An Attachment Theory Approach to the Short-Term Treatment of A Woman With Borderline Personality Disorder and Comorbid Diagnoses

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Abstract: The current case study highlights the treatment of “Thelma,” a 48-year-old woman of African American and Hispanic descent who was diagnosed with borderline personality disorder (BPD), major depressive disorder, post-traumatic stress disorder, and bulimia. An attachment theory approach was used to elicit core structure change in Thelma’s BPD symptoms after traditional modern cognitive approaches proved ineffective. It was hypothesized that treating her Axis II disorder would actually serve to reduce her Axis I symptoms. The attachment approach entailed a shift toward second-order change processes, a shift away from problem-solving approaches, a focus on the quality and intensity of the relationship, and a more relaxed approach to boundary setting in the context of treatment. The approach did appear to reduce many Axis I symptoms including self-mutilation, suicidal ideation, and binging and purging behaviors and appeared to improve her interpersonal functioning.

Keywords: borderline personality disorder; attachment; constructivist; comorbidity

THEORETICAL AND RESEARCH BASIS

Borderline personality disorder (BPD) is the most common personality disorder in clinical settings (Widiger & Frances, 1989). However, it remains difficult to treat. One reason is the fact that BPD is often comorbid with other diagnoses. Individuals with BPD are often at increased risk of developing other Axis I diagnoses such as major depression (Pilkonis & Frank, 1988; Reich & Noyes, 1987; Sullivan, Joyce, & Mulder, 1994; Zimmerman & Mattia, 1999), panic disorder (Reich & Noyes, 1987; Zimmerman & Mattia, 1999), bipolar disorder (Benazzi, 2000; Kay, Alshuler, Ventura, & Mintz, 1999), eating disorders (Gartner, Marcus, Halmi, & Loranger, 1989; Matsumaga et al., 2000), post-traumatic stress disorder (PTSD; Zimmerman & Mattia, 1999), and substance abuse disorders (Driessen, Veltrup, Wetterling, John, & Dilling, 1998; Nace, Davis, & Gaspari, 1991; Nace, Saxon, & Shore, 1983; Verheul, van den Brink & Hartgers, 1998;
Zimmerman & Mattia, 1999). As many of these studies indicate, individuals with comorbid diagnoses have poorer prognoses and more complicated treatment presentations.

There is a growing body of evidence that suggests attachment theory may play a role in the developmental etiology of BPD (Bender, Farber, & Geller, 2001; Laporte & Guttman, 1996; Liotti & Pasquini, 2000; Lyddon & Sherry, 2001; Paris, 1997, 1998; Sabo, 1997; Sherry, Lyddon, & Henson, in press; Sinha & Watson, 1997; Zanarini & Frankenburg, 1997). Risk factor research has provided some evidence of this relationship by outlining some of the specific types of threats to attachment during childhood. For example, people with BPD have a higher incidence of trauma and abuse, particularly sexual, at a young age, repeated, and intrafamilial (Laporte & Guttman, 1996; Sabo, 1997). These clients have also experienced a higher incidence of parental neglect, early separation and loss, parental psychopathology, and social disintegration (Paris, 1997, 1998). The parenting that occurred when these clients were children is often described as overprotective, inconsistent, or demanding, providing the child with very little sense of stability or structure by which to regulate his or her emotions (Laporte & Guttman, 1996). Some researchers even speculate that because caregivers are often inconsistently available during traumatic childhood events, the emotional neglect and absence of other adult attachment figures may be as powerful as actual traumatic events in the development of the personality style (Sabo, 1997).

Attachment theory's principle concern is with the role that enduring affectional bonds between child and caregiver play in shaping one's personality and life (Bowlby, 1969; Lopez, 1995). Central to attachment theory is the concept of cognitive working models of self and others (Bowlby, 1973). These working models help to organize cognition, affect, and behavior in close relationships and to shape self-image (Bowlby, 1973). Working models of the self consist of one's expectations about one's own ability to elicit need-meeting responses from a caregiver. Working models of others consist of one's expectations about the accessibility and responsiveness of one's caregiver (Bowlby, 1973). According to Bowlby (1973), it is the confirmation of these early working models through subsequent interpersonal relationships with both caregivers and others throughout development that determines the persistence of cognitive schemas about oneself and others. In the case of personality disorders, the hypothesis is that the quality and intensity of the client's attachment experiences are so detrimental over time that individuals from these families ultimately grow to anticipate their worlds in much the same way they did as children. As a result, their personality structure becomes dominated by assimilative, feedforward mechanisms that become fixed and inflexible to new information encountered in adulthood. In other words, these individuals anticipate their environments in ways that become self-confirmatory over time, searching for confirming rather than disconfirming evidence related to interpersonal interactions (Lyddon, 1993; Mahoney, 1991).
2 CASE PRESENTATION

