Comparing models of borderline personality disorder: Mothers' experience, self-protective strategies, and dispositional representations
Patricia M. Crittenden and Louise Newman

Clin Child Psychol Psychiatry 2010 15: 433
DOI: 10.1177/1359104510368209

The online version of this article can be found at:
http://ccp.sagepub.com/content/15/3/433

Published by:
SAGE
http://www.sagepublications.com

Additional services and information for Clinical Child Psychology and Psychiatry can be found at:

Email Alerts: http://ccp.sagepub.com/cgi/alerts
Subscriptions: http://ccp.sagepub.com/subscriptions
Reprints: http://www.sagepub.com/journalsReprints.nav
Permissions: http://www.sagepub.com/journalsPermissions.nav
Citations: http://ccp.sagepub.com/content/15/3/433.refs.html

>> Version of Record - Jul 5, 2010

What is This?
Comparing models of borderline personality disorder: Mothers’ experience, self-protective strategies, and dispositional representations

Patricia M. Crittenden
Family Relations Institute, USA

Louise Newman
Monash University Victoria, Australia

Abstract
This study compared aspects of the functioning of mothers with borderline personality disorder (BPD) to those of mothers without psychiatric disorder using two different conceptualizations of attachment theory. The Adult Attachment Interviews (AAIs) of 32 mothers were classified using both the Main and Goldwyn method (M&G) and the Dynamic-Maturational Model method (DMM). We found that mothers with BPD recalled more danger, reported more negative effects of danger, and gave evidence of more unresolved psychological trauma tied to danger than other mothers. We also found that the DMM classifications discriminated between the two groups of mothers better than the M&G classifications. Using the DMM method, the AAIs of BPD mothers were more complex, extreme, and had more indicators of rapid shifts in arousal than those of other mothers. Representations drawn from the AAI, using either classificatory method, did not match the representations of the mother’s child drawn from the Working Model of the Child Interview; mothers with very anxious DMM classifications were paired with secure-balanced child representations. We propose that the DMM offers greater clinical utility, conceptual coherence, empirical validity, and coder reliability than the M&G.

Keywords
Adult Attachment Interview (AAI), attachment, borderline personality disorder, danger, Dynamic-Maturational Model (DMM), Working Model of the Child Interview (WMCI)

The primary focus of this study was to compare representations of attachment in mothers with borderline personality disorder (BPD) to those of mothers without psychiatric disorder. The topic is important because BPD is associated with severe disruptions in self-protective behavior and psychological processes, whereas mothers are charged with protecting their children and guiding their children’s psychological development. If the problems that mothers with BPD have protecting and
nurturing their children (Weiss, Zelkowitz, Feldman, Vodel, Heyman, & Paris, 1996) are tied to their inability to protect themselves and represent their own situation accurately, then study of their representational processes might help professionals to intervene more effectively.

Because attachment functions to protect children, we chose to look at representations of attachment. We used two hour-long interviews, one about relationships in childhood and one about relationships with one’s children, to elicit mothers’ representations.

A secondary focus was to compare two conceptualizations of attachment theory, asking what each might contribute to our understanding of BPD. The two models of attachment were: (1) Main’s ABC+D model of stability of attachment across the lifespan and disorganization in response to overwhelming fear (Main & Hesse, 1990), and (2) Crittenden’s Dynamic-Maturational Model of attachment and adaptation (DMM) (Crittenden, 2008) which emphasizes developmental change and self-protective organization in response to fear. Because both models use the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1985–1996) to assess maternal representations, we were able to use one assessment coded in two ways to address differences in representation.

**ABC+D theory regarding BPD**

**Security and disorganization**

As investigators applied Ainsworth’s ABC model of infant attachment (Ainsworth, Blehar, Waters, & Wall, 1978) to wider populations, it became clear that the original three categories of attachment did not fit all infant–mother dyads. One outcome was Main’s addition of ‘disorganization’ to the Ainsworth classificatory system. Disorganization first described a set of behavioral markers observed during the Strange Situation Procedure. These anomalous behaviors were thought to mark moments when the infant had conflicting motivations that could not be integrated into a coherent pattern of response. Later, the notion that fear of a “frightened or frightening” mother led to disorganization was added (Main & Hesse, 1990). Over time, disorganization came to be conceptualized as the failure to organize a single, coherent “inner working model”.

**ABC+D and BPD**

Current thinking about BPD using the ABC+D model posits a developmental process from traumatic abuse and neglect in infancy to disorganized fearful states, (i.e., disorganized attachment) that disrupt the development of self-regulating mental structures resulting in affect dysregulation, poor impulse control, and anxiety (Fonagy, Gergely, Jurist, & Target, 2002; Newman, 2008). By adulthood, the core features of BPD (e.g., impaired interpersonal functioning, fear of abandonment and lack of stable sense of self) reflect deficits in the development of attachment organization leading to poor understanding of mental states and limited reflective capacity (Fonagy, Leigh, Steele, Kennedy, & Mattoon, 1996).

Empirically, studies using the Main and Goldwyn method (M&G) (Main & Goldwyn, 1984–1994) for classifying representations of attachment found that women with BPD had a preponderance of enmeshed/preoccupied patterns and unresolved trauma (75% and 89%, respectively; Fonagy et al., 1996). Moreover, women with BPD are more likely to report having been abused and neglected as children and to have lower reflective capacity (Barone, 2003; Fonagy et al., 1996) than women without BPD. Recent studies using the ABC+D classificatory system find that about 30% of AAIs of mothers with BPD cannot be classified at all, suggesting that lack of organization may be a crucial feature of BPD (Levy, 2005).
DMM theory regarding BPD

Danger and organization

In contrast to the ABC+D model, the DMM approach to attachment postulates that danger, including especially frightening danger, organizes self-protective behavior as survival mechanism. Further, the DMM differentiates danger from trauma, with trauma being a maladaptive and ongoing psychological response to past danger. That is, in the DMM, exposure to danger can either be resolved in adaptive ways or remain as “unresolved psychological trauma”.

