I am the author of the thesis entitled "The role of attachment theory in medical illness: A clinical investigation".

submitted for the degree of Doctor of Psychology (Health)

This thesis may be made available for consultation, loan and limited copying in accordance with the Copyright Act 1968.

Full Name..Loriane Leas ......................................................................................................................
(Please Print)

Signed .................................................................

Signature Redacted by Library

Date................24/4/2005..............................................................................................................
Consultation of Thesis

Please sign this form to indicate that you have used this thesis in accordance with the Access to Thesis form signed by the author of this thesis.

<table>
<thead>
<tr>
<th>NAME (please print)</th>
<th>SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah Vesser</td>
<td>Signature Redacted by Library</td>
<td>24/8/05</td>
</tr>
</tbody>
</table>
The Role of Attachment Theory in Chronic Medical Illness:
A Clinical Investigation

Loranie Leas B.A. (Hons)

Submitted in partial fulfilment of the requirements for the degree of
Doctor of Psychology (Health)
School of Psychology, Deakin University, Melbourne, Australia

December 2004
I certify that the thesis entitled

"The role of attachment theory in chronic medical illness: A clinical investigation"

submitted for the degree of

is the result of my own work and that where reference is made to the work of others, due acknowledgment is given.

I also certify that any material in the thesis which has been accepted for a degree or diploma by any other university or institution is identified in the text.

Full Name...Loriane Leas.................................................................
(Please Print)

Signed .................................................................

Signature Redacted by Library

Date......24/1.6.105...............................................................
ACKNOWLEDGEMENT

I would like to express my appreciation to Professor Marita McCabe for her support and guidance in the development of this clinical portfolio. Marita, thank you for the countless ways you have lighten the burden of my work by your combination of knowledge, skills and efficiency. Your dedication to your work and your students is truly inspirational.

Much gratitude is due to my clinical placement supervisors who have generously shared their experience, knowledge and time. I have gained a greater appreciation of the skills require to integrate the theoretical and clinical aspects of psychology from all of you.

Finally, thank you to the clients who inspired this portfolio. You have provided me with much insight and understanding of the trials and trepidations we all face. I am also grateful for your patience and willingness to work with this trainee psychologist who still has much to learn. I wish you well for the future.
# TABLE OF CONTENTS

Acknowledgement ........................................................................................................ i
Table of Contents ......................................................................................................... ii
List of Tables ................................................................................................................ iv
Abstract ......................................................................................................................... v

## Chapter 1

Attachament Theory
- Bowlby’s attachment theory ........................................................................................ 1
- Ainsworth’s attachment theory .................................................................................... 3
- Attachment and future relationships ............................................................................ 5

Attachament and Physical Illness
- Effects of attachment style on the patient-clinician relationship ................................ 12
- Secure attachment ....................................................................................................... 13
- Dismissing attachment ................................................................................................ 13
- Preoccupied attachment .............................................................................................. 14
- Fearful attachment ...................................................................................................... 15

Conclusion ...................................................................................................................... 17

## Chapter 2

The Case of Jenny
- Polycystic kidney disease ............................................................................................ 18
- Reason for referral ....................................................................................................... 18
- Presenting problems .................................................................................................... 18
- Current situation ......................................................................................................... 19
- Family history ............................................................................................................. 19
- Personal/developmental history .................................................................................. 20
- Mental state examination ........................................................................................... 20
- Formulation ................................................................................................................ 22
- Diagnosis .................................................................................................................... 24
- Treatment plan .......................................................................................................... 24

## Chapter 3

The Case of Angela
- Urinary tract infections ............................................................................................... 26
- Reason for referral ..................................................................................................... 26
- Presenting problems ................................................................................................... 26
- Current situation ........................................................................................................ 27
- Family history ............................................................................................................ 28
- Personal/developmental history ................................................................................ 28
- Mental state examination ......................................................................................... 29
- Formulation ................................................................................................................. 30
- Diagnosis .................................................................................................................... 32
- Treatment plan .......................................................................................................... 32
CHAPTER 4
The Case of Aarron
HIV/AIDS diagnosis and adjustment 35
Reason for referral 36
Presenting problems 36
History of presenting problems 36
Current situation 37
Personal history 38
Developmental history 38
Relationship history 39
Mental state examination 40
Psychometric assessment 40
Formulation 41
Diagnosis 43
Treatment plan 43

CHAPTER 5
The Case of Andrew 47
Reiter’s Syndrome 47
Attachment and coping with chronic pain 47
Reason for referral 47
Presenting problem 48
History of presenting problem 48
Current situation 48
Personal history 50
Developmental history 50
Relationship history 51
Employment history 51
Substance use 51
Mental state examination 52
Psychometric assessment 52
Formulation 53
Diagnosis 54
Treatment plan 54

CHAPTER 6
Conclusion 57

REFERENCES 61
### LIST OF TABLE

<table>
<thead>
<tr>
<th>Table 1.1</th>
<th>Attachment Style Categories and Model of Self and Others.</th>
</tr>
</thead>
</table>

8
Abstract

Recently, researchers have begun to examine the impact of attachment on coping with a medical illness. It is hypothesised that a patient’s responses to unusual or distressing physical symptoms and participation in the patient-clinician relationship can be understood by examining the nature of their attachments. Theoretical links between attachment style and affect regulation suggest that “internal working models” developed in childhood may have implications, not only for the quality of close relationships, such as romantic love, but also for other significant interactions. In the domain of physical illness, patient-clinician interactions represent such a significant relationship. It is proposed that the attachment behaviour of the patient to the clinician in the context of chronic medical illness may impact on medical illness behaviour and illness outcome. This clinical portfolio reviews the literature on attachment theory, health behaviour and the implications of the patient-clinician relationship in the context of a chronic medical illness. Four case studies of different types of chronic medical illness were examined in relation to attachment theory. The cases included: Jenny, a 10 year-old girl with polycystic kidney disease; Angela, a 13 year-old girl with recurrent urinary tract infections; Aarron, a 36 year-old man with Human Immunodeficiency Virus; and Andrew, a 49 year-old man with multiple medical illnesses. It was concluded that attachment theory is a useful conceptual framework for informing clinical formulation and explaining the patient-clinician interaction among individuals with a chronic medical illness.
All identifying information of clients, professionals and agencies reported in this clinical portfolio have been altered to protect their identity.
CHAPTER ONE
Attachment Theory

A large body of literature documents the importance of a good parent-child relationship in building a child’s self-confidence, self-respect, emotional growth, intelligence and sense of connection with others (Ainsworth, 1989; Armsden & Greenberg, 1987; Hazan & Shaver, 1987). An aspect of parent-child relationships is parental attachment. Parent attachment is defined as the consistent pattern of thinking, feeling and behaving a parent has towards a child (Bowlby, 1969; 1977). Bowlby proposed that attachment behaviour functions as a kind of homeostatic mechanism for modulating anxiety. A diagnosis of a medical illness is normally a situation which is anxiety-provoking and often accompanied by an increased need or wish for close and caring others. As such, experience of a medical illness is likely to activate the attachment system and corresponding attachment behaviours.

The aim of this clinical portfolio is to explore the implications of attachment theory in the care of patients with a chronic medical illness. First, an overview of the attachment theory literature is presented. This is followed by an examination of how illness may interact with different attachment systems to guide illness behaviour and patient-clinician relationships. Four case studies are then presented and discussed in relation to attachment theory in the four subsequent chapters. Each of these case studies addresses a specific medical illness and attachment style. The clinical portfolio then concludes with an overview of the issues raised in these cases and a discussion of the implications of an analysis of these cases for clinical work with patients with a chronic medical illness.

Bowlby’s Attachment Theory

It is believed that a positive attachment to parents/care-givers facilitates a person’s social competence and well-being. Bowlby’s (1969) attachment theory centres on the concept of security in early childhood, drawing on theory and research from psychoanalysis. His theory also has links to Darwin’s theories on adaptation and survival, systems theory and cognitive psychology (Holmes, 1993).
Bowlby’s theory was developed from his extensive observations of children who were deprived of maternal care, particularly institution-raised children (Holmes, 1993). He observed that institution-raised children demonstrated poorer development, and had difficulties with acquisition of language and social interaction (Holmes, 1994). He also noted that children who were hospitalised for extensive periods of time (e.g., six to twelve months), with little social or physical interaction, reported more behavioural disturbances, did not thrive as they would at home, and had deficits in forming relationships and cognitive functioning (Bowlby, 1977).

Based on these observations and earlier work, Bowlby (1977) argued that the infant attachment with his or her primary caregiver provides the basis for all later development. He asserted that a child develops a secure base when he or she is nourished physically and emotionally. During infancy, parental physical proximity is all that is necessary to make a child feel secure. When a child gets older, proximity becomes less important and parental availability and symbolic communication become increasingly effective in providing security (Armsden & Greenberg, 1987). According to Bowlby, a sense of security provides comfort, help and protection, or what Kobak and Sceery (1988) termed ‘felt security’. It also promotes autonomy and encourages the child to explore and engage in new experiences (Bowlby, 1977).

By definition, ‘attachment’ is an overall term which refers to the state and quality of an individual’s attachments. These can be divided into secure and insecure attachment (Bowlby, 1969). ‘Attachment behaviour’ on the other hand is defined as “…any form of behaviour that results in a person attaining or retaining proximity to an attached figure; usually a care-giver” (Holmes, 1993 p. 68). Three types of attachment behaviours have been identified in infants: signalling behaviour (crying, smiling and vocalising), orientating behaviours (looking, following and approaching) and active physical contact behaviours (clambering up, embracing and clinging) (Ainsworth, 1973). Attachment behaviours are not present at all times, rather their activation is based on alarm or distress in the infant (Bowlby, 1969).

Bowlby’s (1969) theory proposed that attachment behaviour functions as a kind of homeostatic mechanism for modulating anxiety, a biologically driven mechanism to ensure a species’ survival through attachment to a primary caregiver who can provide
protection and maximises the child's chance for survival. It is hypothesised if the homeostatic mechanism of attachment fails to form adequately, a child is less likely to have the resources to modulate anxiety and may become caught up in a cycle of selective perception of the world as unpredictable or threatening. In turn, this child may grow up to become relatively unstable and not self-reliant, cultivating cognitive and affective states that are conducive to maladaptive coping behaviours (Mauder & Hunter, 2001; Weinfield, Sroufe, & Egeland, 2000; West, Livesley, Reiffer, & Sheldon, 1986).

Ainsworth's Attachment Theory

Although Bowlby’s (1969, 1977) earlier work had substantially changed the view of mother-child relationships in the scientific community in the early-1970s, many questions were still left unanswered about the significance of mother-child attachment. For example, what is the nature of the mother-child bond, how does it develop and what is the role of attachment in everyday functioning, where long-term separations have not occurred? These were the questions that other researchers set out to answer. Mary Ainsworth and her colleagues were some of these researchers.

Consistent with Bowlby’s (1969) attachment theory, Ainsworth, Blehar, Waters, and Walls (1978) proposed that the importance of attachment between mother-child is not limited to significant periods of separation, but that the quality of the attachment that a child has with his/her primary carer is also imperative. Furthermore, unlike the observational work conducted by Bowlby, Ainsworth et al.’s (1978) work involved structured research that examined the quality of mother-child relationships within a controlled setting. This controlled setting was called the ‘Strange Situation’ in which the infant is presented with stressful situations that include the presence of a stranger, and separation of the infant from his or her primary carer and reunion (Ainsworth et al., 1978). Three different styles of infant attachment based on this ‘Strange Situation’ experiment were found: secure, ambivalent/anxious and avoidant.

Securely attached infants were observed to use their parent as a secure base to play and explore their environment. When anxious, these infants were observed to return to their parent and were able to be comforted by their parent. When parent/child
separation occurred, these infants demonstrated distress, but upon reunion, they were happy to see their parent and were easily soothed and comforted (Ainsworth et al., 1978). Infants classified as insecure-ambivalent/anxious were observed as overly clingy towards their parent and unwilling to explore their environment. They are more distressed on separation and were more difficult to soothe and comfort on reunion compared to securely attached infants. They displayed an angry and resistant manner towards their parent. Finally, infants classified as insecure/avoidant are described as overly independent. These infants displayed limited interaction with their parent. In response to their parent's departure these infants showed little distress and avoided or showed little pleasure at reunification.

The types of responses demonstrated by infants in the 'Strange Situation' reflect infants' internal representation of their mother, built over time, based on their everyday interactions and experience with her (Bolen, 2000). It is proposed that infants with a secure attachment have learnt that their primary caregiver is reliable as a secure base, therefore allowing the infant to explore. This promotes the development of self-confidence, self-esteem and trust in others (Ainsworth et al., 1978). In contrast, children with insecure attachment (either avoidant or ambivalent) that have inconsistent parenting or distant parents are required to alter the inherent, biologically driven pattern of exploration. For example, securely attached children learn through experience that caregivers are consistent in their responses to stressful situations, and when confronted with stress, the child is able to acknowledge his/her distress and seek help from others. In contrast, insecurely attached children learn that caregivers may be unresponsive or inconsistent to their distress, and accordingly, they develop strategies to either deny or suppress their distress, so as not to risk further distancing the caregiver, or become overly vigilant to ensure a response from their inconsistent caregivers (Feeney, 2000).

Empirical evidence has indicated that children with parents who are cold, judgmental and lack communication skills may feel angry, worthless, rejected and abandoned (Kobak & Scerrey, 1988). Confidence and self-esteem are diminished and consequently, these children are deterred from exploring the outside world, and develop maladaptive ways of coping with negative emotions.
While Ainsworth and colleagues proposed two forms of insecure attachment, Main and Solomon (1986) argued that not all insecurely attached children could be classified as either anxious or avoidant, and they proposed an additional form of insecure attachment style. This third category was labelled *insecure-disorganised* attachment.