The current case study investigates the use of attachment theory in the treatment of a 48-year-old, never married woman of African American and Hispanic decent. To protect client confidentiality, the pseudonym Thelma will be used during the discussion of the case. The case sought to determine whether Thelma’s Axis I symptomatology would be reduced by focusing on the treatment of her BPD using an attachment approach. Treatment centered around providing a secure base for Thelma’s exploration into her own interpersonal and intrapsychic problems. It was hoped this approach would provide disconfirming evidence regarding insecure attachment schemas, ultimately shifting assimilative cognitive structures into accommodative cognitive structures capable of organizing new information in healthy, secure, more adaptive approaches that reduced her Axis I clinical symptoms. In addition, because the therapist’s position was a 1-year term appointment, the current case study seeks to provide this information from a brief therapy model. Client self-report and therapist observation were used to measure treatment effectiveness.

3 PRESENTING COMPLAINTS

Thelma was referred by her psychiatric caseworker because she was in need of more extensive, long-term psychotherapy. She had had this case worker since receiving psychiatric disability status through the federal government, which enabled her to be excused from any formal employment because of the stress it would have created for her, potentially complicating her psychiatric condition. According to her caseworker and to the client, Thelma had a long-standing depression with few periods of little, if any relief. In addition, she had a history of suicidal, self-mutilating behavior. Thelma indicated that she often engaged in this behavior when she either felt no one was listening or when her emotions were becoming overwhelming and hard to identify. Physical examination revealed more than 100 scars and marks on her arms from cutting, self-mutilating behaviors. Thelma often talked about the fact that her mother, twin sister, and other members of her family were emotionally manipulative and controlling. In addition, she disclosed that she had been sexually molested repeatedly by both of her brothers when she was younger. She also indicated that she had no contact with her biological father, and her stepfather was an alcoholic. Because of these experiences, she avoided associated stimuli by rarely leaving the house or by not becoming involved in romantic relationships. She was also hypervigilant to her immediate surroundings. She reported a long-standing history (8 years) of an eating disorder, bulimia, that continued to cause problems for her at the time of referral. Physical examination revealed sores in her mouth, tooth chipping, and tooth decay as a result of repeated purging behaviors. However, despite this myriad of clinical symptoms, it was her BPD diagnosis that was most problematic for her, and her clinical symptoms could be easily understood in this context. Thelma often engaged
in frantic efforts to avoid abandonment through dysfunctional approach-avoidance behaviors. Her interpersonal relationships outside her mother and twin sister were virtually nonexistent. Her relationships with these two family members were intense, unstable, and constant sources of disappointment for her. She exhibited an unstable sense of self in some core areas of identity including difficulties reconciling her biracial identity and discomfort with her gender identity. She engaged in impulsive spending and binge eating behaviors, displayed recurrent suicidal and self-mutilating behaviors, and complained of depression and dysphoria as well as chronic feelings of emptiness, hopelessness, and futility.

4 HISTORY

Thelma was an identical twin and also had two older brothers and an older sister. She did not know her father, who her mother stated was Hispanic in ethnicity, at all during her life. She had a stepfather, who was an alcoholic, for much of her adolescent life. She suspected he sexually abused her but indicated she could not fully remember. She did remember him being emotionally abusive. She stated that both of her brothers sexually molested her. She said her twin sister described experiencing the same treatment from them. She reported that when she disclosed this information to her mother, her mother told the client that it was her fault. According to the client, her mother consistently placed the sons above the daughters, especially above the client's needs and welfare. During the time of treatment, the client was not sure where her oldest brother and sister were as they had both broken ties with the family. The client described having a close relationship with her twin but also described treatment from her twin as similar to that from her mother. On several occasions, her twin would spend her paycheck on cocaine and other drugs and expect Thelma to loan her money for her living expenses, which Thelma often did, reporting that she felt guilty if she did not help her sister. She was rarely repaid. Both her mother and her twin sister often manipulated Thelma by trying to make her feel guilty when she did not want to do things for them such as loan them money, even though Thelma was on disability and a very fixed income. In addition, her mother withheld love and affection if Thelma did not take care of her physical, emotional, and financial needs. Because of Thelma's intense needs for closeness and fear of abandonment, these tactics proved to be effective.

