

Chapter

Reimagining Attachment Traumas: Perspectives on Using Image-Making in Psychoeducation for People with Borderline Personality Disorder

*Dominik Havsteen-Franklin, Maria Patsou,
Greta Somaini and Jorge Camarena Altamirano*

Abstract

Integrating arts-based practice within psychological interventions has been widely used to increase accessibility and cultural sensitivity and to enable emotional communication and expression. However, using arts within psychoeducation for people with a diagnosis of borderline personality disorder (BPD) where attachment trauma has led to interpersonal difficulties has been less well-documented. This chapter intends to illustrate the experience of patients and facilitators in a mentalization-based psychoeducational programme being delivered in adult mental health services. We will look at the relevance of how images are used to embody relational struggles and how they are used to work through themes of anticipated attachment trauma. We then describe narratives of a 12-week arts-based psychoeducational programme from both the patient and professional perspectives. We conclude that arts-based mentalization focused psychoeducation is a valuable resource for preparing patients with a diagnosis of BPD for further treatment where attachment injury is central to the presenting issues.

Keywords: attachment trauma, borderline personality disorder, art psychotherapy, psychoeducation

1. Introduction

Integrating arts-based practice within psychological interventions has been widely used to increase accessibility and cultural sensitivity and to enable emotional communication and expression. However, using arts within psychoeducation for people with a diagnosis of borderline personality disorder where traumatic events have led to interpersonal difficulties has been less well-documented. This chapter intends to illustrate the experience of patients and facilitators engaging in a mentalization-based psychoeducational programme being delivered in adult mental health services. We will look at the relevance of how images are used to embody relational struggles and how they are used to work through themes of anticipated interpersonal trauma. We then describe narratives of a 12-week arts-based psychoeducational programme from both the patient and professional perspectives.

We present an overview of the rationale of introducing arts-based psychoeducation into a mental health programme for people with a diagnosis of borderline personality disorder (BPD) followed by a description of the structure and a brief vignette of the programme. Finally, we will explore patient perceptions of the programme. All patients are anonymised and have given consent for this material to be published, including any images produced during the sessions. The authors are experienced clinician-researchers and have substantial experience of working within mental health services and related contexts.

1.1 Background

We now know that understanding the relationship between attachment, trauma and affect regulation is central to treating patients with a diagnosis of BPD. Evidence suggests that symptoms of BPD have a multifactorial psychobiological aetiology and include attachment trauma reactions to a range of harmful events, including childhood physical and sexual abuse [1–5], early neglect [6, 7] and invalidation [8]. Attachment traumas in this context refer to an intergenerational disorganised condition of relationship that results in disassociation, high affect arousal ‘stemming from fright without solution’ [9]. In conditions of affect dysregulation due to experiencing attachment traumas, it is hard for the person to make sense of causal factors, including traumatic events and triggers that may produce reactive high arousal states. Stawarczyk et al. [10] proposed that thought suppression is a key survival mechanism developed to mitigate the effects of predictive processing, particularly in relation to interpersonal events. Given the propensity to evade direct linking between affect arousal and events preceding the arousal, acting out emotional experience within an interpersonal context where attachment traumas are perceived to occur is a core part of the work in the restoration of a capacity to mentalize. Here we are referring to mentalizing as having the capacity to imagine intentional states of mind that influence behaviours, for example, desires, beliefs, feelings and thoughts. This is highly relevant to working with patients with a diagnosis of BPD where there is marked reduction in mentalizing [11] due to high affect arousal [12] and attachment trauma triggers within interpersonal contexts [13]. A mentalization-based verbal group model has been developed with this theoretical premise in mind [14]. Mentalizing begins in early infancy through the mirroring actions of parental care that offers a capacity to sensitise to emotional experiences and develop symbolic representations of self-and other as well as narrativisation and restoration of affective homeostasis [12]. The actions of mentalizing another, that is the attuned awareness of internal states influencing behaviours, enable a secure attachment [15]. Where unsuccessful parental mentalizing happens, for example, misattunements, insensitivity, neglect or abuse, the psychobiological vulnerability of the infant is likewise managed with non-mentalizing behaviours. As the pre-requisite for secure attachment is a capacity to mentalize this can cause transgenerational patterns of insecure attachment and attachment traumas, potentially advancing to conditions of severe avoidance of abandonment, identity disturbance, impulsivity and self-harm. These are symptomatic of severe conditions of non- mentalizing and together are considered to be primary symptoms of borderline personality disorder [16]. Most treatments for borderline personality disorder focus on the restoration of mentalizing and enabling a second-order representational system to become established [11, 17, 18]. Second to this, the development of ‘positive thinking’ to replace anticipated catastrophe is also considered to be helpful, particularly for impulsive behaviours [19]. Most treatments are medium to long-term and psychoeducation, as a brief intervention is still in the early stages of development for this clinical group. Given that mentalizing involves imagining mental states and developing representations of self and others, the use of

