least adolescence or early adulthood.

E. The impairments in functioning and the individual's trait expression are not better explained by another mental disorder.

F. The impairments in personality functioning and the individual's personality trait expression are not solely attributable to the physiological effects of a substance or another medical condition (e.g., severe head trauma).

G. The impairments in personality functioning and the individual's trait expression are not better understood as normal for an individual's developmental stage or sociocultural environment (p. 761).

Proposed criteria for BPD in the DSM-5 (2013) using the alternative model is as follows:

A. Moderate or greater impairment in personality functioning, manifested by characteristics difficulties in two or more of the following four areas:

1. Identity: Markedly impoverished, poorly developed or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.
2. Self-direction: Instability in goals, aspirations, values, or career plans.
3. Empathy: Compromised ability to recognize the feelings and needs of others associated with hypersensitivity (i.e., prone to feel slighted or insulted); perceptions of others selectively biased against negative attributes or vulnerabilities.

4. Intimacy: Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or perceived abandonment; close relationships often viewed in extremes of idealization and devaluation and alternating between overinvolvement and withdrawal.

B. Four or more of the seven pathological personality traits, at least one of which must be (5) Impulsivity, (6) Risk-taking, or (7) Hostility.

1. Emotional Lability (an aspect of Negative Affectivity): Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.
2. Anxiousness (an aspect of Negative Affectivity): Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.
3. Separation insecurity (an aspect of Negative Affectivity): fears rejection by- and/or separation from- significant others, associated with fears of excessive dependency and complete loss of autonomy.
4. Depressivity (an aspect of Negative Affectivity): Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feelings of inferior self-worth; thoughts of suicide and suicidal behavior.
5. Impulsivity (an aspect of Disinhibition): Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or

consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behavior under emotional distress.

6. Risk-taking (an aspect of disinhibition): Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; a lack of concern for one's limitations and denial of the reality of personal danger.
7. Hostility (an aspect of Antagonism): Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults. (pp. 766-767)

The Psychodynamic Diagnostic Manual second edition (*PDM-2*; Lingiardi & McWilliams, 2017), offers an alternative to the DSM. Psychologists created the first psychodiagnostic manual following the release of the DSM- III (APA, 1980), which was perceived by some as an attempt to "remove psychoanalytic bias" and incorporate other, newer orientations. The *PDM-2* emphasizes personality functioning, mental functioning, and symptom patterns (Lingiardi & McWilliams, 2017). The manual notes it "aspires to be a 'taxonomy of people' rather than a 'taxonomy of disorders' and highlights the importance of considering *who one is* rather than *what one has"* (Lingiardi & McWilliams, 2017, p. 2).

As such, the *PDM-2* utilizes different categorical descriptions than the *DSM-5* as criteria for BPD (and other disorders). These include describing "key features" which are comprised of: contributing constitutional-maturational patterns, central tension/preoccupation, central effects, characteristic pathogenic belief about self, characteristic pathogenic belief about others, and central ways of defending. The psychodynamic conceptualization of BPD is described as "complex and multi-faceted" and inclusive of the following: use of primitive defenses such as splitting and projective identification, disorganized attachment, psychiatric management

difficulties, lack of mentalization, impaired affect regulation, and lack of continuity of self and others (Lingiardi & McWilliams, 2017, p.53). The *PDM-2* theory of BPD notes the following as having evidence as etiological factors: genetic vulnerability, early attachment disorders, developmental arrest, and severe relational trauma (Lingiardi & McWilliams, 2017, p. 53).

The *PDM-2* describes "key features" of BPD thusly:

> Contributing constitutional-maturational patterns: Congenital difficulties with affect regulation, intensity, aggression, capacity to be soothed.
>
> Central tension/preoccupation**:** Self-cohesion versus fragmentation; engulfing attachment versus abandonment despair.
>
> Central affects: Intense affects generally, especially rage, shame, and fear.
>
> Characteristic pathogenic belief about self: "I do not know who I am; I inhabit dissociated self-states rather than having a sense of continuity."
>
> Characteristic pathogenic belief about others: "Others are one-dimensional and defined by their effects on me, rather than a sense of their complex individual psychology."
>
> Central ways of defending: Splitting, projective identification, denial, dissociation, acting out, and other primitive defenses. (Lingiardi & McWilliams, 2017, pp. 54-55).

The International Statistical Classification for Diseases (ICD) is an internationally utilized classification system for disorders compiled by the World Health Organization (WHO). The ICD-11 takes an approach that appears to include the dimensionality of the *DSM-5* alternate model and the *PDM-2* (APA, 2013; Lingiardi & McWilliams, 2017), and the criteria from the *DSM-5*. The ICD-11 has only one personality diagnosis with specifiers of mild, moderate, and

severe. They use the following pervasive personality traits or patterns to increase specificity. Specifiers include negative affectivity in personality disorder or personality difficulty, detachment in personality disorder or personality difficulty, dissociality in personality disorder or personality difficulty, disinhibition in personality disorder or personality difficulty, anankastic in personality disorder or personality difficulty, and borderline pattern (WHO, 2018). The borderline pattern specifier is extremely similar to the *DSM-5* BPD diagnostic criteria with one criterion described differently "A tendency to act rashly in states of high negative affect, leading to potentially self-damaging behaviours" (WHO, 2018).