The DMM reflects the continuation of work that Crittenden began in Ainsworth’s laboratory. Initially and with Ainsworth’s guidance, Crittenden added compulsive compliance and A/C combinations (Crittenden, 1985) to Ainsworth’s ABC model; both patterns were associated with child abuse and neglect (Crittenden & Ainsworth, 1989). Later, the model was expanded to include a wide array of later-developing and more complex Type A+ and Type C+ self-protective strategies (cf. Farnfield, Hautamäki, Nørbech, & Sahhar, 2010 [this issue]). Type A strategies were hypothesized to be based on reducing perception of threat to reduce the disposition to respond. Type C was hypothesized to be based on heightening perception of threat to increase the disposition to respond. Both strategies can be adaptive and, under conditions that change, an A/C combination can be maximally protective.

DMM and BPD

Based on clinical classification of more than 1000 AAIs, including many of women with BPD, we hypothesized that women with BPD would more often recall being exposed to danger than would other mothers. If so, their perceived need to protect themselves might reduce their availability to care for their infants (cf. Fuertes, Faria, Soares, & Crittenden, 2009). We also expected the threats to include both rejection/abandonment (associated with Type A) and hidden or deceptive threats (associated with Type C). We expected BPD to reflect the confluence of two psychological patterns, one typifying an extreme compulsive Type A strategy with psychosis-like intrusions of forbidden negative affect and one an extreme Type C strategy with misconstrued causal relations.

Among the 1000 AAIs collected by Crittenden, individuals with psychotic symptoms were often assigned to a compulsive Type A3–8 strategy of (a) inhibiting affect combined with (b) depression in both a cognitive form (“Nothing I do will have an effect”) and an affective form (“I feel sad, too tired to do anything”) and (c) intrusions of forbidden negative affect. The depression and intrusions appeared to work in tandem regulating arousal, but only at the extremes such that the individuals were rarely in a comfortable, alert state. Irrational appearing states were observed when the intrusions were dominant; these often alternated with depression. The associated developmental experiences appeared to have been rejection and severe threat or punishment. In Crittenden’s AAIs, the events of being rejected or punished abusively were often coded as unresolved trauma with both preoccupying and dismissing characteristics. One effect of these psychological distortions was to lower the individuals’ awareness of threat, thus making it possible to tolerate the irresolvable conflict of both wanting and fearing the attachment figure without reacting negatively.

The extreme Type C3–8 strategies, on the other hand, reflect an affect-exaggerating strategy in which the individual makes erroneous causal attributions based on childhood experience with unclear or misleading causal contingencies. The basis for the misunderstood causal relations is often (1) triangulation between the parents and the child or (2) family secrets that motivate parents’ behavior without the child being aware of the reasons for the parents’ actions. Avoidant personality disorder (Rindal, 2000) and some cases of eating disorder (Ringer & Crittenden, 2007) are
examples. The effect of these distortions is to heighten awareness of threat and danger, putting the individual on constant alert and increasing the probability of self-protective action – without clarity regarding the source of threat.

In DMM theory, BPD is thought to reflect the co-occurrence of these two developmental histories and psychological self-protective strategies.

**BPD and dispositional representations of self-in-context**

Three fundamental notions are proposed to underlay attachment representations in DMM theory. First, danger functions to organize mental representations of the relation between self and context that, in turn, dispose one to organize self-protective behavior. Second, arousal serves a protective function with high arousal generating protective action whereas low arousal promotes self-protective stillness. Moderate arousal is associated with safety and permits behavior not associated with self-protection. Third, individuals have an array of dispositional representations (as opposed to a single “internal working model”). These representations include (1) somatic representations (the most exquisitely attuned to danger, but also the least explicit about the nature of the danger), (2) preconscious psychological representations of procedures (cognitive/contingency sequences) and images (sensory markers of danger and safety), (3) conscious and verbal representations (both semantic generalizations and connotative language used to convey affective meaning), and (4) integrative representations (both context-specific episodes and more broadly-based reflective integration).

We propose that women with BPD rely disproportionately upon somatic and preconscious representations to regulate perception and organize their behavior, have some access to verbal representations, but almost no experience with reflective integration of discrepant representations (cf., Fonagy et al., 2002). Among women using a Type A strategy, this could lead to reduced verbal recall whereas those using a Type C strategy might recall even small slights and elevate them to the level of danger. Women using both strategies might reflect both effects: recalling some dangers vividly while dismissing their impact or blocking others from recall altogether.

**Comparing the ABC+D and DMM models**

These two models differ in the conceptualization of the effects of fear on organization, in how many memory systems are assessed, and whether there are enduring inner working models or multiple, situation-specific dispositional representations. Most strikingly, they differ in how many strategies (i.e., patterns of attachment) are described for adults and the extent to which these are undergirded by specified differences in information processing. This leads to two differences that we think may have substantial clinical implications. First, having more strategies with greater distortions of information processing may enable the DMM to differentiate meaningful subgroups within clinical populations. Second, taking a strengths approach based on context-defined self-protection may offer a mental health advantage to troubled people, compared to the ABC+D model’s deficit approach based on the notion of disorganization.

**Hypotheses**

We predicted that, compared to mothers without psychiatric diagnoses, mothers with BPD would:

1. Recall more dangers to which they had been exposed in childhood.  
2. Describe more negative consequences from these dangers.
3. Employ more extreme self-protective strategies that contained both Type A and Type C components.
4. Have more unresolved traumas and losses.
5. Display greater swings in arousal.
6. Have more distorted representations of their children.

When comparing the M&G and DMM AAI classifications, we predicted that:

1. The DMM classifications would differentiate the two referral groups more clearly.
2. Recalled danger would predict the DMM classifications more accurately than the M&G classifications.

**Method**

**Participants**

The participants were 32 Australian mothers with full-term infants aged 3–36 months with no known neurological or developmental problems. Fifteen of the mothers had diagnoses of BPD and were referred from local mental health services; their scores on the Diagnostic Interview for Borderlines were > 8. Although there are many issues regarding diagnosis of BPD, we thought the Diagnostic Interview for Borderlines would capture a representative sample. Seventeen comparison mothers were recruited from the community and had no history of mental health problems. Mothers with borderline personality disorder were significantly younger, less educated and more likely to be sole parents than controls; they also had more self-reported symptoms, depression, and parenting stress. The differences are expected because the BPD group is more likely to have relationship breakdowns and difficulty finishing school. To explore the effects of socioeconomic status, we calculated a social disadvantage score for each participant by collapsing relationship status, education, employment status and income. We found no significant correlations between social disadvantage and parenting observational and self-report results; thus, social disadvantage cannot explain our findings (see Newman & Stevenson, 2007 for a fuller explanation).