image-making as a reflexive tool is proposed as being a helpful addition to the models of BPD treatment. That said, in order to mobilise the process, framing the problem, understanding the aetiology and reflecting on relational patterns of behaviour are a fundamental first step towards engaging with treatment. Whilst the authors are not intending to describe the effectiveness of the process of using art in psychoeducation for this population, the development of a trauma focused model or the long term benefits, the authors are intending to understand what happens when art is used as a focal point within a psychoeducation programme and how it effects people's experiences, self-understanding and the participant's preparedness for psychological treatment.

Psychoeducation is widely used in mental health contexts to help patients to understand living with a diagnosis of borderline BPD [20, 21], how and when presenting issues arise and to consider attachment trauma in the context of interpersonal relationships [22], identity and affect arousal [21]. Further to this, psychoeducation has been used to help impulsivity and suicidality often occurring in relation to attachment traumas [23]. In psychoeducation, participants usually engage between one and 2 hours on a weekly basis for 6–20 weeks. There is some evidence to suggest psychoeducation improves relationships, reducing attachment traumas [22] however the evidence of its effectiveness is limited to feasibility and pilot studies [20–24]. However, the true extent of the use of psychoeducation is not accounted for given that psychoeducation is often part of a psychotherapeutic intervention for borderline personality disorder [25]. Within the context of art psychotherapy this was also clear in a survey conducted by the British Association of Art Therapists [26]; it was evident that 50% of the art therapists that responded used psychoeducation as either a stand-alone intervention or as being integrated within their treatment. Springham and Whittaker [26] reflect on the survey outcomes and conclude that psychoeducation could be a 'crucial unique feature of the practice of art therapy with BPD'. This is also clear in the emerging literature in this field where art psychotherapy methods of practice within a psychoeducational framework are often used alongside conventional methods of treatment [27–31]. For example, Sweig [30] uses a model of arts in psychoeducation and 'the role of art therapy in clarifying issues and mobilizing creative energies in service of personal growth.' Likewise Thorne [32] has published a specific model of using art within a psychoeducational framework for patients diagnosed with BPD similar to the one that we employed, that offers a structured and theme-based approach to engaging in understanding and reflecting upon self- and other-experience. Thorne [23] asserts that the image-making process adds to a psychoeducation model for BPD through enabling emotions and experiences to be more richly expressed and contained.

The theoretical assumption guiding the evaluation was that the use of arts in psychoeducation encourages the patient to view the perceived attachment trauma trigger from a 'distance'. An intolerable, affectively charged trauma can be made more tolerable through seeing it as a human pattern of relating that all people may experience, and hence offering some normalisation according to human functioning [33, 34]. The nature of requesting the participant to see their experience through the lens of human patterns of relating and attachment trauma reactions helps the patient to consider potential aetiological factors. This requires the patient to relate to the subject but also to see the problem as an observer of themselves [35]. Psychoeducation uses a teaching-based model that encourages distance from the trauma and desensitisation to the predicated interpersonal response. We hypothesised that in the proposed model of psychoeducation there is a core mechanism that increases the capacity to reflect on the expected attachment trauma. The second key feature of taking a more distanced view of the attachment trauma, relates to the generalisability of the presenting difficulty. Arts psychotherapies engage the person in thinking about what they are expressing, how it is expressed and how the expression

