Response Paper

Targeting Core Beliefs in Treating Borderline Personality Disorder: The Case of Anna

Rebecca V. Fossel and Joseph H. Wright
University of Pennsylvania School of Medicine

The present response paper is one of a series describing various cognitive-behavioral approaches to treating a patient, Anna, who has been diagnosed with borderline personality disorder (BPD) and comorbid major depression (Kuyken, 1999). Anna is a 26-year-old, married, mother of two young children, who recently began a new job. Our case conceptualization focuses on the role of maladaptive core beliefs (A. T. Beck, Freeman, & Associates, 1990) and the avoidant/dependent subtype of BPD (Layden, Newman, Freeman, & Morse, 1993). Three stages of treatment are described (assessment/conceptualization, intervention, and maintenance) from a cognitive therapy perspective, and a cognitive case conceptualization diagram (J. S. Beck, 1995) is utilized to address three problems arising during therapy.

Case Conceptualization

OUR CONCEPTUALIZATION of Anna draws on Beck's cognitive theory of BPD based on core beliefs (A. T. Beck, Freeman, & Associates, 1990) and the avoidant/dependent borderline personality disorder (BPD) subtype described by Layden et al. (1993). Following a brief description of the central concepts of these models, they are applied to the case of Anna.

The basic principle of Beck's cognitive model is that thoughts and beliefs directly influence emotions and behavior (J. S. Beck, 1995). Key features of the model include the cognitive triad (negative beliefs about the self, the world, and the future) and automatic thoughts and cognitive distortions that affect emotional experiences. Cognitive therapy has been demonstrated to be efficacious in treating a broad range of Axis I disorders (A. T. Beck, Sokol, Clark, Berchick, & Wright, 1992; Rush, Beck, Kovacs, & Hollon, 1977). In recent years, it has been expanded and applied to the treatment of personality disorders, including BPD (A. T. Beck et al., 1990).

A. T. Beck et al.'s (1990) cognitive model of personality disorders asserts that an individual's dysfunctional core beliefs about the self and the surrounding world color perception and interpretation of events, and shape behavior and emotional responses in a rigid, maladaptive, and generalized manner. Core beliefs are fundamental, idiosyncratic, absolute "truths" that the person may or may not be aware of holding (J. S. Beck, 1995). It is hypothesized that they initially develop in early childhood based on experiences with primary caregivers (Young, 1990). The individual also develops maladaptive compensatory strategies designed to help cope with dysfunctional core beliefs.

A. T. Beck and colleagues contend that individuals with BPD often hold three key core beliefs: "The world is dangerous and malevolent," "I am powerless and vulnerable," and "I am inherently unacceptable." They also engage in the cognitive distortion of dichotomous or "all-or-nothing" thinking. Additionally, they have weak or unstable senses of identity and often hold strong contradictory beliefs that contribute to identity disturbance and affective instability. A. T. Beck and colleagues explain that the core beliefs, dichotomous thinking, and weak sense of identity of the BPD patient work together to form self-perpetuating maladaptive patterns highly resistant to change.

Although individuals with BPD share many characteristics, they are somewhat heterogeneous. Layden et al. (1993) note that BPD patients may be further distinguished from one another with respect to their concurrent Axis II diagnoses. They identify three distinct subtypes, including the histrionic/narcissistic, antisocial/paranoid, and the avoidant/dependent subtype of BPD. The present case, Anna, appears to be an example of the avoidant/dependent subtype. These individuals often have been emotionally deprived and tend to be very anxious and to believe they are incompetent. The belief in their incompetence contributes to their avoidance and dependence, which are maladaptive coping strategies that reinforce the belief that they are helpless. They avoid close relationships due to mistrust, fear of abandonment, and a fear of losing their identities if emotionally involved with someone else. They are also convinced, however, that they need the help of others, so they remain in turmoil with an extreme version of the "I can't live with 'em, can't live without 'em" syndrome, vacillating between avoidance and dependence (Layden et al.).

In moving from theory to the clinician's consulting room, it is important to address how one can apply these concepts to the case of Anna, tailoring the conceptualization to the specific patient. A cognitive conceptualization involves the clinician pulling together relevant patient data in order to determine what core beliefs a patient holds and how they affect behavior and emotions. In other words, we would advise therapists to attempt to an-

Cognitive and Behavioral Practice 6, 54–60, 1999
1077-7229/99/54–60
Copyright © 1999 by Association for Advancement of Behavior Therapy. All rights of reproduction in any form reserved.

swer the following questions: What core beliefs did she likely develop as a young child based on her life experiences? How do these core beliefs relate to her primary presenting problems? What are the key internal or external triggers that appear to activate these core beliefs? What types of self-defeating compensatory strategies is she employing to cope with her problems?

Conceptualizing Anna, we note significant data from her childhood and hypothesize likely core beliefs. Her parents were very negative and critical, her siblings picked on her, her boyfriend rejected her, her parents argued and threatened divorce, the family moved frequently, and her father had bipolar disorder and was hospitalized. All of these experiences may have led her to conclude she was worthless, incompetent, or that people would hurt or abandon her. We can see how she may have developed the three core beliefs A. T. Beck et al. (1990) contend are typical of BPD: "I am inherently unacceptable," "I am powerless and vulnerable," and "The world is dangerous and malevolent." Anna's mother was also either overinvolved with her or overemphasizing independence. Anna seems to have learned from her mother's behavior two contradictory beliefs: "I can't cope on my own" and "I have to do it all."

Anna also holds other contradictory beliefs that contribute to identity disturbance. For example, she said that she had no psychological problems until recently and that she had many problems, including self-harming, poor self-esteem, and anxiety dating back to grade school. It is likely that although Anna did have longstanding problems, they were masked by her efforts at coping. Maladaptive coping styles can be somewhat successful for quite some time, and individuals with characterological disorders may not recognize their pathological patterns. People with personality disorders often appear for therapy only after their maladaptive coping mechanisms have broken down and they experience the additional difficulties of Axis I disorders. Recently, Anna's compensatory strategies seem to have broken down, and she has developed a major depressive episode. She holds typical depressive beliefs that represent the cognitive triad, "I'm worthless," "No one is there for me," and "It'll never get any better," but her depression is best conceptualized as a symptom of her more enduring BPD.

As noted previously, some of Anna's core beliefs are: "People will hurt/abandon me," "I can't cope on my own," and "I have to do it all." Thus, Anna vacillates between the strategies of avoidance, dependence, and overcompensation. She has been avoiding most close relationships, but is becoming too dependent on her therapist. She tries to overcompensate for her sense of unacceptability and incompetence by trying to appear perfect, to show no weakness, and to be in complete control at all times. This compensatory mechanism breaks down because of its unrealistic nature (she can't do it all perfectly) and due to opposing beliefs (she thinks she is incapable). Anna's compensatory strategies and dichotomous thinking also contribute to self-perpetuating maladaptive patterns. Since she feels unacceptable and that others are malevolent, she avoids close relationships, then sees them in an all-or-nothing manner as "completely superficial," and likely views them as more proof that she is, indeed, unacceptable, and others are malevolent.

Treatment Plan and Anticipated Stages of Therapy

Therapeutic challenges. One of the hallmark features of treating patients with personality disorders, and especially BPD patients, is that treatment planning is more