Upon examination, all the definitions of BPD are fairly similar. All definitions share core criteria including emotional dysregulation, fears of abandonment, negative affect/aggression, impulsivity, and difficulties with unstable identity. (APA, 2013; Lingiardi & McWilliams, 2017; WHO, 2018). Differences include a focus on dimensionality in the models other than the standard DSM-5 (2013) definition and a person versus pathology approach by the PDM-2 (Lingiardi & McWilliams, 2017).

Current Models of BPD

Although several different nosological models define BPD, several of these models (notably, the DSM system) avoid explorations of the etiology of diagnosis and focus instead on its presenting symptoms and signs. Such models reflect the modern move toward observable and measurable markers of a diagnosis. However, it is also essential to understand the etiological models proposed for BPD to help understand where and why it develops in individuals.

There are currently several models that are widely used to conceptualize BPD. Biosocial, psychodynamic, and attachment theories are three of the primary frameworks utilized to conceptualize and treat BPD. The current zeitgeist appears to favor biosocial theory, yet

attachment research seems to be supporting both psychodynamic and attachment theories. As such, it is vital to examine the primary theories which are currently at the forefront of treatment of BPD.

Biosocial Theory. Currently, a widely accepted conceptualization of BPD is that of Marsha Linehan, who proposed that the etiology of BPD is biosocial and posited that the etiology of BPD is a convergence of biological vulnerabilities and an invalidating environment (1993). The invalidating environment is described as, "intolerance toward the expression of private emotional experiences, in particular, emotions that are not supported by observable events" (Crowell et al., 2009, p. 496). Invalidating environments are posited to “intermittently reinforce extreme expressions of emotion” (Crowell et al., 2009, p. 496) while at the same time dismissing and disapproving of the child’s emotions and how they are being displayed. The message communicated to the child is that their emotional expressions are unwanted and should be dealt with on their own. The result, according to Linehan (2003), is emotional dysregulation, which she views as the core of the disorder.

Linehan elaborated on her theory in 2009, reducing her emphasis on early emotional development as a primary etiological factor and placing significantly more focus on biological vulnerabilities. These biological vulnerabilities include genetic influences, abnormalities of brain systems, and frontolimbic dysfunction (Crowell et al., 2009).

"High risk transactions" are used to describe the interactions between the pre-disposed, genetically vulnerable child and the caregiver, that contribute to the development of BPD (Crowell et al., 2009). The researchers posited that children contribute to high-risk transactions as well, with negative affect, impulsivity, and high emotional sensitivity. The caregivers are hypothesized to contribute invalidation and inadequate coaching of a child's emotions, negative

reinforcement of aversive emotional experiences, and ineffective parenting due to the poorness of fit, insufficient family resources or a combination of both (Crowell et al., 2009).

Linehan (1993) describes the invalidating environment as:

> …one in which communication of private experiences is met by erratic, inappropriate, and extreme responses…the expression of private experiences is not validated; instead, it is often punished and/or trivialized. The experience of painful emotions, as well as the factors that to the emotional person seem causally related to the emotional distress, are disregarded…interpretations of her own behavior, including the experience of the intents and motivations associated with the behavior, are dismissed (p. 49-50).

When the predisposed child meets the invalidating environment (emotional invalidation or punishment for emotional responses), Linehan's model theorizes that emotional dysregulation and an increased risk for psychopathology occur due to environmental reinforcement of emotional lability. They proffer that the resultant emotional dysregulation results in the child experiencing difficulties with information processing, organization of non-mood dependent goals, and controlling mood-dependent behavior.

Crowell et al. (2009) further suggested that these difficulties result in "shutting down" and "freezing" behaviors. As these reinforcing interactions repeatedly occur over time, these emotional patterns become traits and have a lasting impact on an individual's social, cognitive, emotional, and behavioral domains. As a child struggles to cope, maladaptive behaviors which developed in order to self-regulate and avoid become reinforced, which results in BPD symptomology (Crowell et al., 2009).

Psychodynamic Theory. Psychology has historically posited several conceptualizations of BPD as being related to early childhood attachment experiences. Psychodynamic theory, particularly object relations, has long hypothesized psychic developmental failures in separation from attachment figures as the etiology of borderline pathology (Kernberg, 1975; Klein, 1946; Mahler, Pine, & Bergman, 1975). Specifically, these failures are posited to occur approximately between the ages of 18 months to 3 years, during what Mahler (1975) referred to as the rapprochement phase.

The conflict of the rapprochement phase essentially consists of the ambiguity the child experiences as they gain awareness of their separateness and the subsequent striving for autonomy while remaining connected to their primary caregivers. Lack of a successful resolution of the rapprochement phase is posited to result in borderline pathology as the sense of self lacks full differentiation from the primary caregiver (Mahler et al., 1975).

Currently, two psychodynamic treatments, Transference Focused Psychotherapy (TFP; Clarkin et al., 2001) and Mentalization-Based Therapy (MBT; Bateman & Fonagy, 2003) appear to be equally efficacious, and in some cases superior to, Linehan's (1993) DBT treatment. Of note, while both MBT and TFP are considered psychodynamic treatments, they both focus heavily on interpersonal/attachment issues and utilize concepts from attachment theory.

TFP was compared to DBT and a modified supportive psychodynamic therapy by Levy et al., (2006). Results indicated that after 12 months of treatment, only the TFP group evidenced significant improvement in attachment patterns, as measured by the Adult Attachment Inventory (AAI; George, Kaplan, & Main, 1985). The TFP group increased from 4.5% of the subjects falling into the secure attachment category to a statistically significant 31.8% of subjects assessed as being in the secure attachment category at the end of the study. The two other groups

each began with one securely attached subject and remained the same at the end of the study. In addition, significant increases in reflective functioning and cohesion of narratives were found within the TFP population. Notably, no changes in the resolution of loss or trauma were indicated in any of the treatment groups (Levy et al., 2006).