might be received. We propose that introducing arts to a psychoeducation model supports the process of imaginative reflexivity in psychoeducation as a method that enhances the person's capacity to regulate affect and improve relating to the other [36–39]. These features of developing imaginative flexibility are also described as a core mechanism in the capacity to mentalize attachment traumas [34] and therefore we deemed this as a helpful addition to the verbal methods of intervention.

Mentalization-based art psychotherapy is becoming an established method of treatment due to the accessibility, cultural sensitivity and scope for emotional communication and reflection [40, 41]. Mentalization based treatment draws on relational theory from attachment theory [42] and restoring mentalizing in the context of attachment trauma as a key part of the work [43]. The concept of mentalization also has its roots in early dynamic theory and cognitive science [44] and refers to a person's capacity to reflect on self and others' intentional states of mind [45].

2. Arts-based psychoeducation within a mentalization based programme in psychiatry

2.1 Overview of the psychoeducation programme

Arts-based mentalization focused psychoeducation is a 12-week programme developed within a secondary care mental health context as both a standalone intervention and as a preparation for an 18-month arts-based mentalization treatment programme. Patients were offered up to four sessions to assess for presenting issues relating to attachment trauma such as self-harm, identity disturbance and affect dysregulation as well as the patient's motivation for receiving therapy. To understand other stressors, a holistic view to the person's life including family, finance, social factors and a risk assessment were assessed in relation to their potential treatment and was shared with patients as an assessment formulation report co-written with the patient. The facilitators regularly reviewed the formulation with the members throughout the programme. Following this process, the facilitators offered a place on the arts-based psychoeducation programme. The sessions included arts and ran for 1 hour and 30 minutes over 12 weeks. The themes for each week were modelled on the programme designed by Karterud and Bateman [46] that described preparatory sessions for mentalization-based treatment (MBT) [47]:

- Week 1: Mentalization and mentalizing stance
- Week 2: What does it mean to have problems with mentalizing?
- Week 3: Why do we have emotions and what are the core emotions?
- Week 4: How do we register and regulate emotions?
- Week 5: The significance of attachment relationships
- Week 6: Attachment and mentalization
- Week 7: What is borderline personality disorder?
- Week 8: Mentalization-based arts therapies - Part 1
- Week 9: Mentalization-based arts therapies - Part 2
- Week 10: Anxiety, attachment and mentalizing
- Week 11: Depression, attachment and mentalizing
- Week 12: Summary and conclusion, feedback

The facilitators informed participants that the focus of the group would be on how we see ourselves and the way we relate to others and how these perceptions link to early attachment patterns and traumas to those attachments. Group rules,

boundaries, confidentiality, respect for others and punctuality were discussed and agreed. Using alcohol, drugs and violence was prohibited in addition to contact between the members of the group, outside of the group. The format of the group included attendance and a refresher of the previous session, presentation and development of the theme of the current session and discussion, image making, feedback and preparation for the next session.

Each session had the purpose of clarifying the concept of mentalization and the point where it can fail, particularly in relation to anticipating attachment traumas and regulating the associated intense affect. The intention of the group was to work with recent attachment traumas, which group members had identified as being emotionally difficult. At the end of the psychoeducation group, there was a collaborative decision made whether further treatment was required.

2.2 Psychoeducation, group work and the clinical process: the art psychotherapists' perspective

The arts were introduced by the fourth author of this chapter and a co-facilitator (both art psychotherapists) to be used in an improvised and explorative way. Materials such as chalks, pens and paints were available to help the patient explore their experience of being in the group in relation to the weekly themes. The narrative uses pseudonyms for the patient names. All members of the group had a primary diagnosis of BPD which had been confirmed through the assessment process. George was a 61 year old, white British man, Henry was a 65 year old white British man, and Dalmar was a 27 year old British Somalian lady.