**Procedure**

Following ethics approval, volunteers were recruited from the Western Area Health Service. The research was explained and mothers provided consent prior to attendance. Each dyad attended two assessment sessions, the first involving general assessment of mental health through self-report measures and the AAI and the second, the Working Model of the Child Interview (Zeanah & Benoit, 1995).

**Assessments**

**Exposure to danger.** We assessed exposure to danger in childhood in two ways: events and severity of effects. First, we constructed a comprehensive list of 21 categories of danger to which children and adolescents might be exposed. The AAIs were coded for the dangers which each mother mentioned. For each coded instance, the mother had to offer a concrete detail regarding the danger and not merely a generic statement. We did not assume that all dangers would be recalled or mentioned. We did assume that our coding would function adequately as an index of individual differences in exposure to danger. The coder was blind to all other information.
The coder evaluated each instance of danger to determine the severity of consequences based on information provided in the AAI. These were rated using four “Severity of Maltreatment Scales” (Crittenden, 1987) for physical abuse and neglect and emotional abuse and neglect. Two scales were added to rate self- and other-directed aggression carried out by the individual. The scales were scored from 0 (no event) to 7 (permanent disability or death). The scales used explicitly stated and concrete evidence of effects, e.g., for physical abuse: no treatment, outpatient medical treatment, going to hospital, suffering permanent disability. Not every coded instance of danger yielded information about severity.

After coding, we computed two theory-derived scales to differentiate between Type A and Type C attachment strategies: Type A: “rejection/abandonment” (the sum of instances of rejection, separations, and abandonment) and Type C: “hidden causation” (the sum of instances of deception, triangulation, secrets, and scapegoating). We also reduced the 21 categories to four: (1) physical danger (abuse, neglect, sexual, and witnessed violence), (2) loss of access to attachment figure (separation and loss), (3) psychological danger (deception and emotional abuse), and (4) self-generated danger (aggression to others, self-harm). Then we tabulated these dangers by age at the time of the incident: infancy (birth–2 years), preschool (3–5 years), school-age (6–12 years), adolescence (13–17 years), and adult (18+ years).

Attachment strategies, trauma, and states of arousal. The AAI was used to assess “state of mind with regard to attachment” using the M&G classificatory method. Based on nine rating scales, the AAIs were assigned to Ds1–3 (corresponding to Ainsworth’s Type A1–2, plus a derogating category), F1–5 (corresponding to Type B1–4), or E1–3 (corresponding to Type C1–2, plus a fearful category), plus the presence or absence of unresolved and preoccupying trauma and loss (corresponding to disorganization). The two coders were trained by Pederson and were reliable. They were blind to all other information about the participants.

The AAIs were coded a second time to identify each mother’s “self-protective strategy” using the DMM method. The DMM coders were trained by Crittenden; all had reached or were close to 80% reliability on five measures of reliability: ten subclassifications, unresolved trauma, unresolved loss, depression, and intrusions. They were blind to all information about the participants.

Because both the history and the discourse of women with BPD were extremely different from those of women without psychiatric disorder, we feared that coders would immediately discern the composition of the sample and that this might bias their coding. Therefore we mixed in a set of 16 “distracter” transcripts of young Australian women with eating disorders; this was a random subset of the sample of 66 such women reported by Ringer and Crittenden (2007). None of these women was known to have any personality disorder. All 49 transcripts were coded for self-protective strategy (A1–8, B1–5, C1–8, A1–8/C1–8), any unresolved losses or traumas (identified by dysfluent discourse or thought errors, not by the fact of an endangering event or death), and depression or intrusions. The DMM method of coding lack of resolution is highly differentiated, including markers of preoccupied, dismissing, displaced, blocked, vicarious, imagined, suggested, hinted, anticipated, depressed, delusional, and disorganized lack of resolution. Unlike the danger codes that required explicit mention of the danger, coding of psychological trauma included implicit evidence of danger that was not explicitly named. Even following our strict rules for inferring such danger, we coded many instances of blocked physical abuse, child sexual abuse, abandonment and severe neglect (see Table 2). For analysis, we reduced the 12 forms of trauma to “preoccupied”, “dismissed”, “any other form of lack of resolution”, or “not present”. We coded pervasive low arousal as “depression” (present, partially present or not present), and intense
peaks of high arousal as “intrusions of forbidden negative affect” (present, present historically in the content, or not present).

**Working Model of the Child Interview (WMCI).** Mothers’ representations of their children were assessed with the WMCI. Compared to the AAI and Strange Situation Procedure, the WMCI is structured more around the topics of interest and less around Ainsworth’s notion of progressively building threat to elicit individuals’ self-protective strategies. Compared to the AAI, it less often employs Bowlby’s notion of juxtaposing probes of the same information through different memory systems. It has been associated with child attachment in a normative sample (Zeanah, Benoit, Hirshberg, Barton, & Regan, 1994). The WMCI was administered by trained interviewers, then transcribed and rated by two accredited Australian coders who were blind to all other data. Interviews were assigned to one of three categories: “Balanced” (B), “Disengaged” (A), and “Distorted” (C). Discrepancies were resolved by discussion to consensus.

**Results**

**Plan for the analysis**

For the M&G classifications, we tested both 3-group (ABC) and 4-group (ABD+D) hypotheses; we report only significant findings. For categorical variables, we used Chi-square based statistics, including the delta prediction statistic for precise cell-by-cell *a priori* hypotheses (Hildebrand, Laing, & Rosenthal, 1977). For sets of related variables, we used a Bonferroni correction. All tests were one-tailed because, in every case, we expected the BPD group to have less advantageous outcomes. We used discriminant analyses to explore the relations between representations and recall of danger.

**Coder agreement**

Coder agreement for the M&G classifications was based on 16 randomly selected transcripts that were double-coded by an independent rater. Inter-rater reliability for four categories was $\kappa = 0.714$, $p < .001$.