Thelma reported never having had a romantic relationship or a consensual sexual relationship with another person. She also expressed no desire for these things, indicating that her abuse had left her with intrusive images of inappropriate sexual behavior. She appeared to struggle with her gender identity in that she dressed androgynously, kept very short hair, and never wore makeup. At one point, she remarked she was uncomfortable with her gender, but was uncomfortable discussing these issues in any detail.
Thelma’s treatment history was quite lengthy. She had been receiving services for 18 years, but because she was on psychiatric disability and using Medicaid for payment, previous treatment had largely consisted of monthly 20 to 30 minute visits to her psychiatric caseworker and 30 to 45 minute visits to her psychiatrist every 3 months. These visits primarily focused on medication effectiveness and side effects and basic skills training. When talk therapy was available to her, temporary professionals such as postdoctoral fellows and psychiatric residents who desired the additional training usually provided it. She had been prescribed Prozac, Paxil, and numerous other antidepressants in the past with little or no success. From time to time, she attended day treatment programs, which usually consisted of group therapy and more one-on-one attention. However, at the conclusion of these programs, she was often unable to transfer what she had learned in treatment to her day-to-day living. She had been hospitalized numerous times to the point that the staff on the psychiatric unit knew her by name. Because of this, when she presented for treatment on the inpatient unit, the staff typically placed her on the temporary observation unit for 24 hours and then released her the next day. The reasoning given for this protocol was her BPD diagnosis.

5 ASSESSMENT

Because the treatment site focused primarily on medication management, few standardized assessments were available. In addition, being a public hospital, there were few financial resources from which such instruments could have been purchased if so desired. However, given that Thelma was of multiple minority status, many of the current traditional assessment instruments did not seem appropriate because they had not shown consistently reliable results with these diverse populations and had not been normed on such populations. Treatment effectiveness was measured primarily in terms of reduction of hospital visits and increased overall psychological stability as reported by the client and witnessed by the therapist. Her Axis I and Axis II diagnoses, as well as relevant associated criteria, were as follows:

AXIS I

PTSD: Exposure to traumatic event and fear and helplessness; re-experiencing of event in intrusive thoughts; avoidance of stimuli (sex, relationships, leaving the house); increased arousal (difficulty concentrating, hypervigilance).

Major depressive disorder, severe without psychotic features, recurrent, in partial remission:
Depressed mood; diminished interest; psychomotor retardation; suicidal thoughts; loss of energy; feelings of worthlessness; difficulty concentrating.

Bulimia nervosa, purging type: Lack of control over eating following by purging.
AXIS II

BPD: Frantic efforts to avoid abandonment; intense interpersonal relationships with family members and inability to develop and maintain long-standing friendships; identity disturbance; impulsive spending and binging; recurrent suicidal and self-mutilating behavior; affective instability; chronic feelings of emptiness.

CASE CONCEPTUALIZATION

Based on 2 months of assessment and many failed initial attempts at modern cognitive interventions aimed at treated her Axis I symptoms (homework assignments, journaling, investigating irrational thoughts, etc.), it was decided that a more effective approach might be to address some of the core driving forces in Thelma’s personality structure. In addition, it was determined that her resistance to the modern cognitive interventions was primarily because of mistrust and insecurity in the therapeutic relationship, which was likely grounded in an insecure attachment schema developed from a history of emotional neglect and sexual abuse by primary attachment figures in her life. It was determined that if Thelma were to experience relief in any of her clinical Axis I symptoms, she would first need to reorganize her insecure attachment schema around a more secure worldview.

As noted in the theoretical and research section, BPD is often associated with a number of Axis I comorbid diagnoses. This was the case for Thelma as well. It appears that having BPD can compromise what could have otherwise been sufficient ego strength and psychological resources for combating the clinical symptoms of Axis I disorders. Therefore, it would stand to reason if the personality structure of BPD could be improved, this may in turn reduce Axis I symptomotology. When Thelma did not respond to traditional modern cognitive approaches, instead of labeling this as resistance, it was determined that the approach was simply not meeting her current need, which was to learn to develop a securely attached and trusting relationship with another person.

