UNIVERSITY OF PADOVA

Department of General Psychology

Bachelor's Degree Course in Psychological Science

Final dissertation

Borderline Personality Disorder and attachment styles in adulthood

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Academic Year 2023/2024

Abstract

The aim of this review is to look into the existing literature on Borderline Personality Disorder (BPD) and on the different attachment styles to investigate the intricate relationship between this disorder and attachment styles in adulthood. Specifically, it will examine how early attachment experiences influence the development of BPD symptoms and the manifestation of specific attachment patterns in adulthood. BPD is a complex mental disorder characterized by pervasive instability in interpersonal relationships, self-image, and affect, often leading to significant distress and impairment in daily functioning. Attachment styles contribute, even if to different extents, to the maintenance and expression of symptoms of BPD. It is very common for individuals with BPD to have an insecure form of attachment (anxious or avoidant), with remarkable implications for their social and romantic relationships.

Another aspect that will be analyzed is that of the use of social media by individuals with BPD, to try and understand the mechanisms that tie BPD to problematic social media use and how. To date, the number of studies that analyze the relationship between BPD and social media use are rather limited, which is why this should be a focal point for future research. Eventually, the results of the review explore potential therapeutic implications of understanding attachment styles in people with BPD, offering insights into how interventions targeting attachment-related vulnerabilities may enhance treatment outcomes for individuals with BPD.

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I. Borderline Personality Disorder

In recent years the interest in Borderline Personality Disorder (BPD) shown by the scientific community and the media has grown exponentially, bringing more and more attention to this complex and intriguing disorder, and to the consequences that it has on the individuals who suffer from it.

The term “personality" refers to “the enduring characteristics and behaviors that comprise a person’s unique adjustment to life, including major traits, interests, drives, values, self-concept, abilities, and emotional patterns” (American Psychological Association, 2018). It is nevertheless important to note that the concept of personality and its precise definition are still a hotly debated topic, which has yet to reach a consensus among the scientific community (Bergner, 2020). The word will be used in this review according to the definition offered by the American Psychological Association, as provided above.

A personality disorder is defined as “an enduring pattern of inner experience and behavior that deviates markedly from the norms and expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (DSM-5-TR; APA, 2022). The Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) recognizes 10 personality disorders, which are divided into 3 clusters: A, B, and C. Cluster A personality disorders are characterized by behaviors that show suspiciousness and distrust from others, social detachment, and behavioral eccentricities and oddities (Angstman & Rasmussen, 2011). These are Schizoid, Schizotypal, and Paranoid Personality Disorders. Cluster C personality disorders include Avoidant, Dependent, and Obsessive-compulsive Personality

Disorders. They are the most prevalent ones, and individuals with Cluster C personality disorders often show fearfulness and anxiety (Angstman & Rasmussen, 2011). Cluster B personality disorders are Histrionic, Narcissistic, Antisocial, and Borderline Personality Disorders, whose core features are a tendency to be emotional, erratic and dramatic (Butcher et al., 2017). Specifically, this review will focus on Borderline Personality Disorder.

BPD was first defined in 1978, and subsequently included in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-3) in 1980 and in the ICD (International Classification of Diseases) 10 years later (with the name of "Unstable Personality Disorder"). According to the definition provided by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR; APA, 2022), Borderline Personality Disorder 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". It is estimated that approximately 1 or 2 percent of the population meet the criteria for a diagnosis of BPD. To qualify for a diagnosis, individuals must meet at least 5 of the 9 symptoms indicated by the DSM-5. In clinical settings, around 10 percent of outpatients and 15-20 percent of psychiatric patients are diagnosed with BPD. About 75 percent of individuals diagnosed with BPD are women, even though this might be due to a large difference in treatment seeking rather than the actual sex difference in prevalence of the disorder (Butcher et al., 2017).

