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AUTHOR Rosenstein, Diana S.; Horowitz, Harvey A.
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ABSTRACT

This study examined the role of attachment in adolescent psychopathology among psychiatrically hospitalized adolescents. Subjects consisted of 60 adolescents and 27 of their mothers. Measures included the Adult Attachment Interview classification for both the adolescents and their mothers, and a battery of diagnostic and personality assessment of the adolescents. The findings revealed that the quality of adolescent attachment relationships with parents was strongly related to both clinical diagnosis and personality dimensions. A striking similarity between patients' and mothers' attachment classification also was found. Adolescents whose attachment organization was Dismissing relied upon a strategy of defensive exclusion from awareness of information which portrayed attachment relationships in a negative light. This strategy was shared by adolescent with externalizing disorders (conduct disorder, substance abuse) and by Narcissistic and Antisocial Personality Disorders and traits. Adolescents in the Preoccupied group were extremely sensitive to difficulties in their attachment relationships and overwhelmed by negative perceptions of parents. These patients were likely to have an Affective Disorder, Obsessive-Compulsive, Histrionic, Borderline, and Schizotypal Personality Disorders, and dependent, avoidant, schizotypal, and dysthymic personality traits. (NB)

WORKING MODELS OF ATTACHMENT IN PSYCHIATRICALLY HOSPITALIZED ADOLESCENTS: RELATION TO PSYCHOPATHOLOGY AND PERSONALITY

DIANA S. ROSENSTEIN AND HARVEY A. HOROWITZ

INSTITUTE OF PENNSYLVANIA HOSPITAL

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WORKING MODELS OF ATTACHMENT IN PSYCHIATRICALLY HOSPITALIZED ADOLESCENTS: RELATION TO PSYCHOPATHOLOGY AND PERSONALITY

The study of the role of attachment in adolescent psychopathology presented here is part of a larger study of psychiatrically hospitalized adolescents at the Institute of Pennsylvania Hospital in Philadelphia. The Adolescent Research Group has also been examining the personality and cognitive development and family structure of these adolescents. This group has come to think of relationship as providing the regulatory context in which behavior, affect and cognition find organization around relationships in the developing individual (Horowitz, Overton, Rosenstein, & Steidl, 1992; Rosenstein & Horowitz, in press). Attachment is one means of conceptualizing and describing a basic intrapsychic organization, represented as an "internal working model". Bowlby (1973) believed that models based on inconsistency or insensitivity in parental responsiveness become laden with defensive biases that allow the child to cope with painful affect elicited by the caregiver's incompetence and simultaneously to maintain access to the caregiver. He believed that such defensively biased models are even more resilient than models based on security and confidence in the caregiver. Thus, defensively biased models formed the initial stages of defensive structures, which would ultimately lead to distortions in personality and psychopathology.

From the standpoint of psychopathology, links between attachment insecurity and increased symptomatology have consistently been shown for adolescents. Insecure

adolescents are more depressed, anxious, resentful and alienated (Armsden & G..enberg, 1987; Armsden, McCauley, Greenberg, Burke, & Mitchell, 1990), and are more likely to engage in problem drinking (Kwakman, Zuiker, Schippers, & deWuffel, 1988; Hughes, Francis, & Power, 1989) or drug abuse (Allen & Hauser, 1991). Using th Adult Attachment Interview, the links between depression and Preoccupied attachment (Co , 1991; Kobak, Sudler, & Gamble, 1992) and eating disorders and Dismissing attachmer . (Cole, 1991) have been demonstrated.

HYPOTHESES

The hypothesis of this research is that consistent relationships ought to emerge between differing patterns of insecure attachment and specific forms of psychopathology in adolescence, based on cohesive strategies of affect regulation and defensive patterns. Distinct hypotheses were based on predictions from 1) existing empirical evidence in infancy, childhood and adolescence that link attachment quality and psychopathology, and 2) commonalities in adolescent/adult attachment classificatory criteria and the phenomenological descriptions in the clinical literature of individuals with a variety of major psychiatric disorders.