Lyddon (1990) refers to this therapeutic approach as a focus on second-order change. First-order change, sometimes produced when therapy focuses on the Axis I symptomotology, refers to “any change in a system that does not produce a change in the structure of the system” (p. 122). Such efforts do produce symptom reduction, but because there has been no core structure or system change, this change often does not last, and the client eventually returns to pretreatment levels of functioning once treatment is terminated. This is what appeared to happen to Thelma during the many day treatment experiences she had. She would experience some symptom reduction during these times while she was involved in day treatment, but she would not be able to transfer what she had learned to her day-to-day, long-term functioning. In contrast, second-order change is change whose occurrence alters the fundamental core structure of the system. It would appear that finding a way to elicit core-structure, second-order change in BPD
clients may be a pathway to lessening the effect of Axis I comorbid diagnoses in this pop-
ulation and thus increasing the quality of life for these clients. According to Lyddon
(1990), a proactive or developmental change in cognitive structures is required for sec-
ond-order change. In other words, therapy should focus on approaches in which the
core cognitive system from which the client operates shifts from utilizing assimilative
processes (integration of experiences into existing cognitive structures) to accommoda-
tive processes (developmental change in cognitive structures). Such therapy is likely to
provide learning opportunities by presenting information disconfirming long-standing
assimilative cognitive assumptions and providing a therapeutic environment conducive
to reorganization around newer, more accommodative cognitive structures. Identifying
the developmental etiology behind existing cognitive structures that have become dys-
functional over time is an important piece in the second-order change process. Because
the fundamental tenets of Thelma's system appeared to be related to assaults on her
attachment security during her development, an attachment theory approach to treat-
ment appeared to be an appropriate course. The ultimate goal was to try to establish new
cognitive working models of others as being trustworthy and more predictable through a
secure, predictable, close relationship with her therapist. It was hoped this would lead to
the establishment of a secure base from which other interventions and treatment
techniques could stem and long-term learning could be achieved.

Regarding Thelma's specific attachment schema, she appeared to support Sherry et al.'s (in press) empirical findings. These findings support the notion that people with borderline personality traits have been shown to possess preoccupied and fearful adult attachment schemas. This indicates an overall negative view of the self and a vacillating positive and negative view of those around them. It appears that people with borderline personality features may be highly invested in others, often displaying intense separation anxiety when relationships are not secure. It is this strong investment (i.e., positive view) in others, while still having a negative view of the self, that leads to a preoccupied attachment, especially during times of stress or separation. At the same time, people with borderline personality features often have personal histories that reinforce an idea that they can never fully trust others nor hope to gain all of the affection and support they need (Millon, 1996). This appears to explain the fearful attachment (a negative view of others accompanied by a negative view of the self) found in people with BPD traits (Sherry et al., in press). Related, Thelma seemed to typify Millon’s (1996) “discouraged borderline” subtype of BPD. As such, Thelma attached herself to her mother and twin sister with whom she could display affection, loyalty, and thoughtfulness. However, like the discouraged borderline prototype, these attachment figures were unreliable anchors, and Thelma was excessively attached to people who could not provide a secure base for her, resulting in her security being in constant jeopardy. Coupling Sherry et al.’s (in press) findings with Millon’s (1996) discouraged prototype may help in understanding much of the “black and white” thinking that is common with people with BPD.
The tenuousness of Thelma’s attachment figures is particularly apparent when one considers the fact that Thelma’s mother could not, and arguably from Thelma’s perspective would not, protect her from sexual predators in the family and was herself an emotionally abusive figure in Thelma’s life. Thelma’s twin sister is another example of someone to whom Thelma felt an excessive attachment but who could not provide a secure, healthy relationship example for Thelma. Because of these unpredictable, insecure attachment relationships, Thelma lacked psychological resources that would have otherwise protected her from psychic insult resulting in a core working model of self that was steeped in self-doubt, sadness, lack of initiative, helplessness, hopelessness, and powerlessness.

An attachment theory approach was implemented after 2 months of traditional modern cognitive behavioral therapy aimed at treating her Axis I symptoms was ineffective. Once it was determined that an attachment theory approach would be utilized, changes were made in Thelma’s treatment. Cognitive behavioral homework exercises, keeping a food journal for her eating disorder, and similar approaches were no longer used. Despite the encouragement to engage in such exercises during the first 2 months of treatment, Thelma would not participate. Her lack of participation was consistent with her passive style in that she would never overtly object to assignments or requests; she would simply not do them with little or no explanation. Attempting to implement them during session was no more productive. From a countertransference perspective, this was creating tension in the therapeutic relationship insofar as the therapist felt frustration toward Thelma. However, instead of framing this behavior as resistance, it was instead decided that this behavior was important information indicating that Thelma was not at a place where she was able to address the pathways to her depression or antecedents to her binging and purging behaviors. Her needs appeared to be much more developmentally based and simplistic: the need to trust and connect with another individual. Using this simple need as a guide for the therapist, therapy was initially spent with few objectives other than getting to know one another. Most salient in this attachment approach was the humanistic stance of unconditional positive regard and acceptance of her. From there, past and present relationships with significant people were explored, particularly those with her sister and her mother. Although her relationships with her mother and sister were quite destructive from time to time, there existed such an anxious attachment with them that dissolving these relationships was not an option. In addition, she had few if any other social support networks in place. Instead, the focus of this aspect of her treatment was on setting appropriate limits with them rather than encouraging autonomy. The hope was that the earlier phase of the therapeutic relationship provided her with a new working model of others through a secure attachment relationship with her therapist that would be a framework for healthier relationships with significant others in her life. It was also hoped that this would produce a second-order change process that would provide a foundation from which she could draw when she was transferred to her new therapist on termination.
The secure attachment stance was especially important during times she tested this stance through suicidal gestures and self-mutilation, theoretically in an attempt to elicit responses from the therapist that were familiar and comfortable and that reinforced the status quo of a negative working model of the self and somehow prove to herself that others cannot be trusted. Instead these were learning opportunities for her that reinforced the notion that she could be sad, disappointed, hurt, or even angry without losing care and concern from her therapist and that she need not be vengeful or manipulative or hold a grudge to secure that care and concern.