For the DMM, all 49 transcripts were double-coded. We analyzed coder agreement on depression (3-point scale), unresolved loss (present or absent), unresolved trauma (present or absent), and strategy (4-category) and linear deviation from B. Agreement is reported as kappa statistics for categorical variables and Kendall’s tau b for ordinal categorical variables: depression, Kendall’s tau b = .83, $p < .001$; unresolved loss, $\kappa = .66$, $p < .001$; unresolved trauma, $\kappa = .87$, $p < .000$; strategy, Kendall’s tau b = .86, $p < .001$; linear deviation from B, Kendall’s tau b = .81, $p < .001$.

**Comparison of DMM and M&G classifications**

The 4-category M&G (D, F, E, U) versus DMM (A, B, C, A/C) test was significant ($\chi^2_{9} = 22.72$, $\phi = .84$, $p = .007$), indicating that the classifications were related, but almost entirely by the 14 cases of U/AC overlap (see Table 1).

**Self-protective strategies**

The two groups of mothers differed significantly using the M&G 3-category classifications ($\chi^2_{2} = 6.67$, $\phi = .45$, $p = .036$). There were no securely attached mothers with BPD. There was not a significant difference using subclassifications.
There were 29 different subclassifications possible using the DMM; 15 were used by the 32 participants in this study; the 16 women with eating disorders added another five classifications. The result was startling; there was not one single strategy used by both BPD and community mothers ($\chi^2_{14} = 32, \varphi = 1.0, p = .004$). A further striking difference is that all but one mother with BPD had an A/C classification whereas no community mothers had an A/C classification; half of the women with eating disorders had an A/C classification. Finally, the BPD mothers had classifications numbered 5–8 whereas the community mothers had classifications numbered 1–4 (see Tables 2 and 3). By comparison, the women with eating disorders had classifications numbered 3–6 (cf., Ringer & Crittenden, 2007).

### Unresolved traumas and losses

Using the M&G method, all 15 mothers with BPD and three normative mothers had preoccupied unresolved losses or traumas ($\chi^2 = 19.32, p < .001$).

Using the DMM method, of 17 mothers with unresolved trauma, the two community mothers were preoccupied whereas only one mother with BPD was preoccupied, another was dismissing, and 13 had complex or mixed responses ($\Delta_p = .88, p < .001$). By way of comparison, seven of the women with eating disorders had unresolved trauma, with two being complex. There was no difference for unresolved loss.

### Volatility of arousal

Using the DMM classifications, we expected mothers with BPD to display greater extremes of arousal, as operationalized by having both depression and intrusions of forbidden negative affect, than the community mothers. The split on depression was absolute: all mothers with BPD were coded as having either partial or full depression whereas no community mother (and one woman with an eating disorder) was coded as having any depression. For intrusions, six mothers with BPD displayed intrusions during the AAI and another five described past behavior fitting the definition. The community mothers had no intrusions ($\chi^2_2 = 18.99, p < .001$). Thus, 73% of the mothers with BPD showed extreme volatility of arousal whereas none of the community mothers or women with eating disorders displayed this effect.

### Working Model of the Child

Using the M&G classifications, there was no relation with the WMCI classifications. Nine of the M&G dismissing mothers were classified as balanced on the WMCI.
For the DMM classifications, we reduced the AAI classifications to six (A3–8, A1–2, B, C1–2, C3–8, A/C). The Chi-square was non-significant and counter to the hypothesis; fourteen mothers with A/C attachment had balanced WMCI representations of their children (all were in the BPD group).

### Table 2. Main & Goldwyn and DMM AAI classifications: BPD group

<table>
<thead>
<tr>
<th>Main &amp; Goldwyn</th>
<th>Dynamic-Maturational Model</th>
<th>Depression</th>
<th>Utr</th>
<th>Uloss</th>
<th>Type A</th>
<th>Type C</th>
<th>Intrusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>t</td>
<td>Ds1</td>
<td>Dp</td>
<td>t(b)</td>
<td>PA</td>
<td>A7-8</td>
<td>C6</td>
<td>[ina]</td>
</tr>
<tr>
<td>t</td>
<td>Ds1</td>
<td>Dp</td>
<td>t(p)</td>
<td>PA</td>
<td>A6</td>
<td>C5-6</td>
<td></td>
</tr>
<tr>
<td>t</td>
<td>Ds1</td>
<td>dp</td>
<td>t(ds)</td>
<td>PA,</td>
<td>A7</td>
<td>C6</td>
<td></td>
</tr>
<tr>
<td>t</td>
<td>Ds1</td>
<td>Dp</td>
<td>t(dp)</td>
<td>PA,</td>
<td>A4</td>
<td>C+</td>
<td>[ina]</td>
</tr>
<tr>
<td>t</td>
<td>Ds1</td>
<td>Dp</td>
<td>t(b)</td>
<td>CSA</td>
<td>A4-,8(7)</td>
<td>C5-6</td>
<td>[ina]h</td>
</tr>
<tr>
<td>t</td>
<td>Ds3</td>
<td>Dp</td>
<td>t(p+ds)</td>
<td>PA,</td>
<td>A+ (7)</td>
<td>GF</td>
<td>C5</td>
</tr>
<tr>
<td>t</td>
<td>D2</td>
<td>dp</td>
<td>t(p&amp;i)</td>
<td>PA,</td>
<td>A7</td>
<td>C6</td>
<td></td>
</tr>
<tr>
<td>t</td>
<td>D2</td>
<td>dp</td>
<td>t(p,ds)</td>
<td>arm</td>
<td>A+</td>
<td>C5</td>
<td></td>
</tr>
<tr>
<td>t</td>
<td>E1</td>
<td>Dp</td>
<td>t(p&amp;ds)</td>
<td>EN</td>
<td>A4</td>
<td>C5-6</td>
<td>[ina]</td>
</tr>
<tr>
<td>t</td>
<td>E3</td>
<td>Dp</td>
<td>t(dx)</td>
<td>PA,PN</td>
<td>A8</td>
<td>C5</td>
<td>[ina]h</td>
</tr>
<tr>
<td>t</td>
<td>E3</td>
<td>Dp</td>
<td>t(dx)</td>
<td>CSA,aban</td>
<td>A7</td>
<td>C5</td>
<td>[ina]</td>
</tr>
<tr>
<td>t</td>
<td>E3</td>
<td>dp</td>
<td>t(p&amp;ds)</td>
<td>CSA</td>
<td>A4</td>
<td>C5-6</td>
<td>[ina]</td>
</tr>
<tr>
<td>t</td>
<td>E3</td>
<td>Dp</td>
<td>l(dx)</td>
<td>many</td>
<td>A7</td>
<td>C5(7)</td>
<td>[ina]</td>
</tr>
<tr>
<td>t</td>
<td>E3</td>
<td>dp</td>
<td>l(p)</td>
<td>many</td>
<td>A3,4,5(8)</td>
<td>C5-6</td>
<td>[ina]h</td>
</tr>
<tr>
<td>t</td>
<td>E3</td>
<td>dp</td>
<td>l(p)</td>
<td>F,GFteacher</td>
<td>A+(4,7)</td>
<td>C5</td>
<td>[ina]</td>
</tr>
</tbody>
</table>