Children with either insecure ambivalent or avoidant attachment style, demonstrate a clear strategy that helps them to maintain a level of homeostasis, either by clinging to the primary carer or by ignoring the primary carer. Disorganised children on the other hand may appear to have a predominantly ambivalent or avoidant style, but when stressed, they exhibit contradictory attachment behaviours, a mixture of approach and avoidance (Main & Solomon, 1986). Disorganised attachment styles are commonly seen in children with a history of trauma or a lack of resolution of trauma (Bartholomew, 1990).

The research conducted by Bowlby (1969, 1977) and Ainsworth et al. (1978) has provided both a structure for understanding the significance of attachment between parent and child and the potential impact of that attachment on a child’s development. However, this work has focused primarily on attachment within the first three years of life, with limited focus on the long-term implications of attachment (Rutter, 1981).

**Attachment and Future Relationships**

Bolen (2000) argued that the attachment that a child develops with his/her primary caregiver serves as a template for the development of later relationships. The stability of attachment has been widely supported by longitudinal studies (Main, 1995). For example, in a 20-year follow-up study of 50 infants, Waters, Merrick, Treboux, Crowell, and Albersheim (2000) found that they could predict accurately at or above 70% between classifications given in infancy through the strange situation tool and those given by modified, developmentally appropriate tools such as the Adult Attachment Interview. Similarly, Recent research confirms that attachment relationships continue to be important throughout the lifespan, and secure attachment in emotional and social adaptation remains important in adolescence and adulthood (Vivona, 2000).

Luecken (2000) found that individuals who experienced early parental loss coupled with poor-quality family relationships during childhood, reported lower self-
confidence, ineffective coping skills and a lack of a sense of self-efficacy and self-worth. These individuals are also preoccupied with rejection and abandonment. Consequently, when faced with problems, these individuals cannot cope with distress, and are more likely to engage in 'acting out' behaviours, in which hostility and aggression are projected to the external world or internal self.

In addition to externalised problem behaviours, research has suggested that parents of depressed adolescents are consistently marked by cold, indifferent and overprotective behaviour (Armsden, McCauley, Greenberg, Burke, & Mitchell, 1990). Armsden et al. (1990) contended that insecure attachment significantly affects the development of depressive schemata and attributional styles that lead to cognitive biases, such as self-blame and a higher degree of hopelessness. In their longitudinal study, extending from seventh to tenth grade children, Greenberg, Siegel, and Leitch (1983) found that parental affection correlated positively with well-being and self-esteem. Furthermore, Ge, Best, Conger, and Simons (1996) found that the children of parents high in hostility and low in warmth displayed elevated levels of depressive symptoms. They suggested that adolescents with parents who show intrusive psychological control, and are judgmental and lacking in communication skills may feel angry, worthless, rejected and abandoned. In turn, a child’s opportunities for self-discovery and self-esteem are diminished.

Social and romantic relationship functioning are also claimed to be affected by the quality of early attachment. Hazan and Shaver (1987) proposed that adult’s thoughts, feelings and behaviours in romantic relationships are governed by attachment processes and may be similar to those characterising attachment to primary caregivers during childhood.

Bartholomew and Horowitz (1991) presented a model of adult attachment in which the attachment styles from Ainsworth et al.'s (1978) work were partitioned into four categories based on the individual’s view of self and others: Secure, preoccupied, fearful and dismissing groups. This model determines for the individual whether they are worthy of care (view of self) and whether others can be trusted to provide care (view of others).
Bartholomew and Horowitz (1991) proposed that attachment styles determine individual differences in attachment patterns and thus may have implications for communication within interpersonal relationships. According to Bartholomew and Horowitz, securely attached individuals are characterised by a positive view of self and other. Preoccupied individuals, also known as anxiously attached individuals (Ainsworth et al., 1978), are characterised by a negative view of self and a positive view of other. Dismissing individuals, also known as avoidant attached individuals are characterised by a positive view of self and negative view of other. Finally, fearful individuals are characterised by a negative view of self and other. See Table 1.1 for Bartholomew and Horowitz's four category attachment styles.

Individuals with a secure attachment (positive view of self and others) are characterised as open, confident, flexible and trusting. Secure individuals are said to have had parents who were warm and accepting, or, if not, have resolved their feelings towards their early experiences. While, individuals with a negative self-model (preoccupied attachment) may generally be more likely to seek support and have a tendency to rely on others to relieve them of their negative affect (Bartholomew & Horowitz, 1991). These individuals are characterised by active engagement with significant others, which, because of diminished trust, does not reflect a sense of security and the person is in constant self-doubt of his or her own worth and value. Caregivers of insecure-preoccupied individuals are described as inconsistent in their behaviour towards their children. They can be insensitive to the needs of their children at times, and can also demonstrate the ability to be very sensitive and overly intrusive on other occasions (Blehar, Lieberman, & Ainsworth, 1977). In contrast, individuals with a negative perception of others (dismissing attachment), have learned that people are likely to ignore or reject their attempts to gain support and thus are less likely to seek support and are generally thought to have less self-disclosure and openness in relationships (Bartholomew & Horowitz, 1991). Therefore, dismissing individuals are characterised by a lack of trust and high avoidance of relationships. Individuals with this attachment pattern are generally self-reliant and tend to downplay the importance of close relationships (Ainsworth, et al., 1978; Bartholomew & Horowitz, 1991). Caregivers of individuals with dismissing attachment are generally rejecting, hostile, rigid and critical.
towards their children (Ainsworth et al., 1978). For the last insecure attachment style, individuals with fearful attachment with both a negative view of self and others often present with no coherent pattern of attachment behaviour. Similar to preoccupied individuals, fearful, attached individuals are constantly seeking comfort from others when they are distressed, but when help is given, fearful, attached individuals withdraw and reject help, similar to dismissive, attached individuals. Individuals with fearful attachment are more likely to have had experienced overly rejecting and harsh caregiving (Main & Solomon, 1986).

Table 1.1
Attachment Style Categories and Model of Self and Others.

<table>
<thead>
<tr>
<th>Model of Others</th>
<th>Model of Self</th>
<th>Preoccupied</th>
</tr>
</thead>
<tbody>
<tr>
<td>+</td>
<td>Secure</td>
<td>• emotionally dependent</td>
</tr>
<tr>
<td></td>
<td>• trusting of others</td>
<td>on others</td>
</tr>
<tr>
<td></td>
<td>• feels worthy of others’ attention</td>
<td>• low self-esteem</td>
</tr>
<tr>
<td></td>
<td>Dismissing</td>
<td>• focus on negative affect</td>
</tr>
<tr>
<td></td>
<td>• compulsively self-reliant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• low trust of others</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fearful</th>
</tr>
</thead>
<tbody>
<tr>
<td>• approach-avoidance behaviour</td>
</tr>
<tr>
<td>• fearful of intimacy</td>
</tr>
<tr>
<td>• low trust of others</td>
</tr>
<tr>
<td>• low self-esteem</td>
</tr>
<tr>
<td>• focus on negative affect</td>
</tr>
</tbody>
</table>

Note. Adapted from Bartholomew and Horowitz (1991)

Most research on parent-child attachment has focused on insecure attachment styles in emotional and social development. Recent evidence has suggested that attachment theory provides a useful framework to examine illness behaviours and
subsequent physical health outcomes (Feeney, 1999). For example, Feeney and Ryan (1994) found evidence that ambivalently attached individuals displayed a higher number of visits to health care professionals than securely attached individuals. Moreover, strong evidence for an association between precursors of attachment insecurity and adult diseases were found in a 9,508 patients (Felitti, et al., 1998). In the following sections, the relationship between attachment style and physical illness will be presented.

**Attachment and Physical Illness**

Several models have been developed to explain the association between insecure attachment and physical illness. For example, Maunder and Hunter (2001) proposed three pathways in which insecure attachment can influence physical illness: a) affect stress regulation, b) alter use of external regulators of affect, and c) alter use of protective factors.

The first pathway emphasised the importance of attachment in stress appraisal and stress regulation. Maunder and Hunter (2001) hypothesised that insecurely attached individuals are more likely to be hyper-vigilant (preoccupied attachment) or adopt a stance of denial to mask their anxiety (avoidant attachment) in stressful situations. If the stressful situation is not resolved, stimuli that trigger memories of the stressful response may activate physiological hyperarousal (Anderson & Hines, 1994). Over a prolonged period of time, chronic physiological hyperarousal may increase sensitivity to pain stimuli and illnesses, such as cardiovascular illnesses (Melzack & Wall, 1982; Castelli, 1984). In support of this theory, a study of women who experienced childhood sexual abuse found that women with a history of abuse exhibited increased cortisol and heart rate responses to a standardised stressful condition compared to women without such a history (Heim et al., 2000).

In addition to stress appraisal and regulation, attachment plays a role in determining the impact of stress by influencing the individual’s ability to establish and utilise social support networks (Maunder & Hunter, 2001; Pakenham, Dadds, & Terry, 1994; Persson, Gullberg, Hanson, Moestrup, & Östergren, 1994). Social support, particularly, emotional support from close relationships has been shown to be an important mediator of health outcomes by buffering the effects of stress (Cohen & Wills,
1985; West, Livesley, Reiffer, & Sheldon 1986). As such, from an attachment perspective, one would expect that individuals who have a positive view of both themselves and of their social network would be more likely to perceive greater social support and seek support than those with a negative view of self and/or others. In support of this contention, Florian and Mikulincer (1995) found that students with secure attachment perceived more social support and reported greater social support seeking behaviour than insecurely attached students. Therefore, for individuals with insecure attachment, ineffective use of social support can lead to limited social networks and a poor quality of social support, thus reducing the potential of social support to buffer stress and illnesses (West et al., 1987).

The second pathway described by Maunder and Hunter (2001) concerns the higher utilisation of external regulators that are used by insecurely attached individuals to alleviate dysphoric affect. Common behavioural strategies that are used to regulate negative affect include cigarette smoking, over-eating, drinking alcohol and engaging in risky sexual behaviours, all of which have been shown to increase the risk of physical illnesses (Brownson, Remington, & Davis, 1993). For example, Cooper, Shaver, and Collins (1998) found that not only did ambivalent and avoidant people report the highest symptomatology levels and the poorest self-concepts, but they also reported the highest levels of problematic and risky behaviours. Parents who did not provide encouragement and physical signs of affection, and provided little exchange of advice and guidance, were more likely to have adolescent children who regularly became intoxicated and engaged in health-compromising behaviours (Rice, 1990; Smith, 1997).

Finally, the third pathway hypothesised that insecure attachment may alter the use of protective factors, such as treatment adherence and accurate and consistent symptom reporting (Sherbourne, Hays, Ordway, DiMatteo, & Kravitz, 1992; Suls & Fletcher, 1985). Cienhanowski, Katon, Russo, and Walker (2001) investigated the influence of attachment style on adherence to treatment in diabetic patients. These researchers found a correlation between dismissing attachment and poorer treatment adherence. Thus, this finding suggests that in the context of diabetes, patients who exhibited dismissing attachment had significantly worse glucose control than patients with other forms of attachment (Cienhanowski et al., 2001). In another study, these same authors also found
an association between symptom reporting and both a preoccupied and fearful style of attachment in adult female primary care patients (Ciechanowski, Walker, Kato, & Russo, 2002). Results of the study indicated that women with preoccupied attachment had the highest primary care utilisation, and that women with fearful attachment had the lowest primary care utilisation. In addition, women with preoccupied and fearful attachment had the highest level of physical symptom reporting, and dismissing patients were least likely to report physical symptoms. The commonality between preoccupied and fearful attachment is that these two attachment styles are characterised by a negative view of self, low self-esteem and the tendency to focus on negative affect and signs of distress (Ciechanowski et al., 2002; Mikulincer, 1995). Other research has also provided evidence that insecure attachment is related to inconsistent self-reported levels of pain and disability in patients with arthritis or related conditions (McWilliams, Cox, & Enns, 2000).

There are other avenues through which attachment may affect physical illness apart from its relation to stress, social support and utilisation of protective behaviours. Recently, research has found that the impact of the patient-clinician relationship significantly predicted physical health outcomes (Hunter & Maunder, 2001).

Bowlby (1969, 1977) suggested that stressful experiences are especially likely to activate the attachment system and make attachment processes focal. The experience of a medical illness is potentially stress-evoking for the individual with the illness, their families and friends. Individuals not acknowledging or dealing with an illness may ordinarily function adequately, but when the individual becomes unwell they may become so anxious to the medical stressor that emotional equilibrium is disrupted and the individual may regress to early attachment behaviours (Bowlby, 1977; Melamed, Siegel, & Ridley-Johnson, 1988; Mohl & Burstein, 1982). This focus of regression may result in the expression of behavioural patterns that have been learned or reinforced throughout their relationship histories. For example, Hunter and Maunder (2001) found that individuals with insecure attachment style tended to adopt maladaptive ways of coping with negative emotions. In stressful circumstances, such as during an illness, they vent their emotions towards themselves or behave inappropriately, straining and interfering with their relationships with the treating health professionals.
The impact of attachment styles on patient-clinician relationships within the context of medical illness will be discussed in the following sections. The term "clinician" used throughout this portfolio refers to all types of health care professionals, from physicians to psychologists.