MBT (Bateman & Fonagy, 2003), which overlaps significantly with TFP, has also been shown to be an effective treatment for BPD. In a later study by Bateman and Fonagy (2009) randomly assigned patients with BPD showed significantly more reductions in both self-reported and clinically significant problems, including suicide attempts and hospitalization, than patients assigned to the treatment-as-usual group.

Attachment Theory. Attachment theory (Bowlby, 1969, 1973, 1980) posited that early interactions between primary attachments figures and infants form internal working models which become the basis for a person's view of self and others. Research on attachment, namely the Strange Situation, led to three initial categories of attachment: secure, avoidant, and ambivalent (Ainsworth et al., 1978), followed by an additional category of disorganized attachment (Main & Soloman, 1990).

In the Strange Situation observations, securely attached infants freely explored their surroundings, utilizing their mother as a base, appeared distressed when their mother left, but quickly recovered upon the mother's return (Ainsworth et al., 1978). Results from the Strange Situation indicated that 63% of infants were securely attached.

The two other categories, avoidant and anxious-ambivalent, fall under the category of insecure attachment. In the Strange Situation, the avoidantly attached infant seemed disconnected from the mother, often not noticing when she left the room and did not approach the mother upon her return (Ainsworth et al., 1978). The anxious-ambivalent infants appeared

intensely distressed when the mother left, sought attention upon her reappearance, but were not easily consoled upon her return (Ainsworth et al., 1978).

Disorganized attachment (Main & Solomon, 1990) was added a decade later to describe infants who experienced chaotic behavior patterns in their parent's presence, such as crawling toward the mother then falling on the ground. These children appeared to have impaired strategies for connecting to the mother (Ainsworth et al., 1978). The *PDM-2* suggests this disorganized, insecure attachment style is a likely contributor to the development of BPD (2017).

The three theoretical conceptualizations of BPD (Linehan's model, psychodynamic, and attachment) have much in common. All consider early childhood interactions to be impactful regarding the development of BPD. They differ primarily in that psychodynamic and the attachment models emphasize that the child's early experiences with caregivers, including poor or disrupted attachment and/or PM (e.g. trauma) are necessary etiological factors in the development of BPD (Ensink, et al., 2016, Fonagy, Steele, Steele, Moran, & Higgit, 1991; Kernberg, 1975; Klein, 1946; Levy, 2005; Mahler et al., 1975), whereas Linehan's (2009) model continues to require an interaction between a biological predisposition and an invalidating environment, carefully and purposely limiting the role of attachment, PM, and trauma.

CHAPTER III: PROBLEMS WITH EXISTING MODELS

The current models' explanations regarding the lack of trauma reported in a minority of those with a BPD diagnosis appear to have significant problems with validity when methods are scrutinized. There are several concerning holes when research on BPD is closely examined. First, when relying on self-reports from patients with BPD, we must acknowledge that many people do not recognize emotionally abusive or emotionally neglectful behavior on the part of caregivers. Unless the researchers specifically probe for more subtle forms of emotional abuse and neglect, such as verbal abuse, psychological manipulation, and lack of basic affection, many people would not consider, or possibly even categorize, such behaviors as abusive or traumatic.

Perhaps the most significant problem with assessing trauma by self-reports is the issue of precognizant memories. The concept of childhood amnesia is well-accepted and an extensive body of research places first childhood memories as generally occurring from ages 3-4 (MacDonald, Uesiliana, & Hayne, 2000; Mullen, 1994; Usher & Neisser, 1993). It is also well accepted within psychology and neuropsychology that early experiences have significant and enduring effects on a child's developing brain and psyche (Bowlby, 1969, 1973, 1980 Ensink, et al, 2016, Fonagy, et al., 1991; Kernberg, 1975; Klein, 1946; Levy, 2005; Mahler et al., 1975; van der Kolk, 2001, 2003; van der Kolk et al., 1991; van der Kolk et al, 2005).

Cordell et al. (2004) concluded in their review of childhood trauma and memory that traumatic events which occur before age two will likely not become part of our "conscious autobiographical memory system, even though these events may continue to influence behavior in the years to come" (p. 127). This realization leaves self-report measures of abuse extremely unreliable concerning traumatic events that took place during critical developmental periods. Essentially, one cannot report what one does not remember or know. Examples of situations that

could occur before a child develops their conscious autobiographical memory include a mother who had severe postpartum depression, a parent who was incarcerated, or a caregiver who was emotionally absent due to substance use. The previous are all examples of experiences which could likely be kept a family secret, or regarded by persons as insignificant, but may, in fact, have significant and enduring effects on a child's interpersonal, biological, and identity development by disrupting attachment. Important, consequential and impactful information may be lost to or withheld from individuals, rendering self-reports likely to be severely underreported.

A retort may be that those with BPD may exaggerate childhood histories of abuse. However, a sound review of retrospective reports in adulthood of major adverse experiences in childhood displayed substantial false negatives or underreporting (Hardt & Rutter, 2004). Additionally, false-positive results were posited to be significantly less, supporting the idea that important events from childhood are more likely to be under, rather than over-reported. Additional studies on the topic were not found.