Thelma was seen usually once a week, but sometimes twice a week, for a period of 10 months, all for 1-hour sessions. She rarely cancelled or no-showed and was almost always on time. Thelma presented for inpatient treatment on her own three times during her treatment. However, only one of those times resulted in admission to the long-term inpatient unit. She improved greatly after this hospitalization, when she remained on the unit for about a month. She was seen almost daily while she was hospitalized. Toward the end of treatment, she participated in a group therapy experience in addition to individual therapy to provide her additional opportunities to seek out secure attachments and form a social support network.

7 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

INITIAL SESSIONS

As noted earlier, for the first 2 months of treatment, Thelma had a difficult time articulating her feelings or even identifying possible antecedents to her condition. It took several months to get a clear picture of her presenting problems because of her trust and disclosure issues. On the surface, she had clinical symptoms stemming from sexual abuse and trauma, an eating disorder, suicidal and self-mutilating behavior, depression, and having been an adult child of both an alcoholic stepfather and an emotionally controlling and emotionally neglectful mother. However, the consequences of this created a woman with a loss of a sense of self, a pervasive mistrust and uncertainty of the world around her, an inability to trust or regulate her own emotional reactions to stimuli, chronic and treatment-resistant depression, and self-hatred. Considering the fact that treatment would be less than a year, her many presenting problems needed to be triaged. Decreasing her suicidal and self-mutilating behaviors was most important as this had to do with her safety. However, correlated with this, her deeper issues of trust and loss of self also needed to be addressed, insofar as they could be in a 10-month period, to create a foundation for future treatment with another professional and to begin to address the core issues driving virtually all of her other symptoms. Because of Thelma’s history of emotional and sexual abuse, and inconsistent and unpredictable emotional attachments, it was anticipated there would be times that Thelma might sabotage this security
by acting out with suicide attempts or self-mutilation. Therefore, on-going, frank discussions about her safety and weekly contracts regarding her safety were essential. Often such discussions can come across as legalistic or impersonal attempts at controlling client behavior. However, using an attachment theory approach, these discussions often included the therapist’s disclosures about the therapist’s feelings about Thelma, the sense of loss the therapist would feel if something happened to her, and sincere concern and sadness that Thelma felt poorly enough to consider endangering her life. In conjunction with this, the therapist would often ask Thelma what was and was not working for Thelma in the context of the therapeutic relationship that might be contributing to these feelings and a joint meaning-making process ensued to identify Thelma’s needs and the ways in which therapy might be able to address them. This appeared to give Thelma a sense of empowerment, a feeling she rarely endorsed as being a part of her current life course. Initially, several cognitive techniques were implemented in an attempt to relieve the intense depression she reported. If given in homework format, she would come back the next week having not attempted the exercise. If given in session, she would simply reply, “I don’t know,” and look to the therapist for the next move. Clearly these approaches were not working for her. There appeared to be a more pervasive, developmental aspect to her functioning, and approaches aimed at targeting only her symptoms did not address any of the core systems driving those symptoms. At this point in therapy, it was decided that traditional modern cognitive approaches would be replaced by an attachment approach to treatment.

2 TO 6 MONTHS

Once it was decided that attachment theory would be the best approach for Thelma, the goal of these early sessions shifted to simply getting to know Thelma. Therapy sessions often consisted of talking about world events, the weather, or events in her life, and at times the therapist shared events in her life. There was no attempt to avoid painful, emotional issues, but at the same time there was no agenda to expose or uncover them either. The conversation was allowed to flow casually at Thelma’s pace. Over time, Thelma began to disclose more and feel more comfortable with the therapist, and eventually she was able to discuss more painful issues more openly.