**Effects of Attachment Style on the Patient-Clinician Relationship**

Attachment theory predicts that when an individual is faced with a threat, he or she seeks out an attachment figure from whom he or she may obtain relief (Bowlby, 1969, 1977). For people with a medical illness, health care professionals may be seen as providing the patient with a temporary attachment figure, who can be utilised by the patient to relieve anxiety (Bowlby, 1977; Maunder & Hunter, 2001; Schmidt, Nachtigall, Wuethrich-Martone, & Strauss, 2002).

Once the secure base is established, the person can begin to explore the issues related to the medical illness, for example, the meaning of the illness and utilisation of appropriate health care. When a patient fails to form this secure base, the patient may employ ineffective attachment behaviour and coping strategies to reduce the anxiety associated with the illness. It is these maladaptive attachment behaviours which have been hypothesised to have had a negative impact on illness experience and illness outcome (Ciechanowski et al., 2002; Maunder & Hunter, 2001).

Although attachment working models have been found to be relatively stable across the lifespan, evidence has suggested that internal working models of self and others are dynamic and can be altered by life events, change in primary caregivers or exposure to relationships that model adaptive coping responses (Feeney & Noller, 1996; Waters et al., 2000). Weinfield et al. (2000) found that the stability of infant attachment is dependent on the stability of the child’s care giving environment and that attachment security can be subject change and alterations with regard to external life events. This finding is important, and have significant implications for intervention work aimed at repairing an individual’s attachment. Therefore, clinicians can play a role in assisting patients to revise their internal working models of self and others. This assumption provides the rationale for incorporating attachment framework in the patient-clinician interaction.
In the following sections, Bartholomew and Horowitz’s (1991) four category attachment style (secure, dismissing, preoccupied and fearful attachment) will be discussed in relation to the patient-clinician relationship and the implications of this relationship on health outcome.

**Secure Attachment**

As described previously, individuals with secure attachment operate from a position whereby they can rely on the primary caregiver’s responsiveness when they are vulnerable and distressed (Ainsworth et al., 1978; Bartholomew & Horowitz, 1991; Bowlby, 1969). Based on these earlier experiences, during time of stress and uncertainty, such as coping with a medical illness, individuals with secure attachment will seek and anticipate helpful encounters from others, because they have an expectation that help will be given, and that clinicians can be trusted (Schmidt et al., 2002). In terms of patient-clinician relationship, individuals with secure attachment are anticipated to seek information and consultation from health care professionals (Maunder & Hunter, 2001). They will also demonstrate an openness to communicate and are articulate in expressing their needs, concerns and physical symptoms (Ciechanowski et al., 2002; Mikail, Henderson, & Tasca, 1994). This behaviour is reflective of their positive view of self and others (Bartholomew & Horowitz, 1991).

**Dismissing Attachment**

A dismissing attachment style is similar to Ainsworth et al.’s (1989) “avoidant attachment style”, characterised by early childhood attachment experiences from caregivers who were consistently unresponsive. As a result the individual develops an internal working model of self as reliable and isolated, while others are viewed as rejecting and untrustworthy (Ainsworth et al., 1978; Bartholomew, 1990; Bartholomew & Horowitz, 1991).

In the context of a medical illness, individuals with dismissing attachment present as self-reliant, undemanding, and coping well (Mikail et al., 1994). Initially, these patients may be easy to manage. However, over time, their interpersonal distance, rejection of help and minimisation of illness poses challenges to the treatment
relationship (Mikail et al., 1994). In particular, medical illnesses that require extensive support from health care professionals create enormous conflict for these individuals, because of their limited trust in others and preferred strategy of self-reliance (Kotler, Buzwell, Yolanda, & Bowland, 1994). Furthermore, given these individuals need to be in personal control, increased reliance on health professionals is likely to produce great anxiety and fear. Consequently, this intense fear often leads to the rejection of medical advice and non-adherence to medical regimes (Ciechanowski et al., 2001; Dozier, 1990). A lack of response to treatment, less self-disclosure and help seeking behaviour that is directed towards an institution rather than to an individual health professional are common among individuals with dismissing attachment style (Waller, Scheidt, & Hartmann, 2004).

Successful management of dismissing attached individuals, as outlined by Grove (1978) and Hunter and Mauder (2001), requires an acknowledgement of their need for independence. Efforts to support dismissing attached individuals in their attempts to control their environment and interpersonal conflicts are also useful (Hunter & Mauder, 2001). Encouragement and re-channelling efforts into proactive health seeking behaviours, such as regular medical check-ups, will maintain their personal sense of internal self-locus of control. In order to attenuate dismissing attached individual’s anxiety about trusting others, Hunter and Mauder (2001) also proposed that demonstration of reliability and flexibility, such as a willingness to accommodate their needs around appointment times, and consistency in treatment and interpersonal interaction will also provide positive gains.

**Preoccupied Attachment**

Individuals with a preoccupied attachment pose different challenges to the treatment process. They present themselves as vulnerable, distressed and compliant with treatment. They may also present as eager to please, and extremely needy, in an effort to keep health professionals involved. The strategies often employed to maintain clinician proximity and ensure a response from the clinician include flattery and unconscious seduction (Grove, 1978). Initially, patients with preoccupied attachment style may appear to be keen and compliant. However, as treatment progresses, preoccupied
individuals tend to present as ambivalent, persistently expecting that their needs will not be met and when their symptoms are relieved, another set of symptoms mysteriously appear (Mikail et al., 1994). The purpose of such behaviour is to ward off the anxiety of failing and abandonment (Grove, 1978). As a result, the constant and persistent demand for attention exerted by individuals with preoccupied attachment, often leads to clinicians’ exhaustion and “burn-out” (Grove, 1978). These patterns of interaction are further compounded by the individual’s behaviour of seeking out multiple doctors, thus preventing development of meaningful relationships with health care professionals (Ciechanowski, Katon, Russo, & Dwight-Johnson, 2002; Kolb, 1982). This group of patients are often described as “doctor shoppers”, and are overly dependent or “clingy” (Bartholomew & Horowitz, 1991). This type of care-seeking is reflective of an internal working model that holds a positive view of others, but has considerable uncertainty as to whether others will be responsive to their needs (Ainsworth et al., 1978). Such uncertainty is further compounded by a negative view of self which holds that the self does not possess the requisite resources to deal with continued threat and the associated affect (Ainsworth et al., 1978).

The main management recommendations when working with individuals with preoccupied attachment is to set out clear limits and boundaries. More specifically, setting realistic expectations of clinician’s time and effort, and the progress of treatment need to be emphasised. Consistency of treatment delivery, such as weekly appointments at the same time also reassures the patient that assistance will be provided regardless of whether or not the patient complains of symptoms, and that their distress will be contained (Hunter & Maunder, 2001).

**Fearful Attachment**

The final category of insecure attachment style is that of fearful attached individuals. Fearful individuals reflect a state of distrust of others’ responsiveness or capacity for nurturance, with an accompanying view of the self as unworthy or not entitled to care (Bartholomew & Horowitz, 1991). They often present as always in “crisis” but have limited reliable strategies to cope with stress (Hunter & Maunder, 2001). This type of attachment closely resembles Main and Solomon’s (1986) insecure-
disorganised attachment style, commonly seen in children with a history of abuse or with overly rejecting or harsh caregivers (Bartholomew & Horowitz, 1991). Individuals with this attachment style are likely to delay seeking help and usually present for treatment at a point when they are feeling desperate and in considerable distress (Mikail et al., 1994). When help is finally sought they assume a stance of helplessness and hopelessness on the one hand, and are angry and dismissive on the other (Hunter & Mander, 2001). Thus, these individuals' help-seeking behaviour is often characterised as extreme and unpredictable. They change rapidly between seeking help and withdrawing and rejecting help. Withdrawal behaviour is usually as a result of a fear of intimacy and rejection from others (Ciechanowski et al., 2002). The result is help-seeking behaviour that is inconsistent and disorganised, causing considerable frustration for health care professionals (Mikail et al., 1994).

Medical and psychological treatment progress for these individuals is often negligible (Hunter & Mander, 2001; Mikail et al., 1994). As a result, health professionals feel helpless and frustrated in treating the fearful attached individual and thus will often continue to refer these patients to other health professionals. This pattern of attachment behaviour was supported by Ciechanowski et al.,'s (2002) findings, which found that fearful attached individuals were the least likely to schedule primary care visits but reported more physical symptoms than individuals with other types of attachment.

Treatments for fearful attached individuals are limited. Hunter and Mander (2001) asserted that optimal care for these patients is to limit the degree to which the patient disorganises and fragments the treatment team. This can be achieved by educating staff about patients’ behaviour and their motivations. Another advantage of a coherent and reliable environment and treatment team is that it challenges the patient’s view of the world as unreliable and distrustful. Setting limits and boundaries of acceptable behaviour also conveys to patients that they will not be allowed to become so close as to be engulfed nor so distant as to be rejected. A balance of proximity and distance is important for these patients (Grove, 1978).
Conclusion

In summary, attachment theory has provided a theoretical paradigm from which to investigate the complexities of development throughout life. Recently, research has began to examine the extent to which an attachment model impacts on adjustment within the context of a medical illness. Although attachment theory has increased our understanding of symptom perception and health behaviours, attachment theory also provides a useful theoretical framework to explain patient-clinician relationships, and the impact that this relationship has on illness behaviour and outcome.

In this portfolio, four case studies are used to illustrate how attachment theory can inform and be applied in clinical work with individuals with a chronic medical illness. It should be noted that attachment theory in the current portfolio was viewed as one of many tools that the clinician used to understand the patients, and that its utilisation served to compliment and enhance other treatment modalities. The case presentations comprise patients with different types of medical illness and from varied age groups. Although the choice of patients and medical illness cannot be considered to be representative of all medical patients, the selection covers a broad range of attachment styles and experiences caused by different medical illnesses. All case presentations are outlined using attachment theory as a conceptual framework. The case presentations include:

- Jenny, a 10 year old female with autosomal recessive polycystic kidney disease
- Angela, a 13 year-old female with urinary tract infection (UTI)
- Aarron, a 36 year-old male with Human Immunodeficiency Virus (HIV) and major depression
- Andrew, a 49 year-old male with multiple medical diagnoses, including Reiter’s syndrome and chronic pain.
CHAPTER TWO
The Case of Jenny

In this chapter, a brief description of autosomal recessive polycystic kidney disease will be outlined before presenting the case of Jenny.

Polycystic Kidney Disease

Polycystic kidney disease (PKD) is a genetic disorder characterized by the growth of numerous cysts in the kidneys. The PKD cysts can slowly replace much of the mass of the kidneys, reducing kidney function and leading to kidney failure. Kidney failure usually occurs after many years; the patient will then require dialysis or kidney transplantation. Some of the symptoms of PKD include pain in the back, pain in the lower side, headaches, urinary tract infections and blood in the urine (Trachy, 1987).

Reason of Referral

Jenny is a 10 year-old girl who was diagnosed with autosomal recessive polycystic kidney disease in March 2003. She was referred to the hospital consultation-liaison psychiatry unit for psychological treatment in October 2003 because of increasing concerns about her refusal to go to school, her anxiety, social isolation, negative affect, and reported bullying.

Presenting Problems

Jenny has had multiple hospital admissions for irritability and stabilization of hypertension due to her medical diagnosis. The medical diagnosis coincided with the commencement of school bullying. Anna (Jenny’s mother) reported that the bullying occurred nearly every day through term 1 to 3 and slowly decreased during term 4 in 2003. As a result, Jenny’s school attendance was reported to be sporadic, with her missing 29 days of school. Anna also expressed concerns about Jenny’s heightened levels of anxiety, sadness and sensitivity. She described Jenny as a “real worrier”, with an “adult-like personality” since she was a baby. Anna had tried different strategies to support Jenny, including spending a large amount of time with her, a behavioural plan and consultation with school staff, all of which achieved limited success.
Current Situation

Jenny is the oldest child of four children. She has three younger half-siblings. The half-siblings in order are: Jane, Jake, and Mike. Anna described her relationship with Jenny as very close, to the point that Jenny is "clingy" and demands her attention constantly. Anna also reported that her close relationship with Jenny has often created conflict between her and her partner (Tim). Anna expressed that Tim resents Jenny's "clinginess" and tries to compete with Jenny for Anna's time and attention.

Jenny's relationship with her biological father and half-siblings was reported to be good, with the exception of her relationship with Jake, which is often marked by verbal abuse and at times physical confrontations. Anna reported that Jake has had a longstanding history of "strange" and "acting-out" behaviour. No adequate medical explanation has been found to date to explain his hyperactive, aggressive and unpredictable behaviour. In 2002, Jake exhibited increasing aggressive behaviour and his behaviour had deteriorated significantly during January 2003.

Family History

Anna reported that the family has a high genetic loading for intellectual disability and X-linked dystonia. Also there is familial history of schizophrenia, obsessive-compulsive disorder (OCD) and bipolar disorder.

Maternal Personal history

Anna reported long-standing significant physical abuse by her mother and sexual abuse by her brother when she was growing up. Currently, she has a strained relationship with both her mother and brother, but has a good relationship with her father. Anna has had several sexual partners, all of whom were physically and emotionally abusive. Anna stated that she tries to have a close relationship with her children, and attempts to be involved in all her children's lives, particularly Jenny's life because she feels that Jenny is the most fragile. Anna was diagnosed with OCD and bipolar disorder when she was 18 years old, before Jenny was born. Anna reported that Jenny has witnessed her going through manic episodes on many occasions. Anna described that during these manic episodes, Jenny was physically and emotionally neglected.
Personal/Developmental History

Jenny was an unplanned pregnancy. There were no complications during the pregnancy or birth. Jenny’s developmental milestones were unremarkable. There were no reported delays with the onset of speech/language or motor milestones. However, at 18 months old, Anna reported that Jenny began to have difficulties sleeping by herself, always wanting to be close to Anna. Jenny was reported to have had difficulties separating from Anna, even during short periods. Furthermore, Anna described that Jenny tended to behave as “the second mother”, always attentive to Anna’s needs and trying to take care of her half-siblings.