One of the key symptoms is the presence of pronounced fear of abandonment, which is experienced as fear/panic or anger/fury in response to real or imagined separation from those with whom they are attached (American Psychiatric Association, 2022). This could be seen in the form of fear of remaining alone or thinking that loved ones will come to experience a harmful situation. This may lead to a constant state of preoccupation that causes impairment in several

areas of functioning, such as academic, social or occupational functioning (Matthies et al., 2018). It is interesting to note that the fear of abandonment found in individuals with BPD is also a core feature of Separation Anxiety Disorder (SAD), which is characterized by extreme fear/anxiety related to being separated from major attachment figures. This could mean that there are shared etiological pathways linking the two disorders. Although the research concerned with the relationship between SAD and BPD is still not thorough, this highlights the importance of addressing separation anxiety in therapeutic interventions for BPD (Matthies et al., 2018).

Even though the causes that lead to the development of BPD and the expression of its symptoms are not yet entirely clear, a study conducted by Leichsenring et al. (2011) has found that there seems to be an interaction between genetic predisposition and having experienced adverse life conditions, which facilitates the appearance of the disorder. In fact, individuals with BPD tend to report, on average, an elevated frequency of separations from significant others before the age of 5 compared to controls, and also indicate higher scores on the Separation Anxiety Symptom Inventory (Silove et al., 1993; Matthies et al., 2018). This finding becomes intriguing when taking into consideration the fact that 44.8% of patients with an anxiety disorder were identified to have at least one personality disorder. Conversely, patients with BPD often suffer from an anxiety disorder as well, which shows the high comorbidity between the two, suggesting potential shared underlying mechanisms (Matthies et al., 2018). Treatment success was also shown to be limited for patients with BPD due to their elevated abandonment issues and separation anxiety. Moreover, patterns of insecure attachment can also complicate the therapeutic relationship (Matthies et al., 2018).

The intolerance for aloneness shown by individuals with BPD and the overwhelming fear

of abandonment are often accompanied (or followed) by intense emotional reactions and impulsive behaviors, such as self-mutilation (also known as non-suicidal self-injury, NSSI) or suicidal ideations. Individuals with BPD, with an average of four lifetime attempts, in fact attempt suicide more often compared to the non-clinical population (Mendez-Miller et al., 2022).

On the neural level, some studies with structural MRI on people with BPD have identified, compared to healthy controls, reduced volume in the amygdala (Leichsenring et al., 2011), which is assumed to be a fundamental structure for processing fear, anxiety, and intense emotional states (Davis, 2001). Negative early life experiences and stress could result in changes in the amygdala, and reduced amygdala volume could predispose to BPD (Schmahl et al., 2003). BPD was also found to be correlated with decreased volume in the hippocampus (Schmahl et al., 2003). A smaller hippocampal volume has been associated with stress (Schmahl et al., 2003), and individuals with BPD usually show an excessive production of cortisol, often conceptualized as "the stress hormone" (Leichsenring et al., 2011), and experience repeated exposure to acute stressful situations, such as intense rage and uncontrollable impulsivity (Bourvis et al., 2017). There have also been reports of reductions in grey matter volume in the anterior and posterior cingulate gyrus (Hazlett et al., 2005). This may represent a neural correlate of the emotional instability found in people with BPD, as the posterior cingulate cortex specifically is likely to be involved in emotional processing (Vogt et al., 2000).

BPD is usually diagnosed through the administration of self-report questionnaires and semi-structured interviews conducted by clinicians to check whether a subject meets the diagnostic criteria for this disorder. After a diagnosis has been disclosed, the patient should be informed of the following steps in their treatment, such as the type of psychotherapy that is going to be administered, the duration of the treatment, and possible pharmacotherapy. The main