The artworks were treated as an important part of their personal and group experience and were kept until the end of the 12th session. Over the weeks, the patients' engagement with the arts appeared to develop in emotional complexity, competency and confidence which was reflected in the way they used the arts media. With the presence of anticipated attachment traumas, the arts were also offered as a way of regulating feelings through making doodles or experimental marks when it felt too difficult to reflect on or explore themes. As sessions passed an increasing engagement with the arts was encouraged and there was clear intent to produce figurative drawings with a narrative that related to attachment trauma and how mentalizing could be restored in relation to the themes discussed.

A way of developing initial cohesion in the group was clear in Week 3, in response to the theme of 'Why do we have emotions and what are the core emotions?', George described how his image making on the first week was driven by the curiosity of using the pencil colours that were available, as it gave him an opportunity to 'get a feel for being in a group'. In Week 3, his initial anxieties were reformulated to form rhythmically drawn patterns in distinct shades on the right top corner of the paper (**Figure 1**). The early stage of the work in the group and how the forms co-existed became a strong motif for his experience, where the spaces between people, the nuances of emotions and feelings remained compact and connected in a controlled space. We felt that the patient was using the arts materials to regulate his emotional response to feeling cornered, hemmed into a group where he was uncertain about how people could interact and function without disagreement and the resulting personal trauma and potential disassociation. His marks represented a tapestry like presence where form and colour could coexist in a similar way as his emergent feelings in the group's context.

Similarly, in the same session, Dalmar described her artwork (**Figure 2**) she said that her relationships were like these stone structures that had 'collapsed', 'heavy and helpless', 'immovable' and 'stuck'. These terms are typical of the disorganised attachment state where there is no solution or relational flexibility and ultimately there is a



Figure 1.
'Myself in the group'.

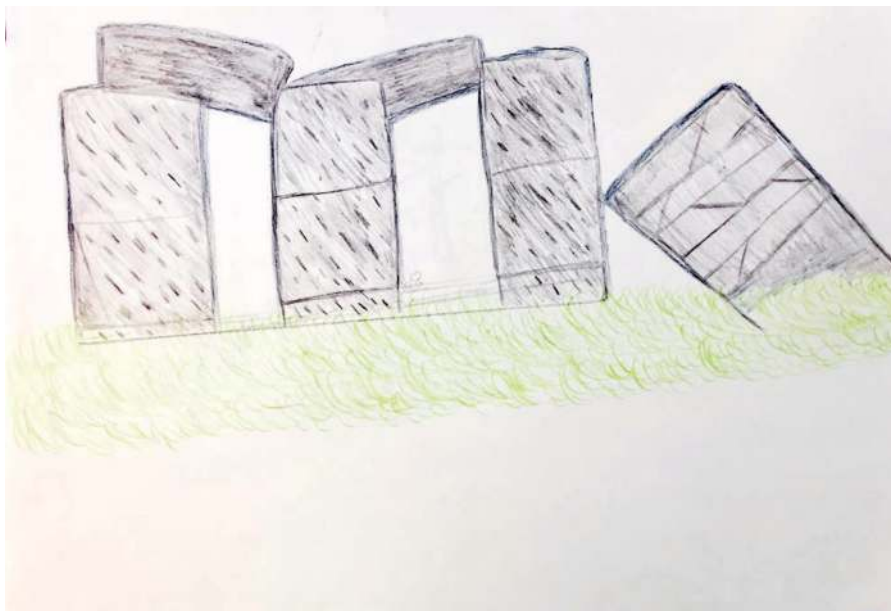


Figure 2.
'Relationships as collapsing stones'.

sense of unresponsive or misattuned neglect. These early images showed a capacity to use image making as a tool for embodying complex emotional narratives that anticipated attachment traumas in ways that could be communicated within a group context.