Educationally, initial transition to kindergarten was marked by anxiety and tearful separations, but Jenny eventually settled. The transitional difficulties were repeated when Jenny commenced primary school. Jenny was reported to have significant difficulties interacting with peers at school. Jenny reported being bullied and victimized. It was reported that bullying started in March 2003 and that Jenny had been constantly bullied everyday.

Currently, Jenny’s medical illnesses include mild asthma, eczema and autosomal recessive polycystic kidney disease. No psychiatric illness was reported; however, Jenny was reported to engage in regular cleaning of her hands resulting in redness, dryness and blisters.

Mental State Examination

Appearance and Behaviour

Jenny presented casually dressed on all occasions and the skin on her hands appeared to be excessively dry and scaly. She was of smaller than average height and appeared her stated age of 10 years. Jenny appeared relaxed, yet she was quiet and reserved, but responded appropriately to questions. However, at times, Jenny became teary when asked about her experiences of been bullied, her family situation and her medical illness.

Mood / Affect

At the time of individual assessment, Jenny reported her mood as “a bit sad”, rating her sadness as 5 out of 10 with a high score indicating a high level of sadness.
Congruent with her mood, Jenny presented as withdrawn, flat in affect, and anxious about the interview process.

**Speech**

Jenny’s speech was of low volume and of a slower rate than normal. Her speech was polite and fluent and there did not appear to be any obvious difficulties in comprehension and communication. Jenny provided limited spontaneous conversation, only responding to questions, but there were no indications of apparent word finding difficulties, stuttering or articulation problems. Jenny was able to convey her feelings in words and pictures. Her verbal skills and verbal abstraction was average to high average.

**Thought**

Jenny exhibited a slow and hesitant thinking process. She spoke only when asked questions. Her thought processes appeared logical and coherent. Jenny reported no delusions or abnormal obsessions, compulsion or phobias. Her thought content included concerns about her illness and feelings of “being different from other kids”, and mathematical difficulties. Jenny communicated that she was particularly worried about her mother and current home environment, particularly her brother’s escalating aggressive behaviour. When asked about her illness, Jenny became teary and responded “I am really, really scared”. She was unable to provide further elaboration.

**Perceptual Disturbances**

No hallucinations, illusions or depersonalisation were reported.

**Cognitive Functioning**

There were no disturbances of consciousness. Jenny was orientated to person, place and time. She did not complain of any difficulties with concentration, attention or memory. She demonstrated an ability to focus and sustain attention and her concentration was not impaired.

**Insight / Judgment**

Jenny demonstrated moderate insight into her emotions and her difficulties relating to her peers. Although Jenny was aware of these difficulties, she has limited understanding and coping skills relating to her medical illness, the bullying at school and her brother’s behaviour at home.
Formulation

Jenny is a 10 year-old girl with autosomal recessive polycystic kidney disease who was referred because of increasing concern about school refusal, anxiety, somatic complaints, social exclusion and bullying by peers. Jenny's mother, Anna, reported a 12-month history of increasing anxiety, including separation anxiety. Anna reported that she believed that this was related to Jenny's difficulties adjusting to her medical illness and bullying experienced at school.

There are a number of possible reasons underlying Jenny's inability to cope with her medical diagnosis and current stressors. First, Jenny's heightened anxiety appears to be overwhelming her ability to cope effectively. This seems plausible, as there is a strong maternal family history of mental illness. Anna has been diagnosed with Obsessive Compulsive Disorder and Jenny has been exposed to her mother's anxiety regarding hygiene. Jenny has a genetic vulnerability to develop a mental illness with further predisposing factors of anxious temperament, low self-esteem, negative cognitions, sense of powerlessness and a limited coping repertoire.

In addition to the possible diagnosis of anxiety, attachment issues may have contributed to Jenny's anxiety and difficulties relating to others. Anna's pregnancy with Jenny was unplanned and there was significant conflict and violence in the relationship between Anna and Jenny's father which resulted in a temporary separation during the pregnancy, and final separation when Jenny was 8 months of age. This was described as quite a traumatic time for Anna. Thus, it may be possible that Anna's reported unhappy and traumatic childhood experiences, own mental health issues and difficulties with personal relationships would have impacted on her parenting ability and coping resources. Jenny may have been subjected to a mixture of parenting styles from Anna. As reported, there was some level of neglect. Jenny experienced a lack of parental emotional and physical responsiveness and availability during times when Anna was acutely unwell. In addition, when Anna was well and available, Anna's determination to have a close family would have created an environment that allowed a closer, more intrusive relationship between her and Jenny. The impact of these unpredictable and inconsistent early attachment and bonding experiences may have contributed to Jenny's "preoccupied" internal working model. An internal model that informed and shaped her
beliefs that others are unpredictable and that self is not able to regulate anxiety. This, in turn, contributed to Jenny’s difficulties in separation and individuation. Jenny subsequently went on to develop problems with separation, peer relationships and persistent pre-occupation about Anna’s safety and well-being. Perhaps with the diagnosis of a serious and chronic disease, by displaying a degree of helplessness, avoiding school and exhibiting high levels of anxiety, Jenny was able to obtain care and attention from Anna where previously it had been limited or inconsistent.

Jenny’s rejection and bullying by peers and her brother’s escalating violent behaviour, which she perceives to have the potential to harm Anna, is most likely to have precipitated the presenting problems. Other contributing factors include Jenny’s poor relationship with Anna’s most recent partner, Tim, and a fear of losing Anna’s attention during this stressful period.

The above problems are perpetuated by Anna’s inability to deal effectively with Jenny’s problems because of her emotional and psychological issues, including past issues of trauma, relationship separation, and an inability to manage her son’s behavioural problems. The strategies used by Anna tend to reinforce Jenny’s dependence on her. In addition, Jenny’s difficulties in expressing her emotional experiences and needs, low self-esteem and limited coping strategies contribute to the tendency for Jenny to express her distress indirectly and at times ineffectively. Jenny’s excessive and persistent requests for help, display of helplessness and preoccupation with other’s safety are attempts to control her anxiety of coping with the loss and grief of the medical diagnosis, and to obtain and maintain proximity to Anna.

In sum, Jenny’s experience of inconsistent attention from her mother may have contributed to her representational model of attachment that includes the knowledge that being open and direct about her needs will not work. She may infer that she is unlovable and unworthy. For Jenny, the strategy that worked most often was appearing to be an adult, assisting her mother and caring for her siblings, as a way of getting her needs met. The representational model derived from her childhood experiences will probably lead Jenny to be distrustful, manipulative, and resentful in the patient-clinician relationship. She may have difficulties accepting that some people are quite willing to give nurturance and protection when she simply asks for it.
Diagnosis

Axis 1  309.21 Separation Anxiety Disorder – Early onset
       309.28 Adjustment Disorder with Mixed Anxiety and Depressed Mood
Axis 2  No diagnosis
Axis 3  493.90 Mild asthma
       692.9 Dermatitis, contact
       585 Failure, Renal, chronic
Axis 4  Enmeshed relationship with mother, difficulties with peers, and chronic
        concern about brother’s behavioural problems
Axis 5  GAF  70 (current)

Treatment Plan

The primary goal of Jenny’s treatment is to assist her to adjust to her recent medical diagnosis and reduce her anxiety through the implementation of stress management, using cognitive behavioural strategies. However, it appeared that Jenny’s perceived stress is very much influenced by her early formation of an insecure “preoccupied” attachment style. Therefore, treatment aimed at engaging Jenny in examining her attachment style would be useful and complementary to the primary treatment aim of assisting Jenny to adopt a more adaptive stress appraisal, response and management related to her medical illness.

Establishing a working alliance with a particular focus on attachment framework would include the clinician providing Jenny with a reparative experience that does not re-enact the old relational patterns or confirm maladaptive templates. A particular focus will be on forming a secure, consistent therapeutic base from which Jenny can explore her relationships with others. Therapy that assists Jenny to identify situations in which she is trying too hard to please other people in order to feel lovable would be beneficial. Providing a safe environment for Jenny to talk about these difficult situations, such as bullying at school, and the significance that these situations have on her emotionally, would provide Jenny with some insight into her emotions. Such insight could help her to experience less stress. Her stress could be alleviated due to realizing that she is investing unduly in relationships with rejecting or overly critical individuals who do not provide adequate validation for her worth.
In relation to Jenny’s experiences with her mother’s inconsistent parenting, setting appropriate limits and boundaries would be beneficial. For example, setting weekly therapy sessions will provide an opportunity for Jenny to experience a degree of consistency and reliability and introduce the belief that she is worthy of attention from the clinician. This experience of self as important and others as trustworthy may lead to modifications of Jenny’s internal working model, which could lead to an increase in her self-esteem. This, in turn, may decrease Jenny’s over-expression of helplessness and efforts to obtain and maintain proximity to her mother. Setting regular sessions will also demonstrate to Jenny that support will be given to her and she does not need to resort to extreme methods to gain support.

In developing a treatment plan, it is important to recognise Jenny’s beliefs that she is of “worth” only when she was taking care of others and their needs. This is evident in her relationship with her mother, where she was often the caretaker, helping around the house, enquiring about her mother’s needs, and comforting her mother when she was ill. It is imperative that the clinician is highly cognizant of the extent to which Jenny may be overly compliant and go along with everything that the clinician wants. A therapeutic relationship that encourages Jenny to be autonomous, and yet is directive and containing would be optimal.

In relation to Jenny’s structured CBT sessions for stress management, these sessions would include a process to identify stress and link cognitions, affect and behaviour in relation to perceived stress, relaxation exercises, distraction techniques and thought stopping. Restructuring Jenny’s negative thoughts around her illness, problem-solving and social-skills training would also be emphasized. Furthermore, it is important to encourage Jenny’s participation in social activities, sport and extra-curricula activities. This would further increase her self-confidence and social-skills. Finally, parent sessions to provide support for Anna would be beneficial. Parent sessions may introduce or reinforce Anna’s problem-solving skills, skills on setting boundaries and time management. For example, Anna may allocate a personal weekly time for each family member. This routine setting may alleviate Jenny’s anxiety and fear about losing Anna, because she is assured that Anna will be available for her exclusively at least once a week. Setting boundaries will also encourage Jenny to be independent and autonomous.
CHAPTER THREE

The Case of Angela

In this chapter, a brief description of urinary tract infections will be outlined, followed by a case presentation of a 13 year-old girl called Angela.

Urinary Tract Infections

Urinary tract infections (UTIs) are bacterial infections that cause irritation of the lining of the bladder, ureters, and kidneys. The infection is usually accompanied by pain in the abdominal and pelvic area, fever and frequent voiding of urine. Young people are at greatest risk for kidney damage from UTIs, especially if they have unknown urinary tract abnormality. UTIs are treated with antibiotics. Other treatments of UTIs involve behavioural strategies, such as drinking a sufficient amount of water, appropriate hygiene management and recognition of early signs of UTI onset (Hummers-Pradier, Denig, & Oke, 1999).

Reason for Referral

Angela, a 13 year-old girl was referred to the hospital consultation-liaison psychiatry unit in September 2003 for psychological assessment for potential psychological therapy to assist her in the management of her chronic urinary tract infections (UTIs). Other concerns were Angela’s oppositional and aggressive behaviour, severe mood swings, sleeping difficulties (need to sleep outside of grandparents’ bedroom), being verbally abusive, and refusal to take showers for up to three days.

Presenting Problems

Angela was diagnosed with UTIs in January 2003. Symptoms of the UTIs include: persistent voiding of urine, burning sensation when passing urine, inflammation and irritation localised in female sexual organs and lower abdominal pain. No pattern of onset of UTIs symptoms were found or reported. The UTI is most frequent and severe when Angela is at home, during the evenings. Angela could not identify the triggers or articulate what factors attenuate the UTIs. To date, little progress has been made, despite extensive medical and behavioural intervention.
In relation to Angela’s aggressive behaviour, Jane (maternal grandmother) reported that the current difficulties with Angela began in April 2003 when the family changed residential address after gaining permanent care of Angela’s half-brother, Eddie. Since the relocation, Angela’s tantrums, anger outbursts and sleeping difficulties escalated. In contrast, Angela was of the view that her behaviour was “not that bad” and that the reason she has to shout and scream is that she often feels that “people do not listen” to her and that she is “treated like a child”.

Jane’s attempts to control Angela’s behaviour through verbal arguments, incentives and taking away privileges has had limited success. Each attempt at disciplining Angela has resulted in increased verbal arguments, acting-out behaviour and tantrums.

**Current Situation**

Jane and David (maternal grandparents) have had legal custody of Angela since she was three years old, after the arrest and conviction of Mary’s (Angela’s mother) partner for sexually abusing Angela. Mary was unable to care for Angela due to Mary’s support for her partner and her significant substance dependence.

The relationship between Jane and Angela was reported to be warm and close, but deteriorated when Angela began experiencing frequent UTIs. Similarly, Angela’s relationship with other family members (grandfather, maternal aunt and half-brother) had been close but has become conflictual over the past year.

During family assessment, the grandparents and maternal aunt (Kim) all expressed feelings of helplessness regarding Angela’s aggressive behaviour and unpredictable anger outbursts. The family feels unable to control or contain Angela’s behaviour.