Definitions of Trauma

It becomes important to define what may be considered traumatic. There is no single definition of psychological trauma. Stressors fall on a continuum, and there are not clearly delineated demarcations between ordinary and traumatic stressors.

Some definitions of trauma are more inclusive than others. For example, Merriam-Webster (online) defines trauma as **"**a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury" (2018). The U.S government-funded program, Substance Abuse and Mental Health Services Administration, states that "trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse

effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2012, p. 2). Another definition of trauma (Horowitz, 1989, p. 265) posits that an event can be traumatic if it "contradicts one's worldview and overpowers one's ability to cope."

In stark contrast to the previous definitions of trauma, the DSM-5 (2014) defines trauma as exposure to "actual or threatened death, serious injury, or sexual violence" (p. 271). This definition is narrow and used to establish Criteria A in a diagnosis of PTSD. A search of "trauma" on the APA website resulted in this description "Trauma is an emotional response to a terrible event like an accident, rape or natural disaster" (APA, 2018).

The trauma which the DSM-5 refers to has been criticized by many in the trauma treatment community as not capturing the effects of chronic interpersonal trauma (Cloitre et al., 2013, 2014; Courtois & Ford, 2013; Grossman, Spinazzola, Zucker, & Hopper, 2017; Herman, 1992; Marinova & Maercker, 2014; van der Kolk, 2001, 2014). Abuse, neglect, exploitation, betrayal, rejection, and abandonment within a framework in which one cannot escape (a child, a prisoner of war, or a person in an abusive relationship) would be considered chronic interpersonal trauma (Courtois & Ford, 2013; Herman, 1992). Interpersonal developmental trauma (trauma which occurs during critical developmental periods), specifically emotional abuse, has been correlated with the highest levels of symptom severity and diffuse, severe psychopathology in adulthood, yet there is no current diagnosis which fully captures the full impact of such trauma (Cloitre et al., 2013, 2014; Grossman et al., 2017; Herman, 1992; van der Kolk, 2001, 2014).

Complex Trauma

The psychological community has posited new definitions of traumatic disorders in order to expand the definition of what is traumatic. Complex Posttraumatic Stress Disorder (CPTSD),

as well as Developmental Trauma Disorder (DTD), explain the differences found in those who experience ongoing versus single event trauma (Herman, 1992; van der Kolk, 2005). Differences between those who experienced chronic interpersonal trauma and those who experienced isolated incidents have led to the proposition of CPTSD (Herman, 1992). Posttraumatic Stress Disorder (PTSD) and CPTSD (which is not in the *DSM-5*) are proposed to be both qualitatively and quantitatively different. Examining the differences between PTSD, CPTSD, and BPD are essential in understanding trauma's role in psychopathology.

Definitions of Current Trauma Disorders

Posttraumatic Stress Disorder (PTSD). PTSD is considered a fear-based disorder, is limited to fear-based reactions, and may occur following a single incident. Originally, PTSD was developed to address the symptoms experienced by those returning from war, specifically Vietnam. *DSM-5* (APA, 2013) criteria require exposure to actual or threatened death, serious injury, or sexual violence; intrusion symptoms; persistent avoidance of stimuli associated with the event(s); negative alterations in cognition and mood, marked alterations in arousal and reactivity. Symptoms must cause significant impairment or distress in critical areas of functioning, and the duration of symptoms must be longer than one month.

PTSD does not encompass psychological-only abuse and does not address prolonged exposure to multiple events. The diagnosis may be more appropriate for survivors of a car accident, one-time sexual assault, or single military trauma exposure. Prisoners of war, individuals in emotionally abusive relationships, and victims of multiple traumatic experiences across their lives would not be best served by a PTSD diagnosis, as it lacks the recognition of the more characterological changes caused by early and/or repeated trauma (Herman, 1992; van der Kolk, 2014).

Complex Posttraumatic Stress Disorder (CPTSD). CPTSD was conceptualized to encompass the additional symptoms not covered by PTSD, such as difficulties with emotional regulation, interpersonal relationships, and self-concept (Cloitre et al., 2013; Herman, 1992). Given the repeated nature of the interpersonal trauma, often during critical developmental periods, and one's inability to escape the situation, those with CPTSD tend to have more significant pathology than those with a single exposure to trauma (Herman, 1992; van der Kolk 2005, 2014). It is posited that CPTSD effects core aspects of the self, such as identity, the ability to tolerate and manage emotions effectively, and can cause chronic difficulties in relating with others (Cloitre et al, 2013, 2014; Courtois & Ford, 2013; Grossman, Spinazzola, Zucker, & Hopper, 2017; Herman, 1992; Marinova & Maercker, 2014; van der Kolk, 2005, 2014).

ICD-11(WHO, 2018) proposed symptom criteria for CPTSD included all proposed symptom criteria for PTSD (re-experiencing, avoidance, and sense of threat) with additional disturbances in self-organization reflected in the categories of emotional regulation difficulties, negative self-concept, and interpersonal problems (Cloitre et al., 2014). CPTSD occurs in cases of repeated trauma and tends to permeate more areas of functioning and produce more significant clinical pathology (Cloitre et al., 2013, 2014; Courtois & Ford, 2013; Grossman et al., 2017; Herman, 1992; Marinova & Maercker, 2015; van der Kolk, 2001, 2014). It is notable that ICD-11 identified physical and sexual childhood abuse as experiences which could cause CPTSD, but did not name emotional or psychological abuse or neglect as qualifying events (WHO, 2018).