treatment for BPD is psychotherapy (Gunderson, 2011). A review by Gunderson (2011) identified four types of evidence-based psychotherapy that, over the years, have been shown to be effective in the treatment of this disorder. The first one is Dialectical Behavior Therapy (DBT; Linehan, 1993): this intervention includes both individual and group therapy and uses a cognitive-behavioral model that combines acceptance, distress tolerance, and emotion regulation. The goal is to have the patient develop adaptive strategies to manage their behaviors and feelings with the help of stress-managing techniques and of the therapist who acts as an active and validating figure (Gunderson et al., 2018). In studies comparing DBT with treatment-as-usual, DBT was found to be more effective in reducing self-harming behavior and impulsive behavior, but not in decreasing suicidal ideation and behavior (Leichsenring et al., 2011). The second one is Mentalization-Based Therapy (MBT; Fonagy & Bateman, 2010): here the emphasis is on thinking before acting and learning how to recognize and identify one's and others' emotions (mentalizing). The third is Transference-Focused Psychotherapy (TFP; Kernberg, 2008): it's an individual form of therapy that focuses on the patient's misunderstanding of others and on understanding one's own subconscious emotions and intentions. The last one is General psychiatric management, which was developed following guidelines established by the American Psychiatric Association. While focusing on the patient's interpersonal relationships, it also leaves room for family interventions and pharmacotherapy. In this regard, selective serotonin-reuptake inhibitors (SSRIs), atypical antidepressants, mood stabilizers, and atypical antipsychotic agents are the most commonly administered drugs in the treatment of BPD (Gunderson, 2011; Leichsenring et al., 2011). However, the effects of these drugs are usually pretty modest, and side effects commonly occur (such as weight-gain) (Lieb et al., 2010). Nevertheless, the currently available research on the pharmacological treatment for the symptoms of BPD is rather limited

and underfunded (Gunderson et al., 2018), and more evidence is needed in order to make conclusive recommendations.

II. Attachment styles and Borderline Personality Disorder

Attachment theory was developed by John Bowlby, between the 1960s and the 1980s. This is a developmental theory rooted in the examination of interactions between infants and caregivers during the early stages of development. Attachment is defined as "lasting psychological connectedness between human beings" (Bowlby, 1969/1982, p. 194). The infant, pushed by survival needs and evolutionary processes, is motivated to create a meaningful attachment to the primary caregiver (in most cases, the mother). In times of distress, the child looks for support and turns to the mother to receive it, and the mother responds with behaviors that enhance intimacy and nurturing. The intimate connection with the mother is represented in the so-called "internal working models of attachment", which consists in interconnected systems that manage expectations relating to 1) whether oneself is someone who a close other will respond to with sensitivity and 2) whether the other individual will respond effectively to a need (Bowlby, 1973). Disruption of either one of these models due to improper caregiving will result in the individual developing an insecure form of attachment (Ainsworth et al., 1971).

Attachment styles are defined by the American Psychological Association (2018) as "the characteristic way people relate to others in the context of intimate relationships". They play an essential role in all types of relationships in adulthood, and develop as early as in the initial years of childhood. Four distinct styles of adult attachment have been identified: dismissive/avoidant attachment, fearful/disorganized attachment, preoccupied/anxious attachment, and secure attachment. The secure attachment style is characterized by a positive and optimistic view of oneself and others, while the avoidant attachment involves a negative view of others but a positive view of the self. Both the preoccupied and the fearful attachment styles are characterized by a negative view of the self, but the fearful style also involves a pessimistic view of others,

while people with a preoccupied attachment style perceive others in a positive way (Choi-Kain et al., 2009). If the primary caregiver does not meet the physical, psychological, and emotional needs of the child, the child will develop an insecure attachment and will have poorer emotional adaptation capabilities (Ghiasi et al., 2016). Bowlby himself believed that insecure attachment during childhood can obstruct or delay the development of emotional skills necessary to navigate relationships and contribute to a series of issues in adulthood, such as struggling with intimacy and showing an inability to form stable relationships.