**Abbreviations:**

- **Classification components**
  - Dp = depression
  - dp = partial depression
  - t = unresolved trauma
  - l = unresolved loss
  - A+ = mixture of compulsive strategies
  - C+ = mixture of coercive strategies
  - (#) = partial strategy e.g., A4(7)
  - [ina] = intrusion of forbidden negative affect
  - [ina]h = intrusions in the history, not discourse

- **Psychological processes in unresolved**
  - p = preoccupied
  - ds = dismissed
  - dp1 = displaced
  - b = blocked (repressed)
  - v = vicarious
  - l = imagined causation
  - s = suggested (by interviewer)
  - a = anticipated
  - h = hinted
  - dp = depressed
  - d1 = delusional
  - dx = disorganized

- **Events/people**
  - M = mother
  - F = father
  - B = brother
  - Sibs = siblings
  - GF = grandfather
  - PA = physical abuse
  - PN = physical neglect
  - EN = emotional neglect
  - CSA = child sexual abuse
  - Aban = abandonment
  - DV = domestic violence

Downloaded from ccp.sagepub.com at Monash University on May 16, 2013
Recalled history of danger and severity of maltreatment

Comparing the diagnostic groups, the mothers with BPD recalled significantly more physical abuse, physical neglect, sexual abuse, drug abusing attachment figures, rejection, familial suicide, betrayal by attachment figures, witnessing domestic violence, being scapegoated, self-injury, and substance abuse. Moreover, they recalled an average of 11 dangers per mother whereas the community comparison mothers recalled only two ($t_{30} = 4.68, p < .001$). The comparison on rejection/abandonment (Type A) approached significance ($t_{30} = 1.50, p < .07$) and the comparison on hidden causation (Type C) was significant ($t_{30} = 3.33, p < .001$).

We found a significant difference in severity for the four types of maltreatment and two types of aggression (see Table 4). We then charted the age of exposure to danger for physical danger, loss of access to attachment figure, psychological danger, and self-generated danger. There were peaks of perceived danger from physical abuse, separation, and deception in the school years and from self-generated danger in adolescence (see Figure 1).

Looked at through the lens of attachment, there was a significant difference in the number of recalled dangers, using the M&G categories, between “unresolved” and the other three categories.
Using the DMM classifications, there was a linear trend from Types A and B (fewest) to C and A/C (\(F_{3,28} = 19.63, p < .001\)).

Recalled danger and representation

We used a set of ANOVAs to test whether the severity scales, plus rejection/abandonment, hidden causation, and total danger differentiated the M&G, DMM, and WMCI groups. The WMCI showed
no significant group differences on any variable. There were significant findings for four of the eight variables for the 4-category M&G (Ds, F, E, U), for seven of the eight variables for the DMM 4-category classifications (A, B, C, and A/C), and for six of the eight variables for DMM 6-category classifications (A+, A1–2, B, C1–2, C+, A/C) (see Table 5).

We used discriminant analyses to compare the power of recalled threats and severity of effects of danger to differentiate the attachment groups. The M&G 4-group classifications were accurately predicted in 47% of cases (Wilks’ lambda = .506, $\chi^2_3 = 19.44$, $p < .001$); none of the Ds cases, 33% of the Fs, 100% of the Es, and 53% of the Us were correctly identified. The DMM 6-category classifications were predicted in 18.8% of cases (Wilks’ lambda = .489, $\chi^2_5 = 19.67$, $p < .001$); none of the A+ or A1–2 cases, 83% of Bs, none of C1–2, 50% of C+, and 79% of A/Cs were correctly classified. The DMM 4-category classifications matched prediction in 66% of cases (Wilks’ lambda = .523, $\chi^2_3 = 18.47$, $p < .001$); 63% of the A cases, 83% of Bs, none of the C cases, and 79% of A/Cs were correctly classified. Although it appears that the DMM 4-category solution fit best, the discrepancy in the two DMM discriminant analyses regarding Type A versus Type C raises questions about the discriminating variables.

**Discussion**

We explored borderline personality disorder by assessing mothers’ attachment representations. Here we address three empirical questions:

1. Did the M&G and DMM classifications match and which discriminated the BPD group better?
2. Was either set of classifications associated with mothers’ representations of their children?
3. Were the representations related to mothers’ recall of danger? We then turn to contribution of attachment to understanding BPD.
4. We close with ideas regarding treatment of BPD and the limitations of this study.

**Empirical validity**

Comparing classificatory methods. The M&G and DMM classifications matched in about half of cases. The primary differences were: (1) the specificity of the DMM classifications, (2) the overlap of the M&G community and borderline distributions versus no overlap using the DMM classifications, and (3) the greater association of the DMM classifications with recalled danger. Although our data cannot indicate whether the DMM can differentiate BPD from other diagnostic conditions, other clinical studies have not found the pattern that we found for BPD (i.e., depressed with unresolved trauma, alternating Type A and Type C strategies, and intrusions of forbidden negative affect). The following associations have been reported: abuse (Utr A1) and neglect (Dp A1–4, Seefeldt, 1997); anxiety (mixed patterns, Hughes, Hardy, & Kendrick, 2000); PTSD (disorganized unresolved trauma in an A or A/C strategy, Heller, 2001); eating disorders (trauma with erroneous causation in a triangulated C or A/C strategy, Ringer & Crittenden, 2007). Our recategorizations of the subsample of 16 Australian women with eating disorders did not find the BPD pattern. We conclude that the DMM may hold potential to differentiate among clinical conditions.