Comparing BPD and CPTSD

A latent class analysis was performed by Cloitre et al. (2014) in order to determine if there were distinctions between BPD and CPTSD. The study found that while both disorders share symptoms of emotional dysregulation, they are expressed differently. Those with CPTSD

were found to experience emotional sensitivity, reactive anger, and a lack of effective coping responses. Other differences between BPD and CPTSD found by Cloitre et al. (2014, p.3) include: in BPD identity is shifting as opposed to consistently negative in CPTSD, those with CPTSD tend to avoid relationships whereas those with BPD engage in "sustained chaotic engagement," and in CPTSD there may not be a fear of abandonment. The most significant difference between BPD and CPTSD was described thusly, "perhaps the defining characteristics of the disorder [BPD], include suicide attempts and gestures as well as self-injurious behaviors; events which occur with much less frequently in complex forms of PTSD than in BPD **(**Cloitre et al., 2014, p.3)

CPTSD and BPD are believed by some to be one and the same (Courtois, 2004; Herman, 1992, van der Kolk, 2014) while others believe they are two distinct disorders (Cloitre et al., 2014; Crowell et al., 2009; Ford & Courtois, 2014; Linehan, 1993). Even amongst those who believe BPD and CPTSD are two separate disorders, there is general agreement that, at a minimum, there is significant overlap of symptomology and high levels of co-morbidity between the two disorders (Cloitre et al., 2014; Crowell et al., 2009; Ford & Courtois, 2014).

The proposed criteria for CPTSD was available for online preview (2018) in the currently yet to be published ICD-11 (anticipated release 5/2019). The description on the WHO website previewed ICD-11 is proposed to be as follows:

> Complex post-traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All

> diagnostic requirements for PTSD are met. In addition, Complex PTSD is characterized by severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational, or other important areas of functioning (2018).

Some leading researchers in the trauma community believe that BPD falls on the trauma spectrum. They attribute the symptoms of impulsivity, relational and regulatory difficulties, and fluctuating identity as adaptations resulting from childhood trauma (including attachment trauma; Courtois, 2004; Herman et al., 1989; Herman, 1992; van der Kolk, 2014).

As previously noted, the theory that trauma causes BPD has also been endorsed by well-established researchers such as Bessel van der Kolk and Judith Herman. Trauma theory emphasizes the long-standing emotional, interpersonal, physiological, and neurological effects that repeated, chronic trauma causes (Cloitre et al, 2013, 2014; Courtois & Ford, 2013; Grossman, et al., 2017; Herman, 1992; Marinova & Maercker, 2015; van der Kolk, 2001, 2014). Additionally, trauma theory considers the effects of chronic interpersonal trauma during critical developmental periods. (D' Andrea et al., 2012, Spinazzola et al., 2017; van der Kolk, 2001, 2014).

The Role of Psychological Maltreatment (PM)

Psychological maltreatment (PM) consists of emotional abuse, neglect, or a combination of both. The American Professional Society on the Abuse of Children (APSAC) uses Glaser's (2002) definition "a repeated pattern of caregiver behavior or a serious incident that transmits to

the child that he/she is worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs" (p. 698). Additionally, Glaser (2002) stated that "failure to meet a child's needs as a psychosocial being" constitutes PM (p. 698). As such, APSAC endorsed Glaser's (2002) findings regarding emotional abuse and neglect to include: "parental emotional unavailability, unresponsiveness, and neglect; negative attributions and misattributions to the child; developmentally inappropriate or inconsistent interactions with the child; failure to acknowledge the child's individuality and psychological boundary; and failure to promote the child's social adaptation" (p.699).

If one considers that an infant, unlike most other mammals, is entirely dependent on its caregivers for survival, it is reasonable to assume that an infant or toddler who cannot rouse parental interactions, which lead to their basic physical and emotional needs being met, would be traumatized. As noted previously, childhood PM has been found to have the strongest correlation to diagnoses of BPD (Afifi et al., 2011; Imboden, Park, Hulse & Unger, 1992; Kuo et al., 2015; Lobbestael et al., 2010). In fact, childhood abuse is so significantly correlated with BPD that some clinicians believe posttraumatic stress symptoms are implicit in BPD diagnoses (Herman, 1992; Landecker, 1992; van der Kolk, 2005). In a review of 13 attachment studies with BPD patients, researchers found that each study resulted in the conclusion that there is a strong association between insecure attachment and BPD (Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004).

For the purposes of this research, attachment trauma is based upon the definition by Crittenden (1985), which has been adopted by van der Kolk and summarized as "when caregivers are extraordinarily inconsistent, frustrating, violent, intrusive, or neglectful, children are likely to become intolerably distressed, without a sense that the external environment will

provide relief" (van der Kolk, 2003 p. 296). Unable to rely on caregivers, children who have experienced attachment trauma have been found to experience high levels of anger, anxiety, and a desire for others to care for them (Crittenden, 1985).

There are several ways in which traumatic attachment can occur, such as when the parent is unavailable due to illness or hospitalization, the child is removed from the home, the parent is impaired by substances or mental illness (including depression), the child is psychologically or physically abused or neglected, the parent provides inconsistent care, or the parent is chronically misattuned with the child (Bowlby, 1969, 1973, 1980; Crittenden, 1985; van der Kolk, 2003, 2005, 2014).