We hypothesized that psychiatric disorders commonly labeled "externalizing", such as Conduct Disorder or substance abuse, would co-occur with a Dismissing attachment organization (Table 1). "Internalizing" disorders, such as depressive or anxiety disorders, would be found in individuals with a Preoccupied attachment organization. Personality

disorders and traits which primarily utilize affectively repressive defenses (i.e., denial, isolation of affect, reaction formation) ought to co-occur with a Dismissing attachment. Those disorders or traits which are associated with affective lability and the failure to modulate affect should co-occur with a Preoccupied attachment.

METHOD

Subjects were 60 adolescent psychiatric inpatients (32 males and 28 females) with a wide variety of reasons for admission. Floridly psychotic and retarded patients were not invited to participate. 27 of the adolescents' mothers also participated.

Measures included the Adult Attachment Interview classification (AAI) (George, Kaplan, & Main, 1988; Main & Goldwyn, 1985-1991) for both the adolescents and their mothers, and an extensive battery of diagnostic and personality assessments of the adolescent. The battery (Table 2) attempted to capture multiple facets of adaptive and symptomatic functioning that would yield major psychiatric diagnoses, Personality Disorder Diagnoses and measures of personality traits. The broad range of major psychiatric diagnoses was then sorted into several categories to allow sufficient numbers for analysis. These categories were: 1) Conduct Disorder (CD), primarily Conduct Disorder and Oppositional Defiant Disorder; 2) Affective Disorder (AFF), primarily Major Depressive Disorder and Dysthymic Disorder; and 3) Substance Abuse (SA). All combinations of these categories were used, so that the complexity of psychopathology in subjects with comorbid diagnosis would be reflected in the data.

RESULTS

Attachment Classification Data on attachment classifications were analyzed twice, once using a four category system including Unresolved, and once using the traditional three categories. Subjects who were primarily Unresolved were reclassified by their existing secondary attachment classifications. Using the four category system, and 18% Unresolved. Using the three category system, 3% of subjects were Autonomous, 47% Dismissing, 50% Preoccupied.

Major Psychiatric Disorders 55% of subjects had an Affective Disorder (AFF), 13% a Conduct Disorder (CD), and 20% a combination of Affective and Conduct Disorder (CD + AFF). 12% of subjects did not fit into these categories. Most had an Anxiety Disorder, and one subject had a Multiple Personality Disorder. 30 subjects had a comorbid Substance Abuse (SA) diagnosis.

Attachment and Major Psychiatric Disorders The two Autonomous subjects have been omitted from most analyses. Chi square analyses yielded highly significant associations between attachment and diagnosis (Table 3) Conduct Disorder (with or without Affective Disorder) **predicted** a Dismissing attachment. Affective Disorder alone predicted a Preoccupied **attachment**. Substance Abusers were almost twice as likely to have a Dismissing organization as Non-Substance Abusers (Table 4). Those with comorbid Substance Abuse and Conduct Disorder (with or without Affective Disorder) were highly likely to have a Dismissing attachment (Table 5). The link between Affective Disorder and

Preoccupied attachment became clearer when the Non-Substance Abusing individuals were considered (Table 6).

Sex Differences Strong sex differences were found both in attachment classification and diagnosis.

Relationship to Attachment Classification Since neither sex was favored within the Unresolved category, the four category system was dropped from this analysis. In the three category system, males were overwhelmingly Dismissing and females Preoccupied (Table 7).

Relationship to Diagnosis While Affective Disorders were the most common diagnoses among both sexes, males were more likely than females to be Conduct Disordered, with or without comorbid Affective Disorders (Table 8). Conversely, females showed very high rates of Affective Disorder alone, with consequent low rates of Conduct Disorder with or without comorbid Affective Disorder. No significant sex differences in the distribution of diagnoses were found among either Substance Abusers alone or Non-Substance Abusers alone.

Sex, Diagnosis and Attachment The data were reanalyzed for each sex separately (Table 9). The relationship between diagnosis and attachment classification was significant only for males. The relationship is particularly strong between Conduct Disorder (with or without comorbid Affective Disorder) and a Dismissing attachment for males.