By Week 3 some group members mentioned how the use of the arts seemed to enable a capacity to be more aware and talk about their mental and emotional processes within an interpersonal context. In **Figures 1** and **2**, the artwork allowed the opportunity to expressively articulate thoughts and emotions that had remained unspoken. In Week 4, 'How do we register and regulate emotions?' One group member (Henry) described his image as the traffic light in the middle of his drawing (**Figure 3**). He used the image to help the group reflect on his anxieties of being out of control, again in a disorganised state where he felt helpless and unwanted. He described the predominant affect as fear, represented by the sunset as a loss of light and something blinding. He described his wish to be like the lamp on the left of the page which he commented on as having a more 'pleasant and balanced quality'. Again, key themes about the rupture to attachments as losing the sun and associated high 'fight or flight' arousal of feeling afraid were at the core of the work.

Using themes to structure sessions helped to enable experiences to be shared. For example, another group member (George) (**Figure 4**) described being 'like the hectic river which was crossing and dividing the urban and green space'. In these early sessions, we focused the content on identifying emotional states and understanding how interpersonal contexts stimulate attachment anxieties about anticipated attachment traumas. In **Figure 4**, George described the urban environment as populated with fragile homes with empty windows, and a mass of green fluidity is sharply divided by an insertion of blue. The powerful disruption also described an intense experience of disconnection that he felt was difficult to bridge due to the uncertainties contained in the green grass of the hill and the disappearing, empty-looking town again drawing on the felt experience of the unavailable and unresponsive others.

The cause of these intolerable conditions of loss of control and disorganised attachment was shared in the group. Dalmar stated that if her family understood her, they would not behave the way they do. Firmly stating, 'It's them that's the problem.' (**Figure 5**).

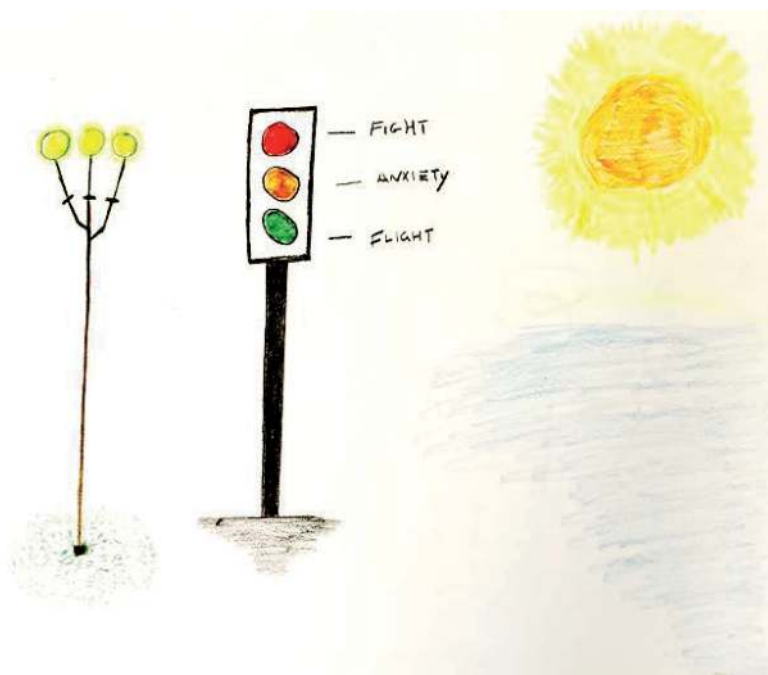


Figure 3.
'Loss of control'.