**Supports**

Jane and David have a moderate social support network through family and friends. Their most significant support is their daughter, Kim, who visits them on a weekly basis, providing informational, emotional and financial support.
Access with mother and father

Angela has had no contact with her mother since she was three-years-old and has never met her father. Similarly, Jane and David have had no contact with Mary since they gained legal custody of Eddie.

Observations during the session

All family members (grandparents and maternal aunt) commented that they were distressed and disapproved of Angela’s behaviour. Jane and David presented as extremely tense, with a heightened level of distress. In contrast, Angela was guarded and appeared angry. Angela frequently disputed and argued with her grandparents’, over their negative comments. In response, Jane and David would readily engage in arguments with Angela and would often digress from the aims of the assessment session.

Family History

Jane reported the family has had many difficult family dynamics in the past. These were primarily a result of Mary’s (Angela’s mother) long-standing history of substance abuse and dependence.

Personal/Developmental History

Angela was an unplanned pregnancy. Her grandparents reported that Mary was substance-dependent during the early stages of her pregnancy. Angela was born eight weeks premature and was hospitalized for nine weeks post-birth. Breast feeding was not attempted because Mary was unable to produce breast milk. Jane reported that Mary had difficulties caring for and settling Angela, and required Jane’s assistance every day for six months post-hospitalisation.

There were no reported delays with the onset of motor milestones or speech/language. Toilet training was difficult and there were persistent reports of incontinence problems. Angela attended kindergarten at four years of age. Kindergarten enrolment was delayed due to significant and lengthy protective issues regarding physical threats toward Angela by Mary’s partner and custody settlement.

Jane described Angela’s transition to school as easy. However, Angela was emotionally immature compared to her peers. Angela’s behaviour was described by Jane as erratic and unpredictable, at times aggressive and loud and at other time passive and
quiet. Furthermore, transition into secondary school was marked by behavioural problems such as stealing and lying, lasting approximately two months. No difficulties with school were reported thereafter.

Angela was hospitalised during the postnatal period for nine weeks and was again hospitalized for two weeks as an eight year-old for unexplained rashes. Gynaecological operations (vagina and uterus) were conducted at four years of age to repair damage from the sexual abuse.

At age 10, Angela commenced two-year intensive psychotherapy with a private psychiatrist to attempt to resolve her feelings about the sexual abuse she experienced when she was two years old. Jane reported that Angela is extremely sensitive about her body and is preoccupied with her physical appearance.

**Mental State Examination**

**Behaviour and Appearance**

Angela presented casually dressed on all occasions. She is of average height and appeared her stated age of 13 years. Her presentation was inconsistent and contradictory. She was quiet, reserved and conveyed a sense of reluctance to engage in the first half of the individual assessment session. In the latter half of the session, Angela impressed as confident and disinhibited. She conveyed a limited awareness of boundaries between her and the clinician and indiscriminant attachment to the clinician in the second half of the assessment session. She asked the clinician private and personal questions and was persistent with her questions until she received an adequate answer.

**Mood and Affect**

At the time of assessment, Angela communicated an affect which was flat, but was reactive. She rated her level of happiness as a 9 out of 10 and that her only concerns were about her homework.

**Speech**

Angela’s speech was normal in volume and rate. Her speech was polite, but with an aggressive tone. There did not appear to be any obvious difficulties with comprehension and communication.

**Cognitions**
Angela exhibited a slow and hesitant thinking process. Her thought processes appeared at times illogical and incoherent. She reported no delusions or abnormal obsessions, compulsions or phobias. Her thought content included her concerns about school, English difficulties and peer teasing and questioning regarding her mother and her living arrangements with her grandparents.

**Perception**

No hallucinations, illusions or depersonalisation were reported.

**Cognitive Functioning**

There were no disturbances of consciousness. Angela was orientated to person, place and time. She did not complain of any difficulties with concentration, attention or memory. She demonstrated an ability to focus and sustain attention and her concentration was not impaired.

**Judgment and Insight**

Angela demonstrated limited insight into her emotions and her difficulties relating to her grandparents. Angela minimised the impact of her behaviour on her family and communicated limited understanding and coping skills relating to her UTIs, anger and frustration.

**Formulation**

Angela is a 13 year-old girl living with her retired grandparents and half-brother, Eddie. Angela was referred for psychological assessment for potential psychological therapy to assist her in the management of her chronic urinary tract infections (UTIs). She was also referred due to concerns regarding oppositional and aggressive behaviour. Angela’s maternal grandmother reported that Angela has severe mood swings, sleeping difficulties, is verbally abusive and her behaviour was unpredictable. Other issues identified at assessment included, sibling rivalry and temper tantrums. Referral was precipitated when Angela was diagnosed with UTIs and when her grandparents gained sole custody of Eddie.

There are a number of complex and enduring psychosocial issues that contributed to Angela’s presentation. Developmentally, Angela was an unplanned pregnancy, which was complicated by eight weeks premature birth, requiring nine weeks hospitalization
She may be experiencing a fear of losing her grandparents’ attention. Her acting out behaviour may be an attempt to gain proximity and to control her environment.

Angela’s limited low capacity to reflect on her situation, insufficient ability to cope with stress, and limited reliable strategy to interact with others, particularly, her family, is reflective of a fearful attachment. Angela’s fearful attachment model may include a distrust of others’ responsiveness, with an accompanying negative view of self (Bartholomew & Horowitz, 1991).

Current difficulties appear to be perpetuated by Angela’s grandparents’ inability to deal effectively with Angela’s behaviour and emotional needs. Furthermore, Angela’s immature development, academic concerns, difficulties expressing emotional experiences and limited coping strategies contribute to the tendency for Angela to express her anger and frustration ineffectively, such as by tantrums and anger outbursts. It is also hypothesized that Angela’s inconsistent adherence to past medical treatment and recommendations for managing her UTIs has perpetuated on-going symptoms of UTIs.

Protective factors include Angela’s remarkable resilience to overcome a considerable history of stress. Angela also has dedicated and supportive grandparents and an aunt committed to her well-being.

**Diagnosis**

<table>
<thead>
<tr>
<th>Axis 1</th>
<th>309.9</th>
<th>Adjustment Disorder, unspecified, features of disruptive behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis 2</td>
<td>No diagnosis</td>
<td></td>
</tr>
<tr>
<td>Axis 3</td>
<td>599.0</td>
<td>Urinary tract infection</td>
</tr>
<tr>
<td>Axis 4</td>
<td>Sexually abused, mother and father unknown, sibling rivalry, academic difficulties and conflictual relationship with grandparents</td>
<td></td>
</tr>
<tr>
<td>Axis 5</td>
<td>GAF = 70</td>
<td></td>
</tr>
</tbody>
</table>

**Treatment Plan**

Angela presented with mixed feelings about the therapeutic relationship. She was fearful about entering treatment, but seemed to appreciate an opportunity to be listened to. Many instances during assessment were indicative of this behaviour; for example, when Angela provided a piece of self-disclosure it was accompanied by her withdrawal
and rejecting of help. This ambivalent interpersonal style is reflective of Angela’s fearful pattern of attachment, resulting from her experiences of significant trauma and aberrant relationships. It is therefore, not unexpected that her ability to interact with and trust other people is severely impaired. As such, to complement the treatment goal of assisting Angela to manage her UTIs effectively and address her disruptive behaviours, a treatment model that helps Angela to work on interpersonal relations and to trust new attachment figures would be beneficial. Addressing Angela’s fearful attachment model may begin with her relationship with the clinician, and hopefully the experience can be generalised to her relationships with others.

The first few therapy sessions with Angela aimed to form a secure, emotional, and safe therapeutic relationship from which Angela could explore and express her emotions and the meaning of having the UTIs. Initially, the therapeutic relationship appeared to assist Angela to gain some understanding of her working model. However, as Angela gained more insight to her situation, she reacted with both anger and distress. Fortunately, the clinician anticipated this reaction based on her experience of interacting with Angela during assessment sessions. With a bit of insight, the clinician acknowledged Angela’s anger and hostility, but at the same time, the clinician expressed and set firm boundaries and limits around acceptable expression of anger and hostility. Clarifying and modelling to Angela that there would be no inappropriate closeness, and the need for respect for each other’s boundaries, helped to establish Angela’s sense of safety and emotional containment. Angela, nevertheless, tried at numerous times to test the boundaries of the therapeutic relationship. She did this by throwing tantrums in the waiting room, refusing to come into the therapy room, and requesting to finish therapy sessions early. Furthermore, Angela tried to see the clinician at unscheduled times by ringing up the office and expecting to be seen immediately. On these occasions, the clinician continued to acknowledge Angela’s distress, but remained firm and told Angela that appointment times and duration were set and were not negotiable. This response was an attempt to demonstrate to Angela that boundaries and limits need to be respected, and that the clinician’s response to her will be consistent, regardless of her behaviour. This strategy proved to be useful, as it challenged Angela’s early experiences of inconsistent and intrusive personal boundaries.
For Angela, it was extremely important for her to see that the clinician cared, respected and was there for her in a consistent way when she was distressed. This was important to disconfirm Angela’s belief that she would be abandoned. Over a period of several months (and after testing the clinician repeatedly to see if the clinician was reliable and truly cared about her), an effective therapeutic alliance was developed with Angela. She appeared less confused about whether significant others truly care for her. At this point in therapy, Angela was willing to explore strategies to address her acting out self-destructive behaviours in response to stressful life events, and was more open to focused, structured therapy to manage her UTIs.

Cognitive behavioural strategies that assisted Angela to manage symptoms of UTIs included early detection of symptoms and consistency in treatment adherence. More specifically, these included keeping a diary of food intake that increased or exacerbated UTI symptoms, drinking plenty of water, adherence to a full course of antibiotics, and maintenance of hygiene. CBT strategies were also helpful in teaching Angela to monitor her emotions, understand the relationship between affect, cognition and behaviour and enhance self-control of moods and negative behaviours.

Due to limited resources, only two parent sessions were provided to support Jane and David. The aims of the sessions were to increase their understanding of childhood traumas, and effective parenting strategies with a focus on setting appropriate boundaries. Jane, David and Angela were then referred to the community child and adolescent mental health services for on-going psychotherapy to address Angela’s strained relationship with her grandparents.

Raising a young child and a teenager is a challenging task for any caregiver. However, when the caregivers are limited financially and are elderly, this challenge is further heightened. As a result, an additional referral was made to a free community family support service ‘Strengthening Families’ to provide Jane and David with extra support, in particular practical support. ‘Strengthening Family’ provides a trained mental health worker who regularly visits a client’s home to observe and assist parents with a range of family difficulties, ranging from budgeting to parenting skills.
CHAPTER FOUR
The Case of Aarron

The literature on the relationship between HIV/AIDS and adjustment will be reviewed briefly, before presenting the case of Aarron, a 36 year-old man with HIV and major depression.

HIV/AIDS diagnosis and adjustment

As the name suggests, the Human Immuno-deficiency Virus (HIV) attacks the immune system, making it weak (Solomon, 1989). The deterioration of the immune system then permits development of infections that normally would be resisted by a healthy person, and the eventual progression to Acquired Immuno Deficiency Syndrome (AIDS) (Solomon, 1989). The physical and emotional devastation of HIV infection and AIDS produces extraordinary challenges to the person infected, as well as their family and friends.

Research indicates a high prevalence of emotional distress, particularly development of a major depressive disorder among patients with HIV/AIDS (Atkinson & Grant, 1994). These levels of depression are higher than among patients with other life-threatening illnesses (Kelly, Raphael, & Statham, 1996). Psychosocial factors have been found to contribute to patients’ emotional distress. Types of coping strategies, attachment style and perceived social support are among the major factors moderating the degree of perceived stress among persons with HIV/AIDS (Lin, Monning, Cain, & Usoh, 1993; Moneyham, Hennessy, Sowell, Demi, Seals, & Mizuno, 1998). For example, Koopman et al. (2002) found in a study of 147 HIV positive patients that a behavioural and mental disengagement coping style contributed positively to high perceived stress. Furthermore, perceived stress was significantly greater among individuals with anxious and/or avoidant attachment styles. This is consistent with Bowlby’s (1977) attachment theory, whereby when an individual with less secure attachment style experiences stress and they engage in attachment behaviours to alleviate this stress, such as being hypervigilant in interpersonal relationships. The strategy, in turn, leads to a misinterpretation of other’s behaviour as rejecting or critical toward themselves, or
alienating them and avoiding help from others. Some of these factors are discussed below in the case of Aarron.

**Reason for Referral**

Aarron is a 36 year-old, single HIV positive man who was referred to the hospital consultation-liaison psychiatry unit in September 2004 for psychological assessment for depression and short-term cognitive behaviour therapy to address medication non-adherence. He was diagnosed with HIV in August 1996.

**Presenting Problems**

Aarron reported increasing feelings of frustration, irritability, and lowered mood most of the day, nearly every day since February 2004. He also reported markedly diminished interest and pleasure in engaging in once pleasurable activities, such as rowing. He stated that there is a lack of purpose and meaning in daily activities, stating his current level of happiness as 5 on a scale of 1 (low) to 10 (high). Aarron considered that his low mood impacted upon his ability to work, in terms of motivation to complete tasks, decreased self-confidence and increased feelings of powerlessness. Aarron believes the antecedents to his depressive mood were deterioration of his physical health, increasing dissatisfaction with HIV management, and work. He also stated that dissatisfaction with his HIV management is the main reason why he is not adhering to his HIV medication. He ceased HIV medication in mid-2003.