6 MONTHS

Thelma’s suicidal gestures and self-mutilating behavior continued from time to time. Twice she admitted herself to the hospital preemptively before she hurt herself. For this, she was praised for taking care of herself. However, in one instance, she left therapy after a seemingly typical session, returned home, cut her wrists, and called the therapist on the phone to report the incident. According to her, there had been some financial stressors that became overwhelming that led her to this decision in large part because of
the financial strain her family often placed on her. Mobile crisis was called, and she was taken to the emergency room for stitches. Before she could be admitted to the psychiatric unit, she left the emergency room against medical advice and returned home. At this point, the sheriff was called to her home with mobile crisis to have her admitted to the hospital. This was about 6 months into her treatment, and there was concern on the part of the therapist regarding what further progress could be made with the 4 months remaining. Overall, she had been showing improvement in her mood and her ability to trust in the therapeutic relationship. However, she continued to display affective instability, with this current suicidal gesture being an outcome of this pattern. One thing that had not been tried was a serious reevaluation of her psychotropic medication. Therefore, when she presented to the hospital for the current suicidal gesture, it was decided that she be admitted to the long-term inpatient unit to accomplish this. She stayed on the inpatient unit for about a month. This was a difficult and disorienting month for Thelma. During this time she had several self-mutilating episodes and one suicidal gesture that was carried out in between 15-minute suicide watch checks. The therapist shifted approach somewhat and encouraged Thelma to start thinking about her treatment as being in large part in her control and affected by her decisions. During this time, she was seen daily by her therapist to reinforce the notion that she would not be abandoned, despite her attempts to test the security of the relationship with her suicidal gestures. During this time, she was placed on the mood stabilizer Depakote, and her impulsiveness and depression began to lift. She was discharged with no suicidal ideation.

7 TO 10 MONTHS

Once Thelma was on an effective medication regiment and individual therapy was progressing, she began to attend a therapy group. Because individual therapy would be terminating in a few months, group therapy was chosen to help her practice some of these attachment skills with other individuals while still having the secure base of individual therapy from which to return. Thelma attended two group therapies, a suicide support group and trauma group. Her individual therapist and group therapist were the same, and although this is typically considered unconventional, in this particular case it appeared to be appropriate. Thelma was able to use individual therapy as a place to process some of the cognitive working models of others she was experiencing in group therapy. Often she would misinterpret someone’s actions as being against her or not “liking her.” The therapist was able to offer alternative explanations and encourage Thelma to test out new theories and assumptions in the following group session. It was a struggle for Thelma to be outgoing in group. Her only sources of social support up to that time were her mother and twin sister and now her therapist. However, in time, she was able to open up a bit more and take more chances socially. By the end of the group experience, the skills she learned in the group generalized to her meeting and creating a new friendship
with a woman in her apartment building. This was the first time Thelma had been able to develop a friendship in several years. At this point, Thelma reported less suicidal ideation and depressive feelings, less instances of eating-disordered behavior, and more episodes of happiness.

**TERMINATION OR TRANSFER**

The transfer process began from the beginning as Thelma was given gentle reminders as to the time-limited nature of our time together. However, about 1 month before our final termination, we had several sessions with Thelma’s new therapist as well as several individual sessions. This gave Thelma the opportunity to discuss with me her fears and concerns about the new therapist and also test her assumptions about her interactions during the initial meetings. In addition, at this time a joint agreement among the three parties was made so that Thelma would be able to contact me in letters through her new therapist from time to time. This way the new therapist could help Thelma balance her need to stay connected to the old therapist with her need to attach and make therapeutic strides with the new therapist. It was important that as the therapist, I was prepared to return her letters in kind or not agree to this arrangement. The last couple of weeks Thelma saw her old therapist and her new therapist individually but separately until the old therapist had left her position permanently.

Several things appeared to be most paramount as she transitioned to a new therapist. First, Thelma was concerned that her therapeutic gains would disappear and she would regress to prior levels of functioning as she had in previous attempts at therapy. This was an important learning moment for Thelma as she was encouraged to see her gains as real core structure changes in who she was and that such insights and changes could not suddenly disappear. Second, as termination became closer, it was important to help Thelma understand that two people can have a healthy goodbye. It was important to dispel the notion that goodbye was synonymous with abandonment or anger. Helping her understand that there were pieces of each other we would take with us and would always have and cherish was essential. As a way of making meaning about this, we exchanged meaningful, inexpensive gifts to provide her a transitional object to keep this in mind. Such gifts were purely symbolic in nature and did not present a conflict of interest, a financial hardship, or a sense of undue obligation for the client. Third, highlighting how she had been able to form additional attachments outside of the therapeutic relationship was important in creating a sense of self-efficacy for her in terms of creating her own attachments without her therapist’s assistance. The relationships she developed through group and in her apartment building were evidence of this. Fourth, and related to this, was her ability to form a close attachment with her new therapist. Although it was anticipated this would be a slow process and at times difficult for her, it was hoped it would be less difficult than when she first began treatment 10 months earlier.
SHIFTING TO AN ATTACHMENT APPROACH