Mothers’ representations of their children. Both ABC+D and DMM theory predict relations between mothers’ attachment representations and representations of their children. We did not find this
Table 5. Differences in perception of danger as function of maternal attachment representations for three sets of representations

<table>
<thead>
<tr>
<th>Measure of recalled danger</th>
<th>Assessment of representation</th>
<th>DMM-6</th>
<th>DMM-4</th>
<th>M&amp;G-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total danger</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A+</td>
<td></td>
<td>3.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1–2 (A) (Ds)</td>
<td></td>
<td>.75</td>
<td>1.88</td>
<td>.75</td>
</tr>
<tr>
<td>B (B) (F)</td>
<td></td>
<td>2.17</td>
<td>2.17</td>
<td>1.83</td>
</tr>
<tr>
<td>C1–2 (C) (E)</td>
<td></td>
<td>2.50</td>
<td>6.50</td>
<td>2.67</td>
</tr>
<tr>
<td>C+</td>
<td></td>
<td>10.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A/C (A/C) (U)</td>
<td></td>
<td>10.93</td>
<td>10.93</td>
<td>9.74</td>
</tr>
<tr>
<td>Hidden cause (C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A+</td>
<td></td>
<td>1.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1–2 (A) (Ds)</td>
<td></td>
<td>1.00</td>
<td>1.25</td>
<td>.50</td>
</tr>
<tr>
<td>B (B) (F)</td>
<td></td>
<td>.33</td>
<td>.33</td>
<td>.83</td>
</tr>
<tr>
<td>C1–2 (C) (E)</td>
<td></td>
<td>.00</td>
<td>1.50</td>
<td>1.00</td>
</tr>
<tr>
<td>C+</td>
<td></td>
<td>3.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A/C (A/C) (U)</td>
<td></td>
<td>2.43</td>
<td>2.43</td>
<td>2.16</td>
</tr>
<tr>
<td>Rejection/Abandonment (A)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A+</td>
<td></td>
<td>3.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1–2 (A) (Ds)</td>
<td></td>
<td>2.25</td>
<td>2.88</td>
<td>.75</td>
</tr>
<tr>
<td>B (B) (F)</td>
<td></td>
<td>1.67</td>
<td>1.67</td>
<td>2.67</td>
</tr>
<tr>
<td>C1–2 (C) (E)</td>
<td></td>
<td>4.00</td>
<td>6.25</td>
<td>2.67</td>
</tr>
<tr>
<td>C+</td>
<td></td>
<td>8.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A/C (A/C) (U)</td>
<td></td>
<td>3.78</td>
<td>1.83</td>
<td>4.95</td>
</tr>
<tr>
<td>Severity of injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A+</td>
<td></td>
<td>.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1–2 (A) (Ds)</td>
<td></td>
<td>.25</td>
<td>.50</td>
<td>.25</td>
</tr>
<tr>
<td>B (B) (F)</td>
<td></td>
<td>.83</td>
<td>.83</td>
<td>.67</td>
</tr>
<tr>
<td>C1–2 (C) (E)</td>
<td></td>
<td>1.50</td>
<td>1.75</td>
<td>.33</td>
</tr>
<tr>
<td>C+</td>
<td></td>
<td>2.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A/C (A/C) (U)</td>
<td></td>
<td>2.07</td>
<td>2.07</td>
<td>2.05</td>
</tr>
<tr>
<td>Severity of neglect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A+</td>
<td></td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1–2 (A) (Ds)</td>
<td></td>
<td>.50</td>
<td>.75</td>
<td>.00</td>
</tr>
<tr>
<td>B (B) (F)</td>
<td></td>
<td>.00</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>C1–2 (C) (E)</td>
<td></td>
<td>2.00</td>
<td>2.25</td>
<td>.33</td>
</tr>
<tr>
<td>C+</td>
<td></td>
<td>2.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A/C (A/C) (U)</td>
<td></td>
<td>2.21</td>
<td>1.41</td>
<td>2.05</td>
</tr>
<tr>
<td>Severity of emotional abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A+</td>
<td></td>
<td>.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1–2 (A) (Ds)</td>
<td></td>
<td>1.00</td>
<td>.88</td>
<td>.50</td>
</tr>
<tr>
<td>B (B) (F)</td>
<td></td>
<td>.67</td>
<td>.67</td>
<td>.67</td>
</tr>
<tr>
<td>C1–2 (C) (E)</td>
<td></td>
<td>2.00</td>
<td>2.50</td>
<td>.00</td>
</tr>
<tr>
<td>C+</td>
<td></td>
<td>3.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A/C (A/C) (U)</td>
<td></td>
<td>3.71</td>
<td>3.71</td>
<td>3.53</td>
</tr>
<tr>
<td>Severity of emotional neglect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A+</td>
<td></td>
<td>1.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1–2 (A) (Ds)</td>
<td></td>
<td>1.25</td>
<td>1.50</td>
<td>.00</td>
</tr>
<tr>
<td>B (B) (F)</td>
<td></td>
<td>.33</td>
<td>.33</td>
<td>1.83</td>
</tr>
</tbody>
</table>

(Continued)
for either set of AAI classifications with the WMCI. The strong association of dismissed and A/C attachment with balanced child representations was perplexing. We offer three possible explanations.

Possibly the WMCI depends too heavily on semantic probes taken at face value and gives too little attention to eliciting the mothers’ strategies. That is, the WMCI presumes that everyone can and will answer questions accurately; therefore the probes are fairly direct. Compared to the AAI, it lacks the process of slowly and carefully introducing threat while concurrently building a supportive relationship with the interviewer. A consequence might be that only mild forms of the mother’s procedural strategies were elicited.

In addition, the WMCI is less structured around juxtaposing different types of representations (e.g., semantic, episodic). A consequence might be that the relatively unthreatened mothers were able to rely upon consciously considered semantic representations of their children. These were more positive for the BPD mothers than for the community mothers, who offered more mixed representations. That is, the BPD mothers might have offered idealized representations of their children, without this being exposed by non-semantic representations.