Early childhood trauma generally refers to the traumatic experiences that occur to children aged 0-6. Because infants' and young children's reactions may be different from older children's, and because they may not be able to verbalize their reactions to threatening or dangerous events, many people assume that young age protects children from the impact of traumatic experiences. A growing body of research has established that young children may be affected by events that threaten their safety or the safety of their parents/caregivers, and their symptoms have been well documented (Courtois & Ford, 2013; Godbout et al., 2019; Spinazzola et al., 2017; van der Kolk, 2014). These traumas can be the result of intentional violence—such as child physical or sexual abuse or domestic violence—or the result of a natural disaster, accidents, or war. Young children also may experience traumatic stress in response to painful medical procedures or the sudden loss of a parent/caregiver (National Child Traumatic Stress Network, 2018).

Even gender differences related to attachment in BPD etiology have been examined and linked to attachment. A study by Godbout et al. (2019) resulted in the finding that maltreatment

which occurs in opposite sex parental relationships (father/daughter, mother/son) predicts BPD symptoms through the development of insecure attachments. The authors noted that their findings strongly suggest that attachment-focused and trauma-focused interventions are indicated as the treatment of choice for BPD.

In summation, there are many reasons to challenge existing models and their dismissal of trauma as necessary for the development of BPD. Aforementioned recent research strongly supports the idea that attachment trauma and PM are strongly correlated to BPD symptomology. The preponderance of evidence appears to be indicating that attachment trauma and PM are likely necessary for the development of BPD symptomology.

CHAPTER IV: TRAUMA IS NECESSARY AND SUFFICIENT FOR BPD

BPD is Caused by Attachment Trauma or Psychological Maltreatment

Emotional abuse or neglect is intrinsically entwined with attachment. They are linked in a way that can explain the 20-40% of those with a BPD diagnosis who do not report a trauma history. In an ongoing study being conducted by the Justice Resource Institute (JRI), preliminary data presented at the 28th Annual International Trauma Conference in May 2017 by Spinazzola, Blaustein, Warner, and van der Kolk indicated that PM had significantly more impact than Sexual Abuse (SA) and Physical Abuse (PA). The result of the study showed those children who experienced PM had equal to or greater than frequency or severity on 27 of 30 measured outcomes than did the groups with sexual abuse and physical abuse combined.

Psychological maltreatment was found to render a "distinct clinical profile" that included a higher level of internalizing problems, specifically non-suicidal self-injury (NSSI) and attachment problems, than those with either SA or PA (Spinazzola et al., 2017). The PM group was found to have greater externalizing problems than those in the SA group and were equivalent to the PA group. The PM group had higher levels of behavioral problems at home than either of the two other groups. PTSD symptoms, however, were found to be equal among the three groups. Depression, generalized anxiety, substance use, separation disorder, and acute stress disorder were all higher in the PM group than the SA and PA groups combined. Overall, findings indicated that PM had a significantly greater impact on pathology than SA or PA (Spinazzola et al., 2017).

Initially, in the JRI's ongoing study, Spinazzola et al. (2017) included two separate criteria for Criterion A – A1. Attachment Disruption and A2. Traumatic Victimization. However, the results of the Phase 2 trials indicated that an attachment trauma was the single most

significant predictor of developmental trauma disorder and that traumatic victimization was not necessary for the development of the severe symptomology. As such, it was proposed to remove Criterion A2 during the next phase of the study. Essentially, attachment trauma alone can and does cause severe symptomology in child populations. Upon examination, the criteria for DTD appears strikingly similar to BPD criteria.

DTD proposed criteria includes:

Criterion A: Attachment Disruption (with or w/out traumatic victimization)

Criterion B: Affective/Physiological Dysregultation

B. 1. Inability to modulate or tolerate extreme affect states

B .2. Inability to modulate/recover from extreme bodily states:

Aversion to (a) touch, (b) sound, (c) unexplained bodily problems

B. 3. Diminished awareness/dissociation of emotional or bodily feelings

B. 4. Impaired capacity to describe emotions or bodily states

Criterion C: Attentional/Behavioral Regulation

C. 1. Attention bias toward or away from potential threats

C. 2. Impaired capacity for self-protection, including extreme risk taking or thrill-seeking

C. 3. Maladaptive self-soothing

C. 4. Habitual or reactive self-harm

C. 5. Inability to initiate or sustain goal-directed behavior

Criterion D: Self and Relational Dysregulation

D. 1. Persistent extreme negative self-perception

D. 2. Attachment insecurity: attempt to care for caregivers, or difficulty

tolerating reunion after separation from primary caregivers

D. 3. Extreme persistent distrust, defiance, or lack of reciprocal behavior in close relationships

D. 4. Reactive physical/verbal aggression

D. 5. Psychological boundary deficits (excessive seeking of intimate contact or reliance on peers/adults for safety/ reassurance

D. 6. Dysregulated empathic arousal (intolerant/indifferent or overly reactive to others' distress) (Spinazzola et al., 2017).

Table 1.