It should be noted that an attachment approach is process oriented. There were several concepts during treatment that became salient parts of this attachment, process-oriented approach. Using Bowlby’s (1969, 1973) conceptualization of attachment, a shift toward the quality and intensity of the relationship instead of the quantity or content of sessions was one core concept throughout the process. This ultimately dealt with the sincerity of our relationship and my availability to Thelma. Similar to this, the perspective of typical therapy to solve or have the client solve problems was replaced with the goal of shifting Thelma’s core structure of working models of others to a steady, secure, and positive view. In Thelma’s case, once an attachment theory approach was implemented, there was very little focus, direct treatment, or discussion of her Axis I symptoms unless it was pertinent to how she was doing in the context of providing a secure base for her. This approach is especially pertinent with clients with BPD because they so often are unable to actually or definitively solve the core issues that bring them in to therapy. Resisting temptations to solve takes enormous pressure off of the therapist and can be more validating for the client as well. Related to this shift is the focus on second-order change mentioned earlier. Shifting the client’s attachment schema represents second-order, core structure change for the client. A final shift was again toward attachment building but away from strict boundary setting. As other mental health professionals were observed interacting with Thelma through the treatment course, it was found that many preferred very strict boundary setting with Thelma to the point that she was truly unable to express her true feelings or be heard by them. This brought to mind the possibility that many mental health professionals enter therapeutic relationships with clients with BPD with an already existing assumption that they will test boundaries and behave inappropriately. When boundaries are set using an attachment approach, the phrase “choose your battles” comes to mind. What is important for the therapeutic relationship? For the client’s safety? And for the outlined treatment goals? Boundary setting with these clients should not be a way the therapist uses to manage his or her countertransference reactions.

8 COMPLICATING FACTORS

With most BPD clients, there are numerous complicating factors, particularly around the issues of safety and triage. Thelma’s safety issues were rarely life-threatening. Even with the suicide attempt that resulted in her hospitalization, it was not a life-threatening gesture. However, there is always the fear that even suicidal gestures by clients may take an unexpected turn and be far more life-threatening than even the client had intended. These safety issues needed to be addressed on an on-going basis.

A second complicating factor was the presence of so many Axis I symptoms. At times, particularly when her binging and purging was at its worst, it was difficult to resist
the temptation to address those issues directly. There were times during the treatment process that some behavioral and cognitive-behavioral interventions were tried again. However, these continued to be ineffective, and the decision to approach treatment from an attachment perspective gained more validity.

A final complicating factor was that the therapist’s position was a 1-year position at the center. In one way, this position was a benefit to Thelma. Because the position was paid for by outside funding, the therapist was able to see Thelma as frequently and for as long as needed with virtually no restrictions from Medicaid. However, on the other hand, it seemed antithetical in some ways to advocate for short-term, attachment-based psychotherapy. How can a therapist create a secure base with the constant threat of termination? There were times, particularly prior to her hospitalization, when there was concern that no lasting gains would be noted after the 10-month treatment time span and that it would take longer than 10 months to undo the 48 years of insecure attachment confirmation that had occurred during Thelma’s lifetime. The issue of termination was a necessary topic of conversation throughout treatment. It was important to set up realistic expectations about the duration of the therapeutic relationship. Termination was framed for Thelma as an experience for her that people can be present and also need to leave, and this had nothing to do with anything intrinsically wrong with her. However, the most important aspect of this issue when deciding to go forward and implement the attachment approach in such a limited time frame dealt with Bowlby’s (1969, 1973) original conceptualization of attachment. He indicated that it was the quality and intensity of the attachment experience that was important, not the quantity or content. It was this assertion that allowed for the attachment approach to continue forward despite the time limitation.