Finally, the bias of the WMCI toward semantic representations might be increased by the video coding procedure that did not involve attention to procedural, imaged, and connotative representations. Although transcription and detailed coding of multiple representations are onerous, they are essential for identification of conflicting representations. Because all people learn to overlook spoken dysfluence in order to grasp what is meant, the absence of detailed coding procedures in any verbal assessment of attachment often leads to misclassification, even when the coder is well trained.

Alternatively, the AAI classifications might be in error. This seems unlikely given (1) their association with BPD status and danger in this sample and (2) the finding that fMRI results differentiated DMM classifications in mothers’ AAs. Specifically, when DMM Type A mothers viewed their infant’s crying face, brain regions involved in cognitive appraisal and negative affect were activated (Strathearn, Fonagy, Amico, & Montague, in press). This suggests that Type A mothers may use an information processing strategy based on cognitive control over negative affective responses.

**Danger and disorder.** The DMM postulates that exposure to danger is the basis for organizing self-protective strategies and that more extreme strategies result from more extreme and less transparent danger. The discriminant analysis supported that notion for the DMM classifications, but not for the M&G classifications. However, early exposure to danger can only be represented

<table>
<thead>
<tr>
<th>Measure of recalled danger</th>
<th>Assessment of representation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DMM-6</td>
</tr>
<tr>
<td>C1–2 (C) (E)</td>
<td>2.00</td>
</tr>
<tr>
<td>C+</td>
<td>4.00</td>
</tr>
<tr>
<td>A/C (A/C) (U)</td>
<td>3.86</td>
</tr>
<tr>
<td>Severity of risk-taking</td>
<td>p = .018</td>
</tr>
<tr>
<td>A+</td>
<td>.00</td>
</tr>
<tr>
<td>A1–2 (A) (Ds)</td>
<td>.00</td>
</tr>
<tr>
<td>B (B) (F)</td>
<td>.17</td>
</tr>
<tr>
<td>C1–2 (C) (E)</td>
<td>.50</td>
</tr>
<tr>
<td>C+</td>
<td>.00</td>
</tr>
<tr>
<td>A/C (A/C) (U)</td>
<td>2.86</td>
</tr>
</tbody>
</table>
non-verbally. Further, the Type A strategy involves avoiding perception of negative experience. Together, these imply that early exposure to danger would not be recalled verbally by anyone and later exposure might not be recalled by individuals using a Type A strategy. This fit our data well: early danger was not recalled at all and Type A mothers recalled less danger than other mothers. This suggests that mothers with BPD may not be able to assess their own or their children’s state accurately. This may explain the difference between the 4- and 6-category discriminant analyses. Depending upon whether the most distorted subgroups were clustered with normative subgroups, either Type A or Type C was not predictable from the danger variables.

The contribution of attachment to understanding BPD

Classification. ABC+D and DMM theories offer different and sometimes incompatible perspectives on attachment. The M&G classifications suggested two subtypes of BPD. Almost half of the BPD sample was classified E3, suggesting the importance of fear in BPD. The other half was classified as dismissing, suggesting inhibition of anger. In addition, preoccupied unresolved trauma was treated as evidence of disorganization. However, the substantial overlap of the sub-classifications (not including U) of the mothers with BPD and those of the community mothers reduces the discriminant validity of the M&G. Thus, this study adds to the growing body of studies that challenge the validity of ABC+D theory and call for expansion of the conceptual framework (cf., Rutter, Kreppner, & Sonuga-Barke, 2009; Thompson & Raikes, 2003). We think that the richer array of constructs in the DMM may address severe psychological disorder.

Turning to the DMM, there was no overlap at all in subclassification. Further, the BPD patterning both fit the diagnostic criteria for BPD and also provided more fully an explanatory basis for the symptoms. Specifically, “affective instability” fits the mixed anger, fear, and desire for comfort within Type C as well as shifts between Type C arousal and Type A inhibition of arousal. Having multiple strategies suggests an explanation for “confusion regarding personal identity” (e.g., “Am I compliant or angry?”). “Intense, unstable, and crisis-prone relationships” would be expected when alternating strategies left other people confused and frustrated. “Sudden and apparently inexplicable reactions” could result from unresolved trauma, particularly dismissed trauma. “Chronic feelings of emptiness” would be associated with depression whereas “inappropriate and intense disruptions” (including self-harm) could reflect intrusions of forbidden negative affect.

The higher numbered DMM strategies (i.e., those used by mothers with BPD) indicate greater reliance on implicit representations. This suggests that, although their behavior was organized and self-protective, women with BPD would find it difficult to explain their behavior. Even their verbal representations were distorted in ways that both heightened and decreased perception of danger. Their episodes were incomplete and marked by misattributions of causality. Frequently, they lacked the events leading up to the danger, the outcome, and how the woman had felt during the experience; instead, an arousing image of the danger was thrust upon the reader without its temporal or personal context. When probed by the interviewer, the woman often blamed herself (e.g., saying she deserved the whipping) or failed to see the effect of parental factors on herself (e.g., not seeing that her mother’s withdrawal could affect the father’s sexual interest in her). As Table 2 shows, at least six of the women had unresolved trauma regarding child sexual abuse and it was always in a form that misconstrued causality, that is, dismissed as causing nothing, blocked from recall all together, or disorganized and, thus, confused causally with other events. These distortions preclude productive reflection. The outcome was misdirected self-protective responses that often generated danger.

For clinicians, this suggests a three-step approach to treatment: (1) making somatic, procedural, and imaged representations explicit (i.e., represented semantically and in connotative language);
(2) connecting experience in temporally ordered episodes that included the feelings of the self; and
(3) guiding attention to reflective integration of discrepant representations.

Heuristically, the notion of two organized and alternating strategies based on developmental histories of both rejection and unpredictable attack adds meaning to the behavior of women with BPD. Knowing what conditions elicit which responses could guide condition-specific treatment. That is, the various components of the DMM classifications might call for different treatment strategies, with failure to focus treatment precisely potentially augmenting the distortions. For example, encouraging control of negative affect might increase intrusions.