**History of Presenting Problems**

Aarron reported a long-standing history of depression and low mood since he was 14 years old. He reported two significant depressive episodes. The first occurred in 1992 during his first year of university. At this time, Aarron reported experiencing feelings of hopelessness and low mood lasting 12 months. The depression was not formally diagnosed. He described this depressive episode as very stressful and remembered feelings of not belonging and no purpose in life. He reported that he did not manage this depressive episode very well, and what helped him during this period was to travel overseas.

The second depressive episode occurred in 1996 in the context of the adjustment to HIV diagnosis and loss and grief issues relating to a relationship break-up. Again, he reported this episode of depression lasted 12 months; however, it was formally diagnosed
by a private psychologist. Aarron reported that his main coping strategies during this period were moving to his own private rental accommodation and having “reflective time” by withdrawing from people. He declined recommendation for psychotherapy.

**Current Situation**

**Living Arrangements:** Lives alone

**Typical Day:** Aarron works full-time and attends part-time studies two nights per week. He stated that when he has a bit of time he likes to read.

**Social Network:** Aarron reported he has a limited social network of friends. His friendships are low in quality and superficial and he was only able to report one close friend who he could depend on. He also stated that his only form of social activity was being part of a sporting team. Similarly, his contact with his family was limited. He contacts his mother via telephone once a month and visits his family two to three times per year, typically during Easter and Christmas. He commented that his relationship with his family was “superficial” and he avoids telling them about his personal life.

**Employment:** Aarron has worked in various para-professional and professional jobs since he finished secondary school. Currently, he works as a researcher. He considers his job as intellectually stimulating and interesting. However, this year Aarron has experienced some ambivalence about his job, stating that the job is becoming too mundane on the one hand and too demanding on the other, causing him frustration and dissatisfaction. In addition, Aarron stated that he is frustrated that he has to be accountable to his superior at work, who he thinks is incompetent and for who he has no respect. He considered changing jobs, but feels unsure whether he can find a job that is more suited to him than the one he has now. Aarron remains ambivalent and frustrated about this issue.

**Physical Health:** Aarron was diagnosed with HIV in 1996 and currently considers his HIV not to be well managed. His last CD4 was 156 (May 2004) and viral load was 6500. He was diagnosed with AIDS in May 2004. This indicates that the immune system is significantly compromised and the prevention of opportunistic infections is less effective. Aarron reported the course of his HIV since diagnosis has not been well managed, stating that his HIV medication regimes were not effective and that he is dissatisfied with his medical treatment. He reported that he distrusts medical doctors and has little faith that
any health professional can help him. He is currently prescribed HIV medication, but has been non-compliant for the past six months.

Personal History

Aarron was raised in a middle-class, Catholic family. He is the youngest of four children. Aarron described his relationships with his two sisters as “not particularly close” because of their considerable age gap (9 years and 11 years). His sisters moved out of the family home when he was 8 years old. He had an older brother who died in a motor vehicle accident. At the time of the accident his brother was 15 years old.

Aarron reported that his parents always maintained a strong religious identity and a façade of superficial happiness. However, he reported that behind this façade there was a significant underlying distance and emotional unavailability. He indicated that his parents were not openly affectionate and provided limited emotional support to him, his sisters and to each other. Aarron stated that his parents’ relationship was “not-warm”, very distant and lacked emotional expression or support. The emotional distance was exacerbated and most apparent when his older brother died suddenly when Aarron was 7 years-old. He remembered that subsequent to his brother’s death, his parents withdrew further from each other and from him. Aarron commented that his parents always expected him to solve and deal with problems on his own. As a result, he became emotionally independent and distant from his parents. There was no significant family psychiatric illness reported. However, Aarron considered his parents to be depressed for a very long time before and after his brother’s death.

Developmental History

Aarron reported that he was an unplanned pregnancy and there were no reported complications with his pregnancy or birth. He considered he reached all developmental milestones appropriately. Aarron reported no significant medical problems during childhood. Aarron described his childhood as a lonely time. He remembered that he often read books and escaped to a quiet place to distract himself whenever he felt upset or sad.

Aarron reported no problems with primary or secondary school academically, but socially he experienced bullying and teasing due to being overweight, academically bright and being “camp”. He had a small and superficial network of friends, because he
had difficulties establishing and maintaining friendships. Aarron described his friends as “convenient friends”. He remembered spending most of his lunch-time in the library.

Aarron also elaborated that he struggled with his identity throughout adolescence, stating that he was in deep denial about being gay. It was only when he moved out of home and went to university that he came to terms with his identity and disclosed it to a few close and trusted friends. Aarron described that he was very careful to whom he disclosed his sexuality for fear of rejection and discrimination. His parents and sisters are not aware of his sexuality or HIV status.

**Relationships History**

Aarron’s first sexual experience was at the age of 21 years, which was not in the context of an on going relationship. Aarron reported to have two significant relationships, the first being a semi long-distant, three-way relationship with Michael and Michael’s partner when he was 28 years old. Aarron met Michael in Sydney during a brief holiday and continued the relationship via telephone and internet. Aarron reported that he visited Michael and Michael’s partner once a month for two years. Aarron indicated that the relationship was intense and intimate, and there was no competition or jealousy between them. Aarron also described the relationship as the first time he felt accepted and understood and “nothing like I have ever experienced before or since.” Aarron reported that the relationship ended when Michael was diagnosed with HIV and shortly after Michael’s partner and Aarron were diagnosed. Aarron indicated that Michael started drifting away from him after the diagnosis and was emotionally unavailable for him during the time he needed him most. Aarron stated that this was a very sad and traumatic period in his life. He described feeling very abandoned, rejected, angry, and disappointed that he never had closure. Grief and loss issues from this experience remain unresolved for Aarron.

Shortly after the break-up of his relationship with Michael and Michael’s partner, Aarron commenced his second significant relationship as a form of coping with the disappointment and shock of having HIV. Aarron described his relationship with Ken as a very turbulent relationship. Ken had severe depression (catatonic) and was often emotionally unavailable. As a result, Aarron became very frustrated and withdrew from
Ken. This, in turn, made Ken feel worthless and depressed. The relationship ended 12 months later when Ken left Aarron without any warning or goodbyes.

**Mental State Examination**

**Appearance and Behaviour:** Aarron presented casually dressed and well-groomed. He maintained good eye contact and was co-operative and pleasant.

**Mood and Affect:** Aarron reported his mood as frustrated and sad. His affect impressed as dysphoric, broad in range and congruent with the topic of conversation.

**Biology:** Reported oversleeping but appetite was good.

**Speech:** Speech was articulate and normal in rate.

**Thought:** Aarron’s thought processes impressed as logical and coherent. There were no signs of abnormal obsessions, compulsions or phobias. His thought content included concerns regarding his career and the uncertainty of his current employment. He expressed a pessimistic view of the future and the meaning of life.

**Perceptual disturbances:** Aarron reported no unusual visual, audio, olfactory or tactile sensations.

**Cognitive functioning:** Aarron was orientated to person, place and time. He did not complain of any difficulties with memory, but reported moderate difficulties with concentration.

**Insight/Judgement:** Aarron demonstrated limited level of insight into his current depressed mood. He reported that he “feels fine” and questioned the relevance of the psychology referral. He stated that he is managing well.

**Self-harm/suicide:** Aarron denied any intention of self-harm or suicide ideation.

**Psychometric Assessment:**

The Depression, Anxiety and Stress Scale (DASS) is a self-reported scale designed to assess three related negative emotional states. Result of the DASS indicated that Aarron’s level of stress was normal and anxiety was moderate in range. However, Aarron’s level of depression fell within the extremely severe range.

The Minnesota Multiphasic Personality Inventory-2 (MMPI-2) was administered to further understand Aarron’s characteristics and behaviours. Aaron’s profile appeared to be valid and interpretatively useful. Aarron’s MMPI-2 indicated elevations on scales 2 and 4. This profile suggests that interpretation of Aarron’s personality may be explained
by the code-types 2-4. People can obtain a 2-4 code type for either of two reasons. First, people with this code type may be psychopathic individuals who have been caught in some illicit or illegal activity and are being referred for evaluation or treatment as a consequence. The depression noted on the elevated Scale 2 in these cases is usually reactive to being caught.

A second group of people with 2-4 code type is more likely to be chronically depressed, unhappy and angry. This description correlates more closely to Aarron’s profile and information obtained from the clinical interview. People with this code type tend to impress as hostile and resentful. They may also present with considerable interpersonal conflict within close relationships, such as the family or work situation. They often harbour feelings of inadequacy, insecurity and self-dissatisfaction. As a consequence, it is not uncommon for individuals with this code type to have relationship difficulties and feel uncomfortable in social interactions.

Aarron was also administered the Schema Questionnaire (Young, 1990). The Schema Questionnaire is a 205-item self-report inventory designed to measure 16 early maladaptive schemas (emotional deprivation, abandonment, mistrust/abuse, social isolation, defectiveness/shame, social undesirability, failure to achieve, functional dependence/incompetence, vulnerability to harm and illness, enmeshment, subjugation, self-sacrifice, emotional inhibition, unrelenting standards, entitlement and insufficient self-control/self discipline). Aarron scored high on the following schemas: emotional deprivation, abandonment, mistrust and abuse, failure to achieve, unrelenting standards and entitlement.

**Formulation**

The onset of Aarron’s lowered mood appears to have arisen from an early age. Aarron’s parents’ history of low moods and limited emotional expression may have contributed to Aarron’s vulnerability to develop depression. Aarron’s parents were physically and emotionally unavailable to him throughout his childhood, particularly during periods of anxiety and vulnerability. In addition, the death of Aarron’s brother exacerbated his parents’ physical and emotional absence. This family tragedy has seemingly impacted on Aarron’s attachment and bonding experiences to his parents, contributing to his feelings of abandonment and isolation. As a result, Aarron’s internal
working model perceives others as not reliable and rejecting, and that he is better off relying on himself. Thus an internal working model that holds a positive view of self and a negative view of others is characteristic of an insecure “dismissing” attachment (Bartholomew & Horowitz, 1991).

Aarron’s experience of bullying during childhood, and limited opportunity to be open about his sexuality has also contributed to his feelings of isolation and alienation. For Aarron, the experience of alienation was further substantiated by his experience of rejection and abandonment by his partners in past significant relationships. These events reinforced his view that others cannot be trusted and will inevitably abandon him when his need is greatest. Aarron’s experience of abandonment and isolation partially explains his dominant conflict, which involves strong needs for interpersonal closeness, counterbalanced by an equally strong striving for self-reliance. Aarron attempts to compensate for feelings of inadequacy and insecurity by overt efforts to be autonomous and self-guided. These efforts are demonstrated by Aarron’s high expectations of himself and others, and his active attempts to conceal his sexuality and HIV status from his family. Moreover, during periods of stress, Aarron prevents the intensification or even emergence of feelings that might overwhelm him. Denial, intellectualisation, and avoidance are among his most frequently used defences. Whilst these coping styles may be effective at times, they also maintain his current difficulties, to the point of being detrimental, as indicative of his non-adherence to anti-retroviral medication. Thus, by not complying with his medication, Aarron can dismiss the symptoms and minimise the enormity of having HIV/AIDS. Despite Aarron’s denial of suicidal ideation, Aarron’s non-compliance with anti-retroviral medication may potentially be a covert attempt to self-harm. In addition, the fact that Aarron’s physical condition has not significantly improved has contributed to his view that health professionals would eventually either be unable or unwilling to help him. It is likely that work, stress and work insecurity have triggered Aarron’s deep-seated feelings of self-doubt, anger and unresolved grief and loss issues, and perhaps heightened levels of distress, fear and uncertainty about the future. However, Aarron’s high level of cognitive capacity and involvement in recreational activities are his protective factors.

In sum, Aarron’s predominant dismissive attachment model is expected to impact on
his relationship with the clinician. His ingrained distrust of others and his compulsive self-reliance prevent him from establishing a fulfilling relationship with the clinician. His avoidance of emotional intimacy prevents him from developing a secure, trusting relationship with the clinician. It is likely that he will deny the importance of the patient-clinician relationship, reject offers of assistance, and aggressively assert his independence.

**Diagnosis**

Axis I: 296.3 Major Depressive Disorder, Recurrent, moderate without psychotic features
Axis II: No diagnosis
Axis III: 042 Human Immunodeficiency Virus (HIV) (symptomatic)
112.0 Candidiasis, mouth
Axis IV: Work stress, medication non-adherence and unresolved loss and grief issues
Axis V: GAF = 65 (Current)

**Treatment Plan**

Aarron presents with long-standing and complex issues that require a combination of long-term psychotherapy focusing on deep-seated feelings of abandonment and cognitive behavioural therapy to address current difficulties with medication non-adherence.

Given Aarron’s experience of rejection and abandonment, it was expected that he would feel an acute sense of anxiety about participating in a therapeutic relationship and that he would maintain an emotionally detached and hostile attitude. To achieve the goal of medication adherence, it was deemed imperative that underlying attachment issues be addressed first, but indirectly, as this was believed to be the driving force of Aarron’s resistance to help and non-compliance. Introducing cognitive behavioural techniques too early in therapy may be ineffective, because Aarron was likely to be dismissive of and minimise the effectiveness of any form of treatment.
In order to address Aarron’s medication non-adherence, the overall goal of treatment was to help Aarron understand the origin of his beliefs, behaviour and the impact these beliefs and behaviours had on current life circumstances. Once this goal had been adequately achieved, an extended aim was to help Aarron express his emotions and needs appropriately, and to gradually replace his maladaptive attachment behaviour.