Symptoms and Personality Dimensions

SCL-90-R All SCL-90 scales were regressed onto attachment classification yielding no significant results. However, comparison of means for the two insecure groups showed that Dismissives rated themselves as less symptomatic on all 9 symptom scales and 3 severity scales when compared to Preoccupieds. Dismissives saw themselves as less somatic, hostile, depressed, anxious, obsessionally preoccupied, sensitive, paranoid, and phobic.

MCMI All MCMI scales were regressed onto attachment classification yielding no significant results. However, post hoc tests based on a priori hypotheses revealed that the Dismissing group differed significantly from the Preoccupied group by being more drug abusing, antisocial, narcissistic and histrionic (Table 10). The Preoccupied group, by contrast, was significantly more avoidant, dependent, schizotypal and dysthymic, with a trend toward borderline and anxiety.

Attachment and Personality Disorders 40% (24 subjects) had a Personality Disorder diagnosis, all in addition to a diagnosis of Affective Disorder. Small numbers prevented statistical analysis. However on informal review, the anticipated relationships between specific personality disorders and their associated attachment classification were found. Both subjects with Obsessive-Compulsive Personality Disorder were females and had Preoccupied attachments. Both subjects with Narcissistic Personality Disorders were males and had Dismissing organizations. Both subjects with Histrionic Personality Disorder were female, with Preoccupied attachments. The subject with a Schizotypal Personality Disorder was male and Preoccupied. Only the group of Borderline Personality Disorders occurred

in large numbers -- 14 of the 24 subjects with personality disorders (Table 11). The majority were female, and more likely to have a Preoccupied organization than Dismissing. All these subjects also had an Affective Disorder diagnosis which is predictive of a Preoccupied attachment organization by itself. **Maternal Attachment Classification** Of the 27 mothers who were interviewed with the AAI, 4 were Dismissing, 2 Autonomous, 10 Preoccupied and 11 Unresolved. When the Unresolved subjects were forced into their best fitting secondary attachment classifications, 5 were Dismissing, 2 Autonomous and 20 Preoccupied. The entire group of Unresolved subjects had secondary insecure classifications. Since mothers volunteered for participation, an obvious self-selection of Preoccupied mothers was at word. The predicted association of concurrent maternal and adolescent attachment classifications was confirmed (Table 12). With the four category system, there was a match of attachment classification of 56% (kappa = .412). With the three category system, the match was 81% (kappa = .615).

DISCUSSION

In this psychiatric sample, the quality of adolescent attachment relationships with parents was strongly related to both clinical diagnosis and personality dimensions. A striking similarity between patients' and mothers' attachment classification was also found. This investigation supports Bowlby's (1973) claim that styles of regulating distress emerge from working models, and evolve in the course of development into styles of adaptation and defense (Kobak & Sceery, 1988; Main, 1981). Ultimately these styles coalesce into

personality traits and symptomatology. Therefore, in adolescence, distinctive personality traits and attachment organizations are well established and clearly measurable. Symptomatology, personality and attachment organization are lawfully related, since they result from the same context in development.

Adolescents whose attachment organization was Dismissing relied upon a strategy of defensive exclusion from awareness of information which portrayed attachment relationships in a negative light. This strategy is shared by adolescents with externalizing disorders, that is Conduct Disorder and Substance Abuse, and by Narcissistic and Antisocial Personality Disorders and traits. The pernicious effects of this exclusion is inferred from the individual's self-defeating behavior (e.g., aggressiveness which is interpersonally alienating or runs afoul of the law; substance abuse which compromises health and academic functioning). The widely observed affective regulatory function of substance abuse can be viewed from an attachment theoretic perspective as a means to cut off awareness of negative affects surrounding attachment, thereby maintaining an idealized view of attachment figures and dismissing personal distress. Symptomatic behavior, such as substance abuse or the aggression seen in a Conduct Disordered adolescent thus reflect, in a displaced manner, the anger generated in the adolescent by ongoing parental rejection or intrusion, coupled with the adolescent's failure to acknowledge his own anger.