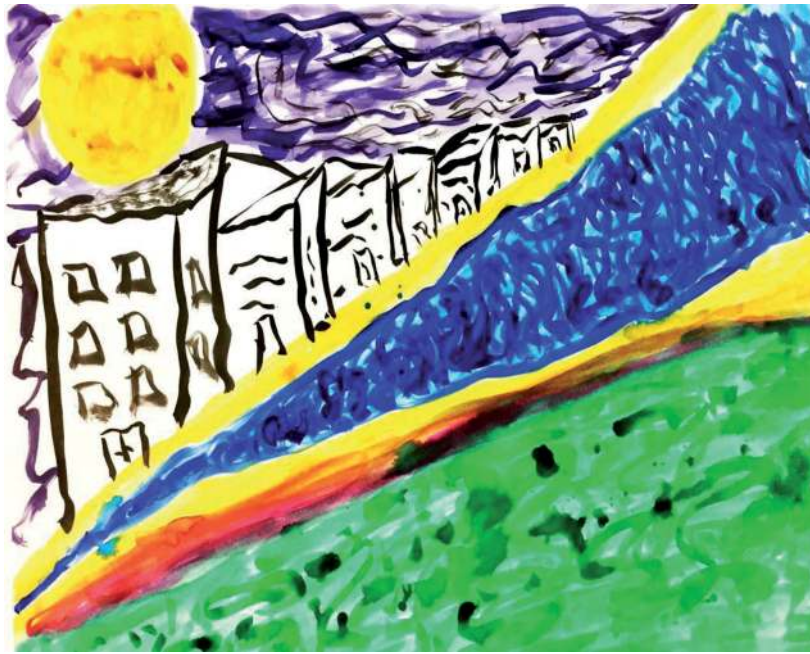


Figure 4.
'I live in the space In-between?'

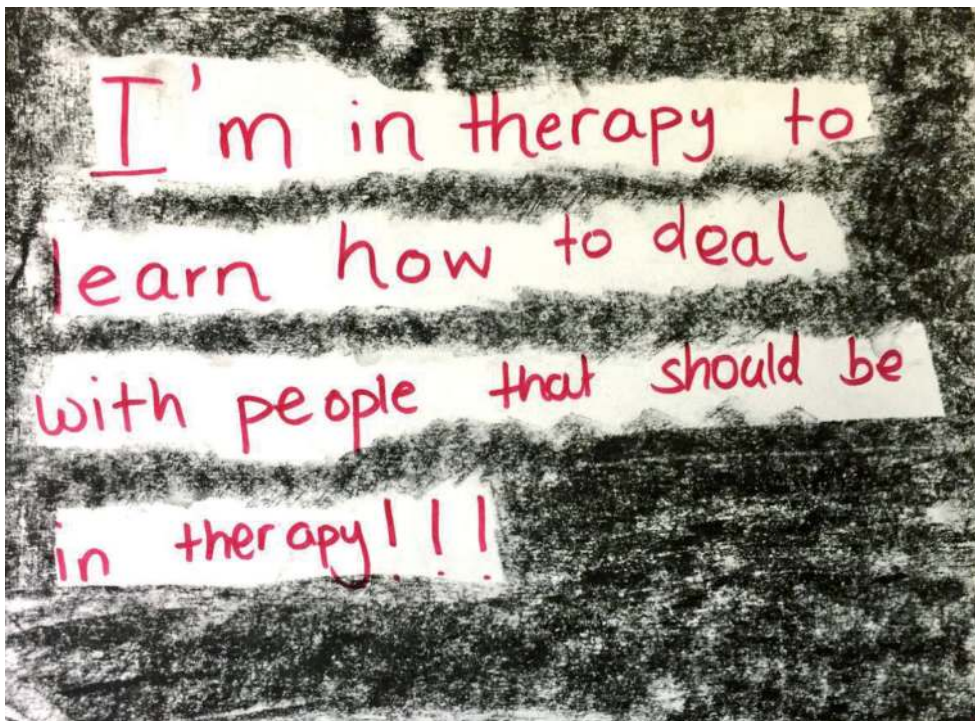


Figure 5.
'It's them that's the problem?'

The same member, later in the work during the session titled, 'Anxiety Attachment and Mentalizing', responded by describing how she manages those states of helplessness and abandonment rather than describing what causes them. She managed painful feelings by harming herself or attempting to overdose on her medication, depicting a blue and white pill in a smudged, surrounded by



Figure 6.
'When I feel abandoned I can only think about dying.'

fingerprint smudges (**Figure 6**). The theme resonated with the group experience. Several people in the group said that this was the first time that they felt that they were being heard. The sense of having a shared experience within the group session contributed positively to the sense of being held in mind by another and developing a capacity to mentalize the other in the context of anticipated social rupture.