Particularly, attachment styles have striking effects on the way a person experiences and navigates relationship. Studies have shown that people with BPD usually tend to report more dissatisfaction and conflict in their relationships, and are prone to getting married earlier but also to experiencing subsequent marital disruption (Smith & South, 2020). A longitudinal study by Lavner and colleagues (2015) followed 172 newlywed couples for 10 years to analyze the effect of wives' and husbands' BPD symptoms on their communication during problem-solving tasks. Results show that couples in which the wife was diagnosed with BPD exhibited more aggressive and defiant behaviors during communication and more difficulties with problem-solving tasks than healthy couples. The study also found that wives' BPD symptoms were linked to lower levels of marital satisfaction and higher levels of conflict and problems for themselves and their husbands. A review by Navarro and colleagues (2017) found that individuals with BPD usually have a higher number of romantic relationships, although oftentimes these are rather short-lived, and that individuals with BPD tend to look for partners who also exhibit more traits typical of BPD. This is in line with the hypothesis that individuals with BPD are prone to assortative mating (Zanarini et al., 2015), a non-random mating pattern in which individuals tend to pair with phenotypically similar (and sometimes dissimilar) partners, more than would be expected

under random mating (Rios Moura et al., 2021). Empirical evidence has in fact found that nearly half of the male dating partners of female patients diagnosed with BPD fulfilled the criteria for one or more personality disorders (Bouchard et al., 2009).

Studies have shown that for individuals with BPD, romantic relationships are frequently marked by higher levels of both psychological and physical aggression towards one's partner (Weinstein et al., 2012), conflict and instability (Chen et al., 2004), and oscillations between extreme idealization and devaluation (Choi-Kain et al., 2009). In this regard, a phenomenon worthy of mention is that of "splitting" (Klein, 1948) observed in people with BPD. It refers to a defense mechanism by which the person with BPD "divides" others, separating their good, satisfying, and gratifying parts from their frustrating and negative attributes. The person sees everything as black or white and is unable to accurately assess the individual and/or the situation. This fragmented view of others as either completely good or completely bad is indeed what lies underneath the fluctuations between idealization and devaluation: this is reflected by the fact that most people with Borderline Personality Disorder report a fearful or a preoccupied attachment style, and often a combination of the two (Choi-Kain et al., 2009). Those who exhibit an anxious attachment to their partner in adulthood are more needy and demonstrate higher dependency: therefore, when individuals feel secure and loved, they tend to crave affection and function more on the idealized side of interpersonal dynamics. Conversely, those who are avoidantly attached are rather scared of intimacy, avoid bonding at a deeper level with their partner and have a pessimistic view of love in general (Hazan & Shaver, 1987). If they start to perceive signs of rejection or abandonment they quickly shift to the devaluing side, and engage in behaviors that leave their partner confused, scared or angry (Choi-Kain et al., 2009). This combination of fearful/preoccupied attachment in BPD creates in the individual a "need-fear dilemma" that fuels

the oscillation between idealization and devaluation of the other person. The most prevalent attachment style in BPD has often been expressed in the form of a battle between anxiety and avoidance: some studies show that a combination of the two is actually more common (MacDonald et al., 2013). This conclusion would suggest vacillating and uncertain internal working models of the self and others (Beeney et al., 2017), with the self perceived as negative and others as either negative (fearful) or positive (preoccupied) (Choi-Kain et al., 2009). In 2020, Smith & South conducted a meta-analysis on BPD and romantic attachment styles. The final results confirmed the initial hypothesis of a combination of anxious and avoidant attachment styles and found that both forms of attachment insecurity can in fact coexist in individuals with BPD. The study revealed that anxious attachment is slightly more strongly correlated with BPD traits than avoidant attachment, but some methodological limitations did not allow for separate analyses.

Ultimately, empirical consensus on a specific attachment style prevalence in BPD has not been reached, and most evidence points to a coexistence of anxious and avoidant styles. The preoccupied attachment style might underlie the dependent and clingy features of BPD, whereas the relationship conflicted and avoidant traits may be more strongly related with the fearful attachment (Choi-Kain et al., 2009). They most likely interact to produce behavioral and emotional manifestations that may appear quite different from either one of the dimensions examined individually. The study by Choi-Kain and colleagues (2009) mentioned above reported that the majority of people with BPD do in fact display either a preoccupied or a fearful attachment, but it contradicted the idea that BPD is a disorder of solely insecure attachment. In their study, a small fraction of individuals with BPD reported high levels of secure attachment. The authors argue that a subset of individuals with BPD may genuinely show a secure form of