Criteria for DTD Compared to Criteria for BPD

Criteria for DTD	Criteria for BPD
D. 2. Attachment insecurity: or difficulty tolerating reunion after separation from primary caregivers	1. Frantic efforts to avoid real or imagined abandonment
D. 5. Psychological Boundary Deficits (excessive seeking of intimate contact or reliance on peers/adults for safety/ reassurance)	2. A pattern of unstable and intense personal relationships alternating between extremes of idealization and devaluation
C. 2. Impaired capacity for self-protection Including extreme risk-taking or thrill-seeking/ C. 3. Maladaptive self-soothing	4. Impulsivity in at least two areas that are self- damaging
C. 4. Habitual or reactive self-harm	5. Recurrent suicidal behavior, gestures, threats, or self-mutilating behaviors

B.1. Inability to modulate or tolerate extreme affect states	6. Affective instability due to marked reactivity of mood
B 3. Diminished awareness/ dissociation of emotional or bodily feelings	4. Transient, stress-related paranoid ideation or severe dissociative symptoms
D.4. Reactive physical/verbal aggression	8. Inappropriate, intense anger or difficulty controlling anger

As shown in Table 1, DTD criteria and BPD criteria are incredibly similar. One notable exception is that DSM-5 criterion 3 for BPD identity disturbance is indicated by a "markedly and persistently unstable self-image or sense of self" whereas DTD proposed criteria describes a "persistent extreme negative self- perception." This difference in identity appears to align with differences between proposed CPTSD criteria and BPD criteria, with CPTSD also utilizing "negative self-view" as proposed criteria. A review of relevant literature does not appear to elaborate theoretically as to the proposed difference between negative mood and unstable mood.

Explaining BPD Criteria with Attachment and Developmental Models

BPD criteria can be explained by utilizing an attachment trauma framework. According to Levy (2005, p. 959), BPD personality structure is a result of "underlying attachment organization." In his literature review, Levy (2005, p. 980), concluded that despite lingering questions regarding specific mechanisms of BPD development an "attachment theoretical perspective within a developmental psychopathology framework appears to be a powerful approach to understanding the mechanisms underlying both the interpersonal and intrapersonal difficulties characteristic of BPD." Attachment theory can explain BPD criteria as defined in DSM 5 (APA, 2013).

Criteria 1. Frantic efforts to avoid real or imagined abandonment. When children develop an insecure attachment style in infancy, efforts to reattach or evoke caretaking behaviors are employed (Bowlby). Those who have experienced attachment trauma appear to be more sensitive to rejection and perceived abandonment (Levy 2005; van der Kolk, 2014**).**

Criteria 2. A pattern of unstable or intense interpersonal relationships, idealization and devaluation. Bowlby (1958, p.11) posited that children who do not have loving, attuned parents have "high libidinal needs" which cause them to continually look for love/affection and "hate those who fail or seem to fail" them.

Criteria 3. Identity Disturbance: markedly and persistently unstable self-image or sense of self. Bowlby (1973) also noted that he believed there to be significant evidence that a child's actual experiences (as opposed to perceived experiences) shape children's internal working models. He further posited that those with multiple, incongruent internal working models tend to have more severe pathology. Utilizing Bowlby's theory, the "unstable sense of self" is easily explained by multiple, conflicting internal working models.

In 2004 Bateman and Fonagy posited that the lack of parental attunement on the part of primary caregivers leads to an impaired ability to develop clear self and other representations. They particularly emphasized that a lack of a caregiver's ability to mirror the child's affect appeared to significantly impact identity development.

Criteria 4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Impulsivity may be viewed as one aspect of emotional dysregulation. Poor attachment, PM or a combination of both frequently result in impairment in the development of emotional regulation (Cloitre et al., 2009: van der Kolk, 2003; Spinazzola et al., 2014.) When parents are poor "co-regulators" (neglectful

or abusive), children fail to develop self-regulation or the ability to effectively self-soothe, which can lead to maladaptive attempts to regulate using substances or other potentially harmful behaviors (van der Kolk, 2013, Spinazzola et al., 2014).

Criteria 5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior. Self-harm was found to be significantly correlated with childhood trauma and maintained by poor attachment (van der Kolk, Perry, & Herman, 1991). The same study also linked dissociation and self-harm, both of which are criteria for BPD. Self-harm can also be related to maladaptive attempts to self-soothe due to poor co-regulation as a child, as well as attempts to exit dissociative states. (van der Kolk et al., 1991; van der Kolk, 2013, Spinazzola et al., 2014.)

Criteria 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days). Sensitivities to perceived abandonment are frequently a precursor to mood fluctuations (Levy, 2005; van der Kolk, 2003). In his 2005 review of attachment studies, Levy examined and concurred with recent studies linking BPD and poor attachment and stated that "impulsivity, affective lability, and self-damaging actions related associated with BPD" are likely "rooted in patterns of interactions with caregivers" (p. 959). Van der Kolk (2003) posited that "lack of ventral vagal modulation of the infant stress response may help clarify how disrupted early attachment patterns…contribute to long-lasting problems with control of affect regulation" (p. 302).

Criteria 7. Chronic feelings of emptiness. The "emptiness" that is found in BPD can be conceptualized several ways from an attachment perspective. Identity diffusion resulting from a lack of effective resolution of the rapprochement phase (Mahler et al., 1975) could result in

feelings of emptiness due to a lack of a cohesive sense of self. Courtois and Ford (2013) suggested that self-estrangement, alexithymia, and feelings of "an internal void" can be traced to "punishment" of emotional displays by attachment figures in childhood (p. 32).

The dissociation connected with BPD may play a role in feelings of chronic emptiness, as dissociation by nature is a split in consciousness in which one cannot be a cohesive self (Macfie, Cicchetti & Toth, 2001). Brain scans of adults who experienced severe early life-trauma were examined and found to have "almost no activation of the self-sensing areas of the brain" suggesting that childhood trauma can literally prohibit the development of a "self" (van der Kolk, 2014, p. 97).