By the end of the 12 weeks, participants were asked to conclude the sessions through sharing thoughts about how they engaged with the use of the arts as a medium to foster reflective thinking about thoughts, emotions, beliefs, and their personal stories.

2.3 Experiences of image-making, affect and relationships: the patient perspective

Following the psychoeducation, all members were invited to give feedback about their experience for the purposes of evaluating the group and for the results to be published. Three members came forward and gave consent for their interview to be published (George, Henry and Dalmar). The interviews were conducted by honorary researchers (authors 2 and 3) who were independent from the programme and who were supervised as part of an early career research initiative [48, 49] founded with the NHS by the first author. Each interview lasted about 1 hour and was semi-structures. Key extracts that appeared to be prevalent or represent the larger themes were extracted and are contextualised within the narrative below.

The first sessions appeared to have a heightened sense of vulnerability and members were tentatively engaging. For example, one member (George.) described drawing an image of a baby without a mother in response to the theme of what it means to have problems with secure attachment, describing the image as having a re-traumatising quality. The image making was originally seen as tentative, bearing no genuine relationship to the psychoeducation, and sometimes felt uncomfortable. Members also expressed cautious engagement through feeling self-conscious and unskilled when using the art media, which they felt expressed a sense of vulnerability and the feeling that using the art media was exposing a sense of vulnerability, feeling like they would fail or not be good

enough. For example, one member stuttered and looked embarrassed when she was asked about the use of the art materials.

'I did feel slightly embarrassed, but or not embarrassed, but...conscious and conscious that I couldn't draw really that well in that short time.'

The unexpected effect of the image was often experienced as both offering helpful insight and emotional disturbance. George described how a sense of profound attachment re-traumatisation was immediately evoked,

'When [the image], features round something that impacted you like, so bad, so much...When it, when you could see what happened, bulging in front of your eyes... it brought back terrible memories.'

Henry also expressed an experience of re-traumatisation from being in the presence of others during the group experience whilst attempting to avoid group conflicts. He described an avoidance of unmanageable disorganised attachment arousal in the group that could be provoked by group conflicts to try to keep his stability.

'It's just that it might have brought up memories that I didn't want to think about... I'm sort of outside the conflicts... [Relationships] can be rocky, chaotic, so again it's a bit like me, I'm stable now but I feel it's a bit fragile...'

However, in this early stage, there was a sense that the structure could contain and guide, often helped to reduce anxieties through a sense of being in a group with a direction which felt supportive; being held by the frame of the task. Henry stated,

'And so to have that...back-up... of other people. Though they, you're not talking... you're, more or less, you know, it's more structured'. Henry said that she had begun to gain a sense of clarity regarding past relationships '[past attachment trauma] is not bothering me so much...cause the only person it's destroying it's me'.

However, through having a practical task, the sense of accomplishment of improvising was felt to be useful and could express a state of attachment trauma rather than acting out interpersonally. George said that he used the image as a retreat when one he 'could not get a word in'. As the work progressed, members said the image making became more comfortable and automatic, perhaps less pre-meditated, but often members said that the relational tension meant that it was hard to be playful or to improvise. As the work progressed, members began to monitor themselves, restore a capacity to mentalize, using the psychoeducation to make sense of their experience. For example, using images helped Dalmar to reflect on the experience of attachment trauma, exploring what felt like part of an illness and what was felt like a 'normal' response to relationships,

'...in relation to like my personality disorder erm ...there is a lot of up and down and stuff... but it's unhealthy but I was just thinking how a lot of it is just normal...'

As the group progressed, what seems to accompany the image making and inform the process were several key areas directly related to the aims of the group. Members said that image-making was used to reflect on feeling states relating to attachment traumas that had otherwise been considered as overwhelming and this marked the beginning of feeling more trusting of others.