Before therapy began, the clinician attempted to establish a collaborative alliance with Aarron, taking particular care to follow Aarron’s lead and not press him to disclose anything. This strategy was important, given that Aarron has strong beliefs that he must rely on himself to accomplish his goals and meet life’s challenges. He demonstrated on several occasions that his preferred strategy was to deal with stress on his own. He expressed dislike in needing support or care from anyone and did not expect support or care to be available if he ever did need it. One particular example was when Aarron questioned the clinician’s competence and brought up the fact that the clinician was a graduate student and not very experienced. Not buying into the countertransference and reacting with defensiveness, it was at this point that the clinician encouraged Aarron to set the interpersonal distance with the clinician, in order to reduce Aarron’s anxiety about dependency and interpersonal closeness. This strategy also aimed to increase his sense of personal control in order to minimise his own feelings of vulnerability. This idea was translated into the following simple strategies:

a) Stating to Aarron that some things were difficult to talk about and that he should take his time;

b) Encouraging Aarron to provide feedback if the clinician misunderstood or misinterpreted what he was saying;

c) Expressing the preference to work collaboratively with Aarron, and that the aim was to work as a team and that the clinician would not always have the answers;

d) Encouraging Aarron’s input and opinions about his treatment and progress;

e) Sharing Aarron’s pessimism that the treatment may not be entirely curative, but at the same time reassuring him that even if modest gains were made, regular follow-up visits were necessary. Such an approach aimed to attenuate Aarron’s fears of abandonment.
Given Aarron’s attachment style, the first few sessions focused on building a secure emotional foundation from which Aarron could feel safe to explore and begin to understand his internal working model. This was, surprisingly, achieved predominantly through interpersonal therapy, open-ended questions, psycho-education and experiential work, such as imagery. That is, as Aarron began to bond with the clinician, the clinician made efforts to encourage him to express his needs and emotions, such as anger. The goal was for the clinician to create an environment that was dissimilar to the one that Aarron knew as a child – one that was nurturing, protective, responsive, forgiving and encouraging of self-expression.

Once Aarron seemed amendable (after many missed appointments) to CBT, techniques were developed to assist Aarron to identify and monitor his affective state so that he was able to express his emotions. This was achieved by self-monitoring techniques and discussion of the relationship between affect and behaviour, particularly resistant behaviour, such as medication non-compliance. The goal of this strategy was to explore with Aarron adaptive behavioural reactions to his affect. These sessions reinforced Aarron’s more adaptive coping techniques to manage his affect.

Cognitive and behavioural techniques were also helpful in building Aarron’s self-esteem, social support, social skills training, and challenging Aarron’s negative self-talk. There was some success in reducing his depressive symptoms.

Finally, with treatment goals in place, we entered the termination phase. This was particularly important in light of Aarron’s abandonment experience. During the last part of the therapy, the clinician met Aarron on an every-other-week basis so that he could achieve some independence from therapy as well as allowing Aarron to maintain a connection with the clinician. The termination phase of therapy was slow and sensitive. The clinician also encouraged Aarron to decide when to terminate therapy, for example, choosing a final date. This was the final attempt to reinforce Aarron’s sense of control.

The current treatment program only addressed issues valid to treatment adherence for his current illness. Aarron was encouraged to consider long-term therapy. Schema therapy may be one form of therapy that may be beneficial for Aarron. Schema therapy may explore his schemas, emotions and thoughts relating to loss and grief issues.
regarding interpersonal relationships and HIV diagnosis. Aarron was hesitant about this suggestion, but he expressed that he will consider it carefully.
CHAPTER FIVE

The Case of Andrew

The literature on Reiter’s Syndrome, pain and attachment theory will be briefly outlined before presenting the case of Andrew, a 49 year-old man with multiple medical illnesses.

Reiter’s Syndrome

Reiter’s syndrome is an arthritic disorder that affects the ankles, feet and sacroiliac joints. Symptoms may include tender joints, sore muscles, pain in the lower back, heel or bottom of the foot, and dull pain in the pelvic area.

Attachment Theory and Coping with Chronic Pain

The substantial literature on coping with pain indicates that attachment theory provides a valuable insight into an individual’s perception and reaction to pain (Mikail et al., 1994). For example, Mikulincer and Florian (1998) in a study of adults with chronic back pain found that individuals with predominantly ambivalent attachment appraised their back pain as more intense and appraised themselves to be less able to cope with the pain compared to securely attached individuals. Similarly, Cienchanowski et al. (2003) found that individuals with preoccupied and fearful attachment styles were more likely to experience higher negative affect and use less adaptive strategies of coping with pain compared to individuals with secure attachment style. This is consistent with the attachment literature, which indicates that individuals with a negative view of self, such as those with anxious and fearful attachment, would have a negative view of self as less competent or able to cope by themselves (Ainsworth et al., 1989; Bartholomew & Horowitz, 1991).

Reason for Referral

Andrew is an unemployed, 49 year-old HIV positive man, with a history of multiple medical problems and depressive episodes. He was referred to the hospital consultation-liaison psychiatry unit for pain management in the context of multiple diagnoses of medical illnesses.
Presenting Problems

Andrew reported he experiences pain every day, throughout the day in multiple areas of his body, stating “the pain is always there and everywhere”. He reported moderate to severe levels of pain. He considers that his pain causes restrictions in activities of daily living, such as walking, lifting, sitting or standing for more than one hour. Andrew also reported feelings of anger towards himself, regarding his inability to “break-out of the cycle” of physical pain and persistent medical problems. He stated that he has had a diminished interest in sex due to pain and medical problems. He reported that this has impacted on his relationship. His partner, John, has found this difficult although he is being supportive. Andrew reported that arthritic and Reiter’s Syndrome pain increases during stressful periods, such as financial worries and relationship disputes, while rest and medication and marijuana provide slight pain relief.

History of Presenting Problems

Andrew’s first experience of pain began when he was diagnosed with Reiter’s syndrome. He reported his Reiter’s syndrome pain would occur every six months, and significantly affects his ability to work and engage in daily activities. Andrew noted that bouts of pain usually occurred during times of stress and when his immune system was compromised. At their worst, pain symptoms prevent Andrew from getting out of bed, walking, lifting, and doing daily activities, such as cleaning and cooking. Andrew reported that the frequency and intensity of pain resulted in him giving up satisfying, full-time employment and pleasurable activities. He has previously attempted a return to casual work on light duties in January 2004, but was unable to continue because of pain and ongoing commitment to medical appointments. In attempts to control his pain, Andrew avoids engaging in domestic and social activities, such as cleaning, working, and socialising with friends. These efforts have been successful in decreasing pain, but at the same time have had negative consequences on his personal relationships and employment.

Current Situation

Living Arrangements: Andrew lives with John, his partner of two years.

Typical Day: Andrew rises at approximately 8am. He described difficulties getting out of bed most days because of pain. Andrew’s typical day is limited to domestic activities
(e.g. cooking, cleaning and grocery shopping), medical appointments and occasionally, when the “pain is bearable”, socialising with John and friends at the local pub. On days when the pain is intense and debilitating, Andrew would cancel appointments, avoid any form of activities and confine himself to the house and wait for John to return from work.

Social Network: Andrew reported that he has one close friend, Rick, and a few acquaintances. Andrew’s contact with Rick consists of phone conversations and meetings at the local pub. He considers Rick as a very good friend and a source of emotional support. Andrew’s contacts with his family are limited to phone conversations with his adopted sister, Mary, and occasional meetings with his half-brother, Sam. Andrew stated that the reason he has a small network of social support was that he usually takes a long-time to get close to people, although he reported no difficulty making or maintaining superficial friendships.

Relationships: Andrew met John through a mutual friend in 2002. Andrew described himself and John as “chalk and cheese”. Andrew considers himself to be the “giver” and John the “taker” in their relationship, describing that in the beginning, he always felt that he was “constantly on the back-foot” because John is very difficult to please, which caused Andrew a great deal of frustration and distress. However, Andrew maintained that John and he have learnt to live with their differences and their relationship is improving. He stated that there is still some friction in the relationship, due to John’s limited awareness and ability to support him with house duties, and that John is “a fussy eater” and therefore “difficult to cook for”.

Physical Health: Andrew reported multiple health concerns. These include: HIV, recurrent Reiter’s syndrome, squamous cell carcinoma in the floor of the mouth (in remission), herpes simplex virus, lesions, arthritis, asthma, and anal wart. Andrew is on the waiting list for surgery regarding anal dysplasia. Andrew reported that he is compliant with medications and medical regimes. When asked about his feelings about his multiple medical illnesses, Andrew was reactive and attributed blame on himself for his HIV status and contraction of other sexually transmitted infections. He also expressed that he was frustrated with the pain and immobility from the medical illnesses and angry that he is unable to “break out of the pain cycle”. He presented with a high
level of helplessness and external locus of control, stating, “there is not much that I can
do when the bouts hit but to take the medications and wait”.

**Personal History**

Andrew was raised by adopting parents. He was adopted at 13 months and is the
eldest child in both his biological and adopted families. Andrew described his adopted
family as very supportive, loving and giving. He stated that his adopting parents were
strict, but fair and that they provided everything that he needed and required. Andrew
was aware about his adoption at a very young age “as long as he can remember”.

At age 30, Andrew’s half-brother’s wife (with whom he maintained intermittent
contact) requested him to attend a wedding to meet his birth mother. Andrew reported
he knew very little about his birth mother, but he did know that he was an unplanned
pregnancy and that during the early months post-birth, he was neglected, consequently
leading to the decision to put him up for adoption. Andrew described his birth mother as
“poorly equipped to take care of a child.” He described his birth mother as emotionally
unstable, who had experienced numerous “break-downs”. Andrew also expressed anger
towards his birth mother for being irresponsible and lacking commitment to the care of
her five children. Andrew’s other half-siblings were all put up for adoption. Andrew
reported being close to his half-siblings. When asked about his current feelings towards
his birth mother, Andrew maintained that he “has forgiven, but has not forgotten”. Andrew
has also met his biological father, but has limited on-going contact with him.

**Developmental History**

Andrew reported that his birth mother was alcohol dependent pre, during and post
her pregnancy with him. No birth or developmental complications were reported. He
considered he reached all developmental milestones appropriately. He reported a happy
childhood with his adopted family. Andrew reported no academic problems with primary
or secondary school. However, socially, Andrew described that he has always been “a
loner” and “stand-offish”, stating that he always had problems with physical contacts and
fear of intimacy. Although he was able to establish and maintain friendships, he
described needing a long period of time before he could get close to a person. As a
result, Andrew believed that he learnt to be independent and self-reliant from an early
age.
Relationship History

Andrew reported three significant relationships, including his current relationship with John. Andrew’s first serious relationship was with Mark. Andrew met Mark when he moved to Sydney and was working as a stripper in a nightclub. Shortly after commencing their relationship, Andrew and Mark moved to Melbourne. Andrew described the relationship as “intense” and that Mark was manipulative. Andrew stated that Mark “knew how to trigger his buttons”, which often made him frustrated, angry and he would then react by becoming physically violent towards Mark. Andrew ended the relationship approximately six months after moving to Melbourne, when he felt that he was becoming a person he did not want to be. Andrew stated that the relationship taught him many lessons, and he had never physically abused anyone subsequently.

Two years later, Andrew met Adam and their relationship lasted for 13 years. Andrew described the relationship as “wonderful” with many fond memories. Andrew ended the relationship after he received a diagnosis of mouth cancer. Andrew described that at the time he felt inadequate and unable to give Adam the relationship Adam deserved because of his physical health symptoms. Andrew stated that currently, Adam has a new partner and is reported to be happy. Andrew indicated that he felt proud and happy that he was able to “let Adam go and allowed him the opportunity to be happy”.

Employment History

Andrew left school at 16 and since then has had numerous jobs in diverse areas, ranging from the public service, to business, and to management of his own business. Currently, Andrew is unemployed.

Substance use

Andrew reported a history of alcohol dependence. He also stated that his biological mother and siblings were heavy drinkers. Andrew reported he drank alcohol heavily; at least six standard drinks five days per week since he was 20 years of age until he was 46 years old. He stated he has recently returned to this pattern of drinking, particularly during periods of intense pain and frustration, but commented that he can stop drinking alcohol at anytime without alcohol withdrawal symptoms. Andrew also reported a history of substance use lasting 15 years. Currently, Andrew reported he used sedative substances at least once per week to alleviate somatic pain.
Mental State Examination

Appearance and Behaviour: Andrew presented casually dressed and well-groomed. He maintained good eye contact. Although Andrew was open and co-operative, he showed discomfort in his posture when sitting and moving. He conveyed an impression of being in pain during all sessions.

Mood/Affect: Andrew reported his mood as frustrated and hopeless, however he believed these were reactive to his level of pain. His affect impressed as sad and flat, restricted in range and congruent with the topic of conversation and life situation.

Biology: Significant disturbance in sleep, reporting to have only 3-4 hours of sleep per night due to somatic back pains. Reported appetite as good, but a need to eat more regular meals.

Speech: Speech was articulate but slow in rate.

Thought: Andrew’s thought processes impressed as logical and coherent. There were no signs of abnormal obsessions, compulsions or phobias. His thought content included concerns about his health and pain. He described feelings of uncertainty regarding physical restrictions and pain. He was pessimistic about his future and recovery from current illnesses; but expressed interest in learning to cope more effectively with somatic pain and health problems.

Perceptual disturbances: Andrew reported no unusual visual, audio, olfactory or tactile sensations.

Cognitive functioning: Andrew was orientated to person, place and time. He did not complain of any difficulties with concentration and attention. However, Andrew frequently commented on difficulties remembering dates.

Insight/Judgement: Andrew demonstrated a high level of insight into his current health problems and pain. He reported a moderate level of understanding about the impact of stress on his body. He demonstrated frequent use of external self-locus of control.