Developmental processes. Our data suggest that women with BPD may have needed to cope with dangers that were beyond their capacity to represent accurately in childhood. Consequently, they used physiological and psychological shortcuts that bypassed the missing information and explanatory processes. These became increasingly maladaptive as the women became older. Being unable to communicate verbally with safe and understanding caregivers about these experiences, they carried erroneous understandings forward; they resolved the accumulating discrepancies by organizing increasingly distorted strategies. Threats that could not be incorporated into strategies remained as unresolved traumas that interrupted strategic behavior. When the combination of misattuned strategies and unresolved threats yields dangerously maladaptive behavior, individuals may enter a state of near constant expectation of danger. In DMM nomenclature, this is a “modifier” of a strategy. In our sample, the almost universal modifiers were depression and intrusions of forbidden negative affect.

DMM classifications can be read like short life narratives. Consider two mothers, both classified as Ut E3 with the M&G method. With the DMM, one was classified Dp Utr(p&ds) PA, aban many A3,4,5(8)C5–6 [ina] h. She was depressed with unresolved trauma in both preoccupying and dismissed forms regarding physical abuse and abandonment and unresolved loss, also in both preoccupying and dismissed forms, of so many people they cannot be listed individually, using an A/C strategy of compulsive caregiving, compliance, promiscuity, and, partially, an externally assembled self, together with an obsession with both revenge and rescue and a history of sudden intrusions of forbidden negative affect. The other case was classified dp l(p) F, GF, teacher l&tr(p & dpl) F suicide A+(4,7) C5 M [ina – anger]. That is, partial depression with unresolved loss in a preoccupied form of the father, grandfather, and a teacher, unresolved loss-and-trauma in a preoccupied and dismissed form regarding the father’s suicide, in a compulsive strategy composed primarily of compliance and delusional idealization of the father and also derogation of the mother, with current intrusions of anger. We think these women are sufficiently different as to need individualized treatment and that this sort of detail can guide clinicians.

Clinical utility
Together, the developmental scenario leading to the psychological distortions in the DMM classifications and the behavioral distortions in the BPD diagnosis suggest several clinically relevant, albeit speculative, conclusions. Because one of us has addressed treatment to improve the mothers’ parental skills (Newman & Stevenson, 2008), we focus here on the needs of the women themselves. Our ideas are tied to our data and DMM theory, but have not been put into practice. Therefore they must be considered speculative.

A central contribution of attachment theory is to focus on the reality of danger, past and present, and its effects on psychological functioning and behavior. In cases of BPD, the first issue is safety. Until women are safe and feel safe, they may not be able to protect themselves or their children.
adequately, nor to think productively. Professionals need to intervene to increase the daily safety of women with BPD, including addressing self-harm and revictimization.

Changing psychological functioning requires access to relevant information, a therapeutic alliance, and a treatment plan. We think the AAI can help with all of these. Given early in the course of treatment by the therapist, an AAI can set the speaker’s mind in motion, even before formal treatment is begun. Managed skillfully, it establishes a way of working together in which the therapist functions as a transitional attachment figure working in the woman’s zone of proximal development to support her psychological exploration of herself and her situation. Coded blindly by a reliable coder, it gives the therapist information beyond the diagnosis with which to develop a functional formulation. A functional formulation integrates the personal and clinical history of the patient with psychological processing. It suggests how the problem developed and the self-protective function of current behavior. This can guide professionals in constructing a treatment plan. Equally important, a functional formulation can assist women – who often feel crazy and out of control – to discover the strategies embedded in their behavior. This can boost their sense of self-efficacy, thus reducing their depression. Treatment can then more effectively address their psychological and behavioral strategies.

Correcting distortions of perception and attribution involves addressing preconscious representations. Although the goal is to transform them to verbal representations, the means are unlikely to be entirely verbal. Indeed, because affect regulation develops interpersonally through parents’ empathy, a similar process with therapists may be needed before women with BPD can regulate their own affect and guide that of their children. Once danger can be represented verbally, mothers with BPD can be guided to construct accurate and complete episodes, particularly of traumatizing experiences. Mothers with BPD may need to learn how to recognize and reflect on discrepant representations, to consider the perspectives of others (i.e., “mentalization”), and to integrate their disparate representations into a comprehensive dispositional representation that can motivate an adaptive response. This is, of course, a very high-level psychological process, but one that is especially important in contexts marked by varied and complex forms of danger.

In choosing treatment strategies, therapists may want to keep in mind both the developmental structure of information processing (from implicit to explicit to integrative) and that the DMM classifications of women with BPD point to patterns of opposites (e.g., A versus C; dismissing and preoccupying responses to trauma; depression and intrusions). This suggests the need for careful attention to when therapeutic techniques are applied and provision of guidance to patients regarding the self-application of regulation strategies. We do think that taking the strengths approach of treating behavior as organized and meaningful, even if complex, has substantial mental health advantages.

Limitations and future studies

This study has fewer subjects than are needed to rule out sample-specific effects. Further, our data regarding danger were compromised by the requirement that the mother spoke about the danger, as there almost certainly were dangers that occurred before conscious recall was possible. Other dangers might have been dismissed from recall. In addition, our data are too limited to test the effects of culture, socioeconomic status, and gender. Future studies should be carried out in other countries, particularly non-Anglo countries, comparing BPD to other diagnoses. Theoretically important comparisons would be with (1) eating and personality disorder (to test the triangulated Type C contribution to BPD), (2) psychoses (to test the effect of depressed compulsive A with intrusions), (3) PTSD (to explore aspects of unresolved trauma), and (4) men with anti-social personality disorder (to test the effect of gender on diagnosis).
It is our hope that assessment of multiple types of representation can provide information beyond that contained in the diagnosis of borderline personality disorder. This, in turn, can focus and order treatment in ways that promote safety and happiness. We cannot change the dangerous past experience of women with BPD, but by sharing with them our understanding of their experience and awareness of the adaptive value of their strategies, we may be able to assist them to find both new meanings for their experience and also respect for themselves.

References


**Author biographies**

Patricia M. Crittenden is an independent researcher and theoretician working in a cross-cultural context. She has published widely on attachment and child maltreatment.

Louise Newman is a child psychiatrist and Director of the Centre for Developmental Psychiatry and Psychology, Monash University, Melbourne. She undertakes research into disturbances of early parenting and attachment.