attachment, but they advance the possibility that this finding stems from biases in self-reports. In fact, they propose that the assessment may be affected by a lack of awareness of one's actual struggles in relationships and by an overestimation of one's relationship skills. Furthermore, BPD may not necessarily result directly from attachment styles, but the developmental precursors of BPD in childhood might resemble the features of insecure attachment (Smith & South, 2020). It is possible that the type of parenting experienced by the individual during their childhood and the pattern of parental reactions and behaviors will, although with variations, persist in peer connections in childhood and in romantic relations in adolescence, reinforcing the behavioral patterns that will subsequently lay the grounds for actual psychopathology in adulthood (Smith & South, 2020). Moreover, other factors such as genetic predisposition and environmental stressors play a significant role in the development of BPD. Some risk factors include childhood maltreatment, sexual abuse, early traumatic experiences, bullying during childhood, and the presence of parental (especially maternal) psychopathology (Bozzatello et al., 2021). Temperamental and personality traits, such as aggression during childhood and adolescence, novelty seeking, anger, and high harm avoidance have also been found to be relevant in the onset of BPD symptoms (Bozzatello et al., 2021).

III. Borderline Personality Disorder and the use of social media

We are currently living in a digital age, where the Internet and the proliferation of social media have modified the way people engage in social relations and communicate with each other. This rapid expansion of digital platforms has facilitated interactions between people who are not physically close and has made access to information quick, easy and affordable. However, alongside its irrefutable advantages, the use of social media platforms can have a negative impact on some individual's mental health and on the quality of social relationships: it can lead to academic failure due to excessive use, sleep problems, and difficulties in establishing and maintaining real-life relationships (Anderson, 2001). Needless to say, these issues have raised concerns which make understanding the implications of social media use on our daily lives a very pressing matter.

As mentioned above, BPD is an intriguing and complex disorder, characterized by severe functional impairments, unstable interpersonal relationships, and an intense fear of abandonment (Butcher et al., 2017). People with BPD constantly try to avoid a real or imagined abandonment and quickly recognize (and often even misappraise) signs of rejection in the behaviors of others (Staebler et al., 2011).

A study by Ooi and colleagues (2020), hypothesized and found that individuals with BPD and with subclinical BPD traits tend to post more often on social media, disclose more intimate information, and experience regret after posting, oftentimes followed by either editing or deleting the post. The authors hypothesized that this is most likely explained by the fact that people with BPD, especially the youth, have a stronger need to feel desired and to experience social connection, but they are also inclined to act more impulsively, which leads them to jump to conclusions very fast and sometimes regret their actions. They found that participants with BPD

regret posting on social media more often (without a difference in gender and age) and that they frequently delete or edit their posts. There was no correlation between BPD traits and time spent online, but there was a positive association between BPD scores and such behaviors as blocking, muting or unfollowing other users on social media. Moreover, a positive correlation was found between the number of posts made and BPD scores.

People with BPD oscillate between seeking reassurance and connectedness and avoiding contact with others, and this could stem from the individual experiencing rejection from significant others. In the online world, this may translate to seeking validation through an exaggerate number of posts, but immediately regretting their actions if the responses received by other users (such as not receiving enough likes or getting negative comments) trigger feelings of social exclusion and disapproval (Ooi et al., 2020).

In 2022, Deutz et al. carried out a study to test the relationship between BPD and online self-disclosure in young patients. Having the ability to self-disclose effectively means recognizing what it's appropriate to share online, when to do so, and to whom (Deutz et al., 2022): for youth with BPD symptoms, this may be more challenging. Problematic online self-disclosure, especially to strangers (such as in online-dating), could increase the risk for unhealthy online behaviors and dangerous online relationships (Deutz et al., 2022).