Psychometric Assessment

The Depression, Anxiety and Stress Scale (DASS), indicated that Andrew’s level of depression fell within the severe range. His stress level was moderate in range and the reported anxiety level was normal in range.
The Minnesota Multiphasic Personality Inventory-2 (MMPI-2) was valid and interpretively useful. Andrew's MMPI-2 configural elevations on scales 2 and 3 suggested that he may be experiencing depression, fatigue, and physical complaints in response to stress. People with this code type tend to impress as passive, docile and dependent. They often harbour feelings of inadequacy, insecurity and helplessness about their life situations. As a consequence, it is not uncommon for individuals with this code type to have difficulties expressing their feelings. This, in turn, will impact on their ability to cope with stress effectively.

The Schema Questionnaire was administered to determine Andrew's underlying schemas. Andrew scored high on the following schemas: abandonment, mistrust and abuse, and emotional inhibition.

**Formulation**

Andrew is a 49 year-old unemployed, HIV positive man who lives with his partner, John. He has a history of multiple medical problems and depressed moods. He was referred for pain management due to long-standing somatic pain.

There are a number of complex and enduring psychosocial issues that contribute to Andrew's presentation. Andrew's early disrupted family structure seemingly has affected his early attachment and bonding experiences. These experiences have contributed to his lack of trust and high avoidance of relationships, yet he has had three significant relationships, two of which were reported to be fulfilling. Although Andrew's adopted family may have compensated for the loss that he experienced, Andrew's rejection and sense of abandonment from his biological mother seems to have persisted, and is likely to have contributed to his external self-locus of control, feelings of helplessness and an active effort to be self-reliant. Furthermore, Andrew's experience of social isolation and development of early independence, coupled with low levels of emotional expression, appeared to have limited his opportunities to learn how to regulate his feelings. Despite these experiences, Andrew presented with good communication skills. However, premorbid personality factors, such as passivity and self-doubts maintain his difficulties to express his emotions, feelings of inadequacy, helplessness and insecurity. Moreover, the fact that Andrew has been unable to cope effectively with
persistent chronic somatic pain and medical illnesses contributes to his depressive symptoms and sense of hopelessness. His difficulties are further compounded by his limited social network, unemployment, feelings of isolation, and deep-seated feelings of uncertainty of managing somatic pain and medical illnesses. Andrew presents with many features that are reflective of a ‘dismissive’ attachment style. However, Andrew’s compliance with medication and treatment and willingness to participate in pain management indicates that his internal working model that “others are not reliable” is not entirely static. It is possible that Andrew’s experience of a secure and nurturing base provided by his adopted family abated earlier negative experiences of abandonment and rejection by his biological mother. This supports the contention that one’s internal working model of self and others can be altered with more adaptive, supportive and responsive relationships (Bowlby, 1969). Therefore, whilst Andrew may present with some of the characteristics of avoidance and withdrawal in times of stress, he is also able to utilise support and seek help when needed. Furthermore, Andrew’s high level of insight, motivation, cognitive capacity and ability to express his pain symptoms articulately will assist him in obtaining benefits from psychological intervention to assist him in managing his pain.

**Diagnosis**

<table>
<thead>
<tr>
<th>Axis I:</th>
<th>309.0</th>
<th>Adjustment Disorder with Depressed Mood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis II:</td>
<td>No diagnosis</td>
<td></td>
</tr>
<tr>
<td>Axis III:</td>
<td>402</td>
<td>Human Immuno-deficiency Virus (symptomatic)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reiter’s Syndrome</td>
</tr>
<tr>
<td></td>
<td>054.9</td>
<td>Herpes Simplex Virus</td>
</tr>
<tr>
<td></td>
<td>794.0</td>
<td>Arthritis (right and left feet)</td>
</tr>
<tr>
<td></td>
<td>493.20</td>
<td>Asthma</td>
</tr>
<tr>
<td>Axis IV:</td>
<td></td>
<td>Unemployment, financial worries, relationship difficulties</td>
</tr>
<tr>
<td>Axis V:</td>
<td>GAF = 59</td>
<td>(Current)</td>
</tr>
</tbody>
</table>

**Treatment Plan**

Although Andrew presented with some features of dismissive attachment style, generally he believes that he is lovable and competent. He ordinarily employs a strategy of communicating openly and directly with health professionals when he needs practical
assistance or emotional support. This was evidenced by his willingness and openness to seek help, such as participating in pain management. Furthermore, Andrew also recognised that some people are unable to help him, and so he was able to make choices about where to seek assistance. This ability to make comparisons of, and contrasts between information demonstrates that Andrew is able to integrate information into an accurate and coherent understanding of reality. Thus, despite his multiple medical illnesses, Andrew presents with a sense of resiliency. It is therefore expected that during times of stress, Andrew is able to seek support and care from health professionals. His demonstration of trust in health professionals to treat him well reflects a representational model that views himself as worthy of care and others as reliable and responsive when called upon.

Even though Andrew was of the view that the clinician can be trusted, establishing a supportive and nurturing therapeutic environment, this sense of trust in others would be reinforced by establishing a supportive and nurturing therapeutic environment. A supportive, honest and transparent therapeutic alliance would be expected to reinforce Andrew’s positive view of self and others. The positive perception of self and others would be expected to lead to an improvement in Andrew’s level of self-confidence and internal self-locus of control. An improved sense of self, in turn, may increase Andrew’s sense of self-efficacy to control his somatic pain and decrease feelings of hopelessness (Jensen, Romano, Turner, Good, & Wald, 1999).

Thus, Andrew’s pain management was structured to give him maximum personal control by providing him with adequate and relevant information regarding his medical illnesses, encouraging him to have input into his medical management and ensuring that the patient-clinician work was a collaborative effort.

Andrew’s pain management treatment when possible, dependent on severity of somatic pain, could incorporate the following themes:

1. Psycho-education regarding the relationship between stress, emotions, behavioural and pain perception;
2. Pain management – using creative visualisation exercises and relaxation exercises;
3. Development of problem-solving strategies to assist Andrew to cope with somatic pain;
4. Cognitive therapy with a particular emphasis on challenging self-talk, building self-esteem and gaining a sense of control over his life and somatic pain;

5. Social network development e.g. consideration of Tai Chi classes. Andrew has expressed that previous participation in Tai Chi classes helped with his management of pain.
CHAPTER SIX

Conclusion

The cases presented in this clinical portfolio illustrate the usefulness of attachment theory in understanding coping and the adjustment responses of patients with chronic medical conditions. Illness challenges the individual’s self-esteem and increases the individual’s feelings of vulnerability. Attachment theory predicts that when an individual is faced with an illness, he or she seeks out an attachment figure to reduce anxiety associated with the illness (Bowlby, 1969; 1977). Health care professionals can be seen as such an attachment figure, and thus, the patient-clinician relationship is likely to have a significant impact on illness management and outcome. As demonstrated in the four case presentations, how an individual manages or functions in the new situation of illness and treatment depends on the earlier success or failure of attachment development during early years.

According to attachment theory, children internalise early interpersonal experiences with their primary caregiver. If no corrective experiences of attachment intervene during their life span, and if a person does not reflect on these attachment patterns, it is likely that the internal working model corresponding to the original patterns of attachment will persist unmodified in adult life (Bowlby, 1973).

The cases of Jenny, Angela and Aarron are good examples of the challenges faced by clinicians in treating individuals with concurrent medical illness and insecure attachment. For example, Jenny’s experiences of unpredictable and intrusive parenting by a mother who struggled to overcome her own abusive history and mental health issues, would have contributed to her preoccupied attachment style. In times of stress, such as a diagnosis of a medical illness, Jenny’s internal working model of others as unreliable, and herself as unable to manage anxiety, resulted in Jenny engaging in overcompensating behaviour to ensure help would be provided. In the patient-clinician relationship, patients similar to Jenny may present as manipulative, with constant distress signals, helplessness, being overly compliant, and extremely dependent on the clinician to regulate their anxiety. These behaviours are strategies to keep the clinician constantly engaged, because of the intense fear of separation. As a consequence, clinicians may feel
overwhelmed, exhausted and stifled. Thus, the key to working with Jenny was to maintain a balance of consistency and directiveness, coupled with encouragement of autonomy and self-expression.

Similarly, the insecure patterns of attachment experienced by Angela influenced her interaction with others when she was most in need and vulnerable. Instead of expressing her needs directly, Angela utilised an approach that ‘cried for help’ but at the same time was rejecting and hostile. Angela’s contradictory behaviour can be seen as a traumatic re-enactment of earlier rejection and abuse. Thus, Angela’s hostility towards the clinician may be expressed in order to dissuade the clinician from leaving, yet her display of intense distress was to ensure that the clinician would provide support. This confusing style of relating frequently generates negative responses, such as frustration from health care professionals. Consequently, clinicians may actively avoid, withdraw or reject these patients, reinforcing and confirming the individual’s fearful attachment style that self is unworthy of care and that others cannot be trusted to provide care. As a result, the type and quality of care received by individuals with a fearful attachment style may be compromised by the difficult patient-clinician interaction. As was demonstrated in the case of Angela, management of such patients requires persistent and firm limits and boundary setting. Facilitating security and consistency within the therapeutic relationship was fundamental in bringing about change for Angela.

In contrast, Aarron’s experience of abandonment and rejection contributed to his perception that others are not reliable and not willing to help, and that he is better off relying on himself. This may be adaptive at times, but when support is needed, this attachment style is detrimental to the patient’s physical progress, as demonstrated in Aarron’s lack of adherence to anti-retroviral medication. Aarron’s denial of help is a defence to protect him from the possibility that the clinician will be unavailable or rejecting. In a patient-clinician relationship, patients with dismissive attachment styles, such as that evidenced by Aarron, may be terrified of establishing a relationship. They may present as distant, detached and possibly hostile. They may also have the tendency to challenge, devalue and minimise the advice of the clinician and are more likely to rely on their own judgement. Consequently, this may evoke in clinicians a sense of anger and defensiveness. Clinicians working with these individuals need to be cognisant of these
countertransferences. Anger and defensiveness serve only to re-enact and confirm dismissively attached patients' old relational patterns and beliefs about self and others. For Aarron, it was important that the patient-clinician relationship was flexible and allowed him to be directive in order to maintain a level of personal control and autonomy.

Andrew's case demonstrated that one's internal working model can be altered. Through positive relationships, the internal working model can become more adaptive. That is, should the primary attachment figure prove unsatisfactory for a child's needs, additional attachment that is positive can actually mediate or in some cases overcome the deficits of the primary attachment (Ainsworth et al., 1978).

For example, although Andrew's early insecure attachment experience was marked by neglect, the secure, responsive and positive experience gained from his adoptive family, influenced his perception that others are reliable and trustworthy and to a certain degree, that he is worthy of care and attention. As a result, Andrew had sufficient confidence and trust in himself to be proactive in managing his distress and sought help from others when needed. Securely attached individuals' positive view of self and others therefore influence their capacity to be open and trusting in interpersonal interactions with clinicians. Thus, during an illness, these individuals' ability to seek help effectively, express their concerns, describe their symptoms non-defensively and accept help and support, will assist them to cope with a medical illness more effectively.

In sum, there are a number of advantages in conceptualising the experiences of patients' interaction with health care professionals in the context of a medical illness by using attachment theory.

First, a general attachment framework assists the clinician to understand how patients construe the self, the clinician, and the experience of the medical illness. Second, awareness of the patients' internal working model informs clinicians on the development of treatment plans that are sensitive to the patients' experiences. Third, understanding of a patient's attachment model can be used to reconstruct the therapeutic relationship. Maladaptive attachment behaviours are learned in interactions with significant others and can be unlearned in current interactions with others who are important, such as the clinician. Reconstruction of a patient's attachment provides an accessible form for teaching and supporting patients to understand their internal working
model of self and others, an important initial step to alter or reinforce the patient's interaction in future relationships (Liotti, 1991). Fourth, working from a patient's pattern of attachment assists with rapport building, bonding and the therapeutic alliance, which are complementary and at times essential in providing a strong basis for other forms of treatment, such as cognitive behavioural therapy. Finally, psychologists working from an attachment framework are in a unique position to inform and provide specialist knowledge and skills in multidisciplinary work settings. Psychologists may engage in a consultative or supportive role in providing insight in patient care-management plan. Psychologists may also provide psycho-education workshop for medical staff in both community and hospital settings to manage difficult patients.

Although there are a number of advantages of working with patients from an attachment perspective, limitations of working within this model should also be noted. Attachment model and therapeutic interventions is designed for an intermediate treatment length of 6-12 months (Young, 1990). This treatment length is not always appropriate for many clients. Furthermore, interventions based on attachment theory often assume that clients can engage in collaborative relationship with the therapist and that clients can access cognitions and emotions and verbalise them in therapy. However, clients with limited intellectual insight are often unable to do so. They may be less responsive to this therapeutic style and may not make meaningful changes. Similarly, clients with disabilities may pose unique obstacles in therapy. Clients with disabilities may have delayed ability to communicate their needs, may be unable to develop links between childhood experiences to current psychological issues and therapists may have difficulties interacting with and understanding their signals. Moreover, clients who are not psychologically ready for therapy might drop out of treatment to avoid experiencing the pain of the lonely, traumatic childhood. They may be unwilling to let themselves become vulnerable enough to trust and become attached to the therapist. If they entered treatment during a crisis, they are at risk to leave once the crisis is resolved.

In conclusion, despite the above limitations the present clinical portfolio supports the view that attachment theory provides a useful theoretical framework to explain patient-clinician relationships and the impact that these relationships have on illness behaviour and treatment outcome.
References