By contrast, adolescents in the Preoccupied group were extremely sensitive to difficulties in their attachment relationships and overwhelmed by negative perceptions of

parents. Preoccupied individuals were unduly sensitive to their own distress, and characteristically exaggerated their affect in order to elicit comfort from the attachment figure, in a manner that blocked their autonomy. Thus, they were likely to have an Affective Disorder, Obsessive-Compulsive, Histrionic, Borderline and Schizotypal Personality Disorders, and dependent, avoidant, schizotypal and dysthymic personality traits.

Overall, the relationship between attachment and clinical diagnosis was not simply a reflection of sex differences. Discrimination of attachment classification emerged even though the majority of subjects of both sexes were Affectively Disordered. As Bowlby so ably described (Bowlby, 1944), the presence of Conduct Disorder in males is pivotal in predicting their attachment organization. From prior studies it appears that sex differences are more likely to be found in adolescent and psychopathological samples. Joan Stevenson-Hinde commented yesterday on the propensity of insecure children to adopt stereotypic sex roles and we believe this to be operating here. Adolescence is also a time of heightened stereotypy in sex role behavior, in an effort to adopt a cogent identity. By this logic, boys with insecure relationships may be encouraged to act aggressively and defiantly, the behavior being overlooked by parents. Possibly, this aggressiveness acts to defend the adolescent boy from an overly close relationship with the mother, with the sexualized overtones that often accompany abusive relationships, as was common in our sample. In addition, many of these boys adopted a posture similar to that of their fathers, who were criminals or substance abusers themselves. Out of idealization of and identification with the father, they prided

themselves on their own antisocial behavior.

Correspondingly, girls from insecure relationships may be encouraged to become their mother's caregiver and attachment figure, particularly as they press for autonomy in adolescence. The conflict between desires for autonomy and efforts to care for parents results in depression.

A child who is insecurely attached since infancy theoretically would be expected to be at high risk for the development of symptomatic behavior in childhood, and for that behavior to intensify until adolescence. Empirically, the relation of each type of attachment insecurity to specific symptomatic patterns in childhood has been inconsistent. Perhaps not until adolescence can the latent effect of attachment insecurity specify the pattern of psychopathology.

Intergenerational Transmission of Attachment

The very high concordance found between adolescent and maternal attachment classification on the Adult Attachment Interview suggests that transmission of attachment style from one generation to another indeed takes place. There was no ability to predict from adolescent sex or diagnosis to maternal attachment classification. However, the child's dependency was associated with maternal Preoccupation, and the child's drug abuse was associated with maternal Dismissing attachment. These results strongly suggest that the adolescent's attachment classification is causal in determining later psychopathology, and not vice versa.

Conclusions

I am frequently reminded by my colleagues Harvey Horowitz and Bill Overton that Bowlby's construction of attachment theory grew as a combination of features from psychoanalytic theory, ethology and systems theory. The latter two theories are frequently evoked in current attachment thinking. Less often, however, attachment's psychoanalytic roots and particularly its roots in the observation of clinical populations, as Bowlby performed in 1944, are overlooked by attachment researchers. It is our hope with this work to return to one of attachment's original missions, and that is the study of the development of personality and psychopathology from an attachment theoretic perspective.

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TABLE 1

HYPOTHESIZED RELATIONSHIPS BETWEEN
ATTACHMENT CLASSIFICATIONS AND
PSYCHIATRIC DISORDERS

MAJOR PSYCHIATRIC DISORDERS

DISMISSING ATTACHMENT	PREOCCUPIED ATTACHMENT
Conduct Disorder	Affective Disorder
Substance Abuse	Anxiety Disorder

PERSONALITY DISORDERS AND TRAITS

DISMISSING ATTACHMENT	PREOCCUPIED ATTACHMENT
Antisocial	Borderline
Narcissistic	Histrionic
Paranoid	Avoidant
Schizoid	Dependent
	Passive Aggressive
	Somatoform
	Obsessive-Compulsive
	Anxiety
	Dysthymia