9 MANAGED CARE CONSIDERATIONS

There were few managed care considerations for Thelma during this treatment because the therapist was being funded by an outside source, thus leaving complete control of the therapy to the therapist. However, this obviously had not always been the case, and some of Thelma’s difficulties in trusting and forming therapeutic relationships could in part be attributed to the managed care she had received in the past. Because Thelma was receiving services through her government disability (Medicaid), resources were extremely low. Psychotherapy in such situations is considered a luxury and is rarely an opportunity. Therefore, much of Thelma’s previous treatment consisted of medication management only, and therapy was only an option during times of crisis for Thelma. This was a potential complication because Thelma had been in need of intensive psychotherapy for a long time and now was faced again with only transient, time-limited treatment by a therapist who would only be available to provide treatment for 10 months.
FOLLOW-UP

Some of Thelma’s changes were apparent at transfer. She began making friends with people in her apartment building and becoming more interested in interpersonal relationships. She also began to wear dresses and some makeup and to style her hair in feminine ways. This appeared to be some limited evidence that she was developing parts of her self, particularly around gender. Her suicidal gestures had stopped, and she reported no longer feeling suicidal.

Following transfer, Thelma sent a total of four letters during a 2 ½ year period. Often these letters were greeting cards commemorating a holiday of some kind. Sometimes she wrote a personal note and updated me on her life and progress; other times she simply signed her name. Each time a letter was received, a response letter was sent to her. Although admittedly this is an unconventional approach, particularly with a client who has BPD, it fits within an attachment framework and likely contributed to some of the positive work that was subsequently done with her new therapist. She indicated in our last communication before this manuscript was written that she had stopped therapy 7 months prior (about 2 years after our termination) because of knee surgery and decreased mobility as a result. At the end of the 2 ½ year period, she had stopped her binging and purging behavior completely and appeared to no longer meet the diagnostic criteria for bulimia. Although she had presented herself to the hospital a couple of times, these visits had decreased significantly and were primarily in times of stress when she needed extra support. In addition, she reported she no longer engaged in self-mutilating behavior and was not suicidal. She also reported that she had lived for a time with her mother and for a time with her sister since termination. Although both of these living arrangements were stressful, she felt positive about the extent to which she was able to set limits with them, something she was unable to do before treatment because of her fears of abandonment.

TREATMENT IMPLICATIONS OF THE CASE

It is unknown the extent to which Thelma’s therapeutic gains can be attributed to her new therapist, her medication regiment, the attachment work, or simply time. These are all confounding factors when reviewing her recovery process. However, given that she had received 18 years of treatment that produced no such gains for long periods of time, it is hoped that the attachment work at a minimum gave her a foundation from which her new therapist, her medications, and time could all capitalize.

Her improvement using this approach calls into question a long-held managed care belief that personality disorders are (a) not treatable and (b) should not be covered by mental health insurance plans. Not only was the approach aimed at her BPD effective, it was able to be implemented in a relatively short amount of time. If one conceptualizes dysfunction dynamically rather than linearly, it makes sense to treat the parts of the
self that appear to be driving the dynamic process of dysfunction rather than simply the symptoms devoid of their context. This managed care view has permeated the treatment community whereby many professionals do not believe that BPD is treatable or recoverable. It is hoped that this study can provide some evidence from which to shift this view.

12 RECOMMENDATIONS TO CLINICIANS

The primary recommendation to clinicians and students is to become familiar with Millon’s (1996) personality disorder subtypes. Although it is my belief that this treatment approach was effective for Thelma, this may have something to do with the fact that she was primarily a “discouraged” subtype of BPD according to Millon. Other subtypes may not respond as well to this approach, particularly the aspects of the approach that allowed for more flexible boundaries during the treatment and after termination.

Second, although many students and beginning clinicians want experience working with personality disorders, often the contexts of their service are time limited as practicum students, interns, and postdoctoral fellows. However, approaches that are depth-oriented can also be brief. Those interested in a more broad view of such approaches are referred to Ecker and Hulley (1996).

Finally, working with BPD clients can be extremely taxing emotionally. Limiting one’s caseload and making sure there is adequate supervision or consultation is essential. Particularly with these clients, one’s countertransference can easily make its way into the therapeutic relationship in ways that are not therapeutic for the client but that possibly provide the therapist with some sense of emotional release. For example, I have seen instances in inpatient facilities where BPD clients are denied extra amenities that other clients are allowed out of frustration and fear on the part of the mental health professional that boundaries will be crossed. In actuality, it is likely more the fear of the mental health professional about how to deal with these clients that precipitates these strict boundary-setting behaviors than it is about what is therapeutic and kind for the client. As with any client with any treatment focus, the careful scientist-practitioner is always testing hypotheses in the therapy. They ask themselves, “What do I hypothesize this client will gain if I use this particular intervention?” All of our behaviors toward our clients intervene in their lives in some way, whether that is our intention or not. It is important that therapist’s behavior toward clients be a purposeful and goal-directed means of increasing the quality of life for them.

REFERENCES


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