'..yeah, my confidence has come back... I think I can trust them, but it's, I..., I don't know, I just don't know.'

Members also described an experience of image-making as a way of processing over-thinking and an opportunity to make sense of the salient teaching points provided by the facilitator.

'I was just feeling reflective like...erm thinking about myself and thinking about what other people were saying I was just sort of processing it in my head and this is how it came out on paper.'

During the latter sessions they described a growing sense of stability and confidence in themselves and their own agency, which enabled a capacity to be more reflective about other people's states of mind. However, this appeared to be less so with the experience of what motivated other people's actions, which often produced feelings of anxiety or distrust. Two of the participants described having a more structured interpersonal experience where they were trying to unravel their problems and consider ways of reflecting on their experience. For example, one participant stated,

'the psychoeducation group has helped me to step back and think about what is happening'.

Towards the end, members suggested an experience of hope that was linked with an educational 'structure' that enabled people to be together and learn about how they might experience one another and what might cause a perceived attachment trauma. There was also an experience of being together and appreciating each other's struggles, in effect beginning to mentalize the others' experience.

'That other people around you, makes you feel comfortable. Make you feel... they're suffering and all. You know, others are in the same predicament as you are.'
(George)

The ending marked a hard transition and whilst the psychoeducation was successful in helping members of the group to reflect on their experience and form tentative relationships, there was also a sense that they were left with uncertainties given the brief period of the group. Members described the first steps towards alternative ways of relating, but they seemed to be left with a fragile footing.

'... well, I'm more positive, I'm more positive in myself. I could lose that stability any moment...'

This brief narrative echoes some similar anxieties as the therapist's account of the session, and overall, the quality and stories of the members felt like a brief but important encounter that opened up the emotionality and contextual issues in relation to their presenting issues. Following the psychoeducation, most members agreed to continue the work of understanding mentalizing in a non-directive mentalization art psychotherapy group.

3. Conclusion

The arts-based psychoeducation offered a structured experiential approach to understanding attachment traumas and mentalizing relationships. The image

making seemed to offer powerful access to feelings and experiences that sometimes, and especially at the beginning of the psychoeducation, could be uncomfortable and even 're-traumatising'. The art psychotherapists' perspective of the work provides a comprehensive narrative, highlighting the small but significant positive changes. In the follow-up evaluation we see the patient's autonomy emerging, also describing a tentative grasp of the concepts and emergent alternative forms of relating. We believe that the image-making process facilitated an affective experience of relationships, often revealing vulnerability in safe ways that could be reflected on.

The images offered a powerful account of this process, and particularly the anxieties and uncertainties about developing a secure attachment. The images also revealed anticipated attachment traumas and an invalidating environment, for example in the stuck, rigid invalidating stones; being surrounded by a family that 'should be in therapy'; the constant traffic light 'fight or flight' dance or being stuck in a turbulent place between haunting empty houses and the green grass. Whilst we believe that the use of arts is a valuable tool for communicating, engaging with and reflecting on feeling states; careful, structured and sensitive facilitation is required to maintain safe and effective practice especially where the focus is on how therapists facilitate brief educational work focusing on attachment trauma.

This study revealed that the psychoeducation can expose deep relational vulnerabilities, where the principal focus for members had often been to manage pain in isolation. Perhaps most importantly, the emergent capacity for group members to recover from attachment trauma and to restore mentalizing indicated that there was the conceptual and reflective infrastructure that formed the foundations for further work and would enable members to engage with explorative forms of psychotherapy.

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Conflict of interest

The authors declare no conflict of interest.

Author details

Dominik Havsteen-Franklin^{1*}, Maria Patsou², Greta Somaini²
and Jorge Camarena Altamirano²

1 CNWL NHS Foundation Trust, Brunel University, London, UK

2 CNWL NHS Foundation Trust, London, UK

*Address all correspondence to: dominik.havsteen-franklin@nhs.net

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