TABLE 2

DIAGNOSTIC AND PERSONALITY INSTRUMENTS

1) Structured Clinical Interview for Diagnosis - Patient Version (SCID-P) (Spitzer, Williams, & Gibbon, 1987)

2) Millon Clinical Multiaxial Inventory (MCMI) (Millon, 1983)

3) Symptom Checklist-90-R (SCL-90-R) (Derogatis, 1977)

4) Rorschach Inkblot Test (Rorschach, 1921)

5) Thematic Apperception Test (Murray, 1943)

6) Sentence Completion Test (Loevinger & Wessler, 1970)

7) Minnesota Multiphasic Personality Inventory (MMPI) (Hathaway & Meehl, 1951)

8) Psychiatric interviews

TABLE 3

THE RELATION BETWEEN MAJOR PSYCHIATRIC DISORDERS AND ATTACHMENT CLASSIFICATION

Four Category System

		MAJOR PSYCHIATRIC DISORDERS			
		CD	CD+AFF	AFF	Total
AAI	Dismissing	6	6	8	20
	Preoccupied	1	1	19	21
	Unresolved	0	5	6	11
	Total	7	12	33	52

$\chi^2 = 16.867$
$df = 4$
$p < .002$

Three Category System

		MAJOR PSYCHIATRIC DISORDERS			
		CD	CD+AFF	AFF	Total
AAI	Dismissing	6	9	10	25
	Preoccupied	1	3	22	26
	Total	7	12	32	51

$\chi^2 = 11.056$
$df = 2$
$p < .004$

Note. Column headings on this and all other tables reporting major psychiatric disorders use the following abbreviations: CD = Conduct Disorder; CD+AFF = concurrent Conduct Disorder and Affective Disorder; AFF = Affective Disorder.

TABLE 4

COMPARISON OF SUBSTANCE ABUSERS'(SA) AND NON-SUBSTANCE ABUSERS'(NON-SA) ATTACHMENT CLASSIFICATIONS

Four Category System

		AXIS I		
		SA	NON-SA	Total
AAI	Dismissing	13	10	23
	Preoccupied	9	16	25
	Unresolved	7	4	11
	Total	29	30	59

$\chi^2 = 2.709$
df = 2
p < .258

Three Category System

		AXIS I		
		SA	NON-SA	Total
AAI	Dismissing	18	10	28
	Preoccupied	11	19	30
	Total	29	29	58

$\chi^2 = 4.48$
df = 1
p < .05

TABLE 5

THE RELATION OF SUBSTANCE ABUSE (SA), IN COMBINATION WITH OTHER DIAGNOSES, AND ATTACHMENT CLASSIFICATION

Four Category System

		MAJOR PSYCHIATRIC DISORDERS				
		SA	CD+SA	AFF+SA	CD+AFF+SA	Total
AAI	Dismissing	0	5	4	4	13
	Preoccupied	2	1	5	1	9
	Unresolved	0	0	2	5	7
	Total	2	6	11	10	29

$\chi^2 = 13.599$
df = 6
p < .034

Three Category System

		MAJOR PSYCHIATRIC DISORDERS				
		SA	CD+SA	AFF+SA	CD+AFF+SA	Total
AAI	Dismissing	0	5	6	7	18
	Preoccupied	2	1	5	3	11
	Total	2	6	11	10	29

$\chi^2 = 4.957$
df = 3
p < .175

TABLE 6

THE RELATION BETWEEN NON-SUBSTANCE ABUSERS' DIAGNOSIS AND ATTACHMENT CLASSIFICATION

Four Category System

		MAJOR PSYCHIATRIC DISORDERS			
		CD	CD+AFF	AFF	Total
AAI	Dismissing	1	2	4	7
	Preoccupied	0	0	14	14
	Unresolved	0	0	4	4
	Total	1	22	2	25

$\chi^2 = 8.76$
$df = 4$
$p < .067$

Three Category System

		MAJOR PSYCHIATRIC DISORDERS			
		CD	CD+AFF	AFF	Total
AAI	Dismissing	1	2	4	7
	Preoccupied	0	0	17	17
	Total	1	2	21	24