Criteria 8. Inappropriate, intense anger, or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights). Children who have experienced attachment trauma have been found to experience high levels of anger, anxiety, and a desire for others to care of them (Crittenden, 1985; Spinazzola et al., 2017; van der Kolk, 2003, 2014). Hyperarousal resulting from repeated perceptions of threats to a child (usually from primary caregivers) overloads developing prefrontal cortexes and can leave neglected and abused children without sufficient inhibitory control (van der Kolk, 2005).

Criteria 9. Transient, stress-related paranoid ideation or severe dissociative symptoms. Paranoia can result from early attachment trauma. Suspiciousness surrounding close relationships and perceptions of others as potentially threatening are a natural consequence of interpersonal trauma occurring during critical developmental periods (Courtois & Ford, 2013; van der Kolk, 2014). As with affective lability, transient paranoia is frequently a response to a perceived threat of abandonment. Severe dissociative symptoms may begin as early as preschool

in maltreated children, leading to the aforementioned difficulties in the development of a cohesive sense of self (Macfie et al., 2001).

CHAPTER V: DISCUSSION

Clinical Implications

Reconceptualizing BPD as a form of attachment trauma could have significant implications for clinical treatment. Currently, BPD carries an incredible stigma. Those with the diagnosis are frequently dismissed and derided. Stefan (1998), in a study of court law, found that women diagnosed with BPD are frequently discredited as witnesses or labeled as mentally disabled, resulting in loss of child custody, parental rights, and mandated psychological hospitalizations/treatments. Becker (2000, p. 422) stated BPD is "viewed as a consequence of character" while PTSD is seen as a "consequence of fate." She further suggested that women with BPD are seen as the "bad girl" and those with PTSD as the "good girl" (Becker, 2000, p. 422).

While changing BPD to another name itself is not likely to have a significant impact on how the disorder is perceived, conceptualizing BPD from a trauma perspective may. In the most popular treatment for BPD currently (DBT), trauma and attachment are not addressed. Imagine a client who experiences emotional dysregulation, terror at the thought of abandonment, and repeated behaviors that drive others away. According to Linehan's model (2003), they have a "biological predisposition" and have experienced an "invalidating environment." There is an implied sense of hypersensitivity and a whitewashing of the physical, emotional, and psychological abuse the majority of BPD clients report. If that same client was informed they showed signs of insecure attachment as a result of unmet needs, neglect, or outright abuse (none of which would be their fault) and was provided psychoeducation regarding attachment trauma, they would likely view themselves and their behaviors very differently.

Explaining to a client that the primitive fear they experience (for example, when a text is not immediately returned) triggers a somatic flashback to precognizant, implicit memories when attachment needs were not met, which in turn, leads to panic and nearly irresistible urges to reconnect, can provide context and understanding of their behavior. From there, those with BPD can learn to recognize when their attachment systems become aroused by such memories, ground themselves, and delay their responses until thinking becomes clearer.

Helping those who have experienced interpersonal trauma understand why they react in ways that seem so out of proportion to others, appears to bring great relief. Nearly 30 years ago, Judith Herman (1992) wrote that when patients are informed of the correlation between their childhood abuse and their symptoms, they "become comprehensible to themselves…they no longer need to attribute them (symptoms) to an inherent defect in the self" (p. 127). Utilizing the trauma model helps those with BPD understand the reason for their reactions, but does not provide an excuse, thereby simultaneously demystifying the experience and encouraging the use of the knowledge to facilitate behavioral changes.

Another likely benefit of conceptualizing BPD as resulting from attachment trauma is that it places the emphasis of treatment, not solely on learning coping skills, but on building reparative, earned attachment within the therapeutic alliance. Providing a secure base and a safe haven in which a patient can experience connection, safety, and co-regulation of emotions with a therapist would almost certainly benefit those who have experienced attachment trauma. Herman (1992) described her belief thusly, "Recovery can take place only within the context of relationships; it cannot occur in isolation" (p. 133). It seems logical that those who have been hurt interpersonally would heal interpersonally.

The preponderance of evidence seems to indicate we are in dire need of a paradigm shift when it comes to conceptualizing BPD. There is ample research that suggests that attachment trauma or PM can explain the 20-40 percent of those with a BPD diagnosis who do not report trauma. Significantly better outcomes for those with BPD may result from trauma-informed treatments that recognize attachment trauma and PM as significant etiological factors in the development of BPD and which focus on improving a patient's attachment.

Areas for Future Research

Future research may include further studying the effects of treating those with BPD utilizing attachment-focused therapy vs. DBT to strengthen results of previous studies indicating more positive outcomes in the area of interpersonal relationships when using MFT and TFT. It may be of benefit to also examine less structured, staged, trauma-informed treatments, such as those proposed by Herman (1992) and Courtois and Ford (2013) in order to assess efficacy when compared to current models, such as DBT (Linehan, 1993). Research involving the difference between persistent negative states v. fluctuating states may be of value as they are noted as a defining difference between CPTSD and BPD. Further neurological studies are warranted to decipher if differences in brain functioning are the result of poor, early negative attachment or are contributing factors to the development of BPD symptoms.

Conclusions

Attachment trauma or PM appear to be significant, necessary contributors to the development of borderline symptomology. As such, treatments for BPD would likely benefit from increasing patient's interpersonal effectiveness by the conceptualization of borderline symptomology as responses to trauma. In addition, treatment focused on attachment appears to lead to more significant gains in interpersonal effectiveness.

Limitations

This review of the literature pertaining to attachment trauma, psychological maltreatment, and BPD is comprehensive, but not exhaustive. This review did not pursue in-depth neuropsychology research, which may have impacted conclusions.

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