According to a study conducted by Liebke et al. (2017), individuals with BPD also tend to report more intense feelings of loneliness, and establishing an online community where they feel safe to share and where they know they will be heard can significantly alleviate these feelings of isolation. These individuals oftentimes experience interpersonal challenges, which brings them to seek reassurance in an exaggerate manner by disclosing too much intimate information about themselves (Deutz et al., 2022). On average, male youth are not as inclined to reveal personal

information online as female youth are: studies show that the latter dedicated more time to online activities, exhibited elevated levels of BPD symptoms, and in general engaged in more self-disclosure than their male counterparts (Deutz et al., 2022). Contrary to what one might think, the fact that female youth spend more time online and disclose more does not give rise to ineffective self-disclosure, as this gives them the opportunity, over time, to learn and practice effective and safer self-disclosure.

An interesting study conducted by Festl et al. (2013) showed that Internet Addiction (IA) was correlated with certain personality traits such as hostility, poor impulse control, aggression, and introversion, and some of these traits are known to be present in BPD (Leichsenring et al., 2011). The expectation of positive outcomes such as stress and tension reduction could lead individuals with BPD to use the Internet as a coping mechanism, and this could foster the development of addiction-like habits (Wu et al., 2016). Another recent study revealed that individuals with mild or severe IA exhibit more pronounced features of Borderline Personality than those who do not show any signs of addiction (Dalbudak et al., 2014). Furthermore, it has been demonstrated that the severity of Borderline Personality symptoms correlates with the severity of IA and predicts Internet addiction even after adjusting for coexisting conditions often associated with BPD, such as depression, anxiety, dissociation, and childhood abuse (Dalbudak et al., 2014).

As mentioned above, many individuals with BPD have elevated rates of comorbid mental health problems: the most common were reported to be anxiety and depression (Grant et al., 2008). With this information in mind, Lu and colleagues conducted a study in 2017 to examine the relationship between BPD symptoms and Internet addiction, while also considering the mediating effect of mental disorders on the association between BPD symptoms and Internet

addiction: they hypothesized that BPD symptoms are directly associated to Internet addiction, and indirectly associated to it through the mediating influence of mental health problems. The study involved 500 Taiwanese college students (238 men and 262 women), aged between 20 and 30 years old. The Taiwanese version of the BSL-23 (Borderline Symptom List; Bohus et al., 2009), the Symptom Checklist-90-Revised Scale (SCL-90-R; Derogatis et al., 1973), and the Chen Internet Addiction Scale (CIAS; Chen et al., 2003) were administered to test, in this order, for severity of BPD symptoms, of other mental health problems, and of Internet addiction. The results indeed showed that the severity of BPD symptoms correlates directly with the severity of Internet addiction, and that this relationship is mediated by other mental health problems, such as depression and anxiety (Lu et al., 2017).

To date, the quantity of research that focuses on the way individuals with BPD use social media remains scarce, and further research is needed to gather a more comprehensive understanding of the interaction between the two.

IV. Conclusion

Individuals with BPD face countless challenges in their day-to-day lives. BPD is extremely difficult to live with and additional research is needed to further analyze and comprehend the nuances that characterize this multi-faceted disorder, its association with attachment styles, and its repercussions on romantic relationships. Understanding the way they interact with each other can provide valuable insight for the development of updated clinical guidelines for patients whose personal relationships are strained and tumultuous due to either BPD or insecure attachment. Interventions focused on emotion regulation and distress tolerance might help mitigate the maladaptive coping strategies characteristic of BPD, offering individuals alternative ways to manage intense emotions without resorting to behaviors that can be self-destructive for themselves and their partners. Often, receiving support from family members and spouses is essential in order to develop a healthy therapeutic relationship with patients with BPD: families have to understand the difficulties that characterize this disorder, be patient, and learn to change their usual way of responding to individuals with BPD (Gunderson et al., 2018). As of today, the most supported form of therapy is DBT, along with MBT and TFP (Gunderson et al., 2018). They all have proven to be more effective at decreasing suicidal behavior and self-harm, anxiety, and depression compared to non-specialized or less intensive therapies (Setkowski et al., 2023). As for pharmacotherapy, to date no form of medication for the treatment of BPD has been officially approved by the US FDA (Food and Drug Administration), and no medication has proven to be significantly and constantly effective in the remission of symptoms (Ripoll, 2013).

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