$\chi^2 = 8.32$
$df = 2$
$p < .016$

TABLE 7

SEX DIFFERENCES IN ATTACHMENT CLASSIFICATION

Three Category System

		SEX		
		MALE	FEMALE	Total
AAI	Dismissing	21	7	28
	Preoccupied	11	19	30
	Total	32	26	58

$\chi^2 = 8.305$
$df = 1$
$p < .003$

TABLE 8

SEX DIFFERENCES IN DIAGNOSIS

		MAJOR PSYCHIATRIC DISORDERS			
		CD	CD+AFF	AFF	Total
SEX	MALE	6	9	13	28
	FEMALE	2	3	20	25
	Total	8	12	33	53

$\chi^2 = 6.335$
$df = 2$
$p < .04$

TABLE 9

THE RELATION BETWEEN DIAGNOSIS AND ATTACHMENT CLASSIFICATION FOR EACH SEX

FEMALES

		MAJOR PSYCHIATRIC DISORDERS			
		CD	CD+AFF	AFF	Total
	Dismissing	0	1	5	6
AAI	Preoccupied	1	2	14	17
	Total	1	3	19	3

$\chi^2 = .435$
$df = 2$
$p < .804$

MALES

		MAJOR PSYCHIATRIC DISORDERS			
		CD	CD+AFF	AFF	Total
	Dismissing	6	8	5	19
AAI	Preoccupied	0	1	8	9
	Total	6	9	13	28

$\chi^2 = 9.818$
$df = 2$
$p < .007$

TABLE 10

MEAN RATINGS ON MILLON MULTIAXIAL PERSONALITY INVENTORY SCALES FOR EACH INSECURE ATTACHMENT GROUP

	ATTACHMENT CLASSIFICATION				
	DISMISSING (N=24)		PREOCCUPIED (N=28)		
RATING SCALE	M	SD	M	SD	p
Avoidant	44.083	29.703	67.750	26.559	.004**
Dependent	47.375	27.150	66.143	24.978	.01**
Histrionic	80.250	19.200	66.571	27.524	.04*
Narcissistic	76.458	25.266	60.000	21.029	.01**
Antisocial	73.208	23.279	57.643	20.939	.01**
Schizotypal	42.083	17.034	54.143	16.577	.01**
Borderline	58.125	17.794	65.286	15.613	.13
Anxiety	68.167	27.704	79.643	22.920	.11
Dysthymia	62.625	28.540	76.786	21.536	.05*
Alcohol Abuse	59.500	20.711	58.143	17.384	.80
Drug Abuse	77.375	18.320	63.750	19.186	.01**

* $p < .05$
** $p < .01$

TABLE 11

BORDERLINE PERSONALITY DISORDER,
SEX AND ATTACHMENT CLASSIFICATION

		SEX		
		MALE	FEMALE	Total
AAI	Dismissing	1	3	4
	Preoccupied	2	7	9
	Autonomous	0	1	1
	Total	3	11	14

TABLE 12

THE RELATION BETWEEN MATERNAL AND ADOLESCENT ATTACHMENT CLASSIFICATION

Four Category System

	MOTHER				
	DISMISSING	AUTONOMOUS	PREOCCUPIED	UNRESOLVED	
ADOLESCENT					Total
DISMISSING	4	0	1	4	9
AUTONOMOUS	0	0	0	0	0
PREOCCUPIED	0	1	8	4	13
UNRESOLVED	0	1	1	3	5
Total	4	2	10	11	27

$\chi^2 = 12.532$
df = 4
p < .014

Three Category System

	MOTHER			
	DISMISSING	AUTONOMOUS	PREOCCUPIED	
ADOLESCENT				Total
DISMISSING	5	0	4	9
AUTONOMOUS	0	1	0	1
PREOCCUPIED	0	1	16	17
Total	5	2	20	27

$\chi^2 = 11.111$
df = 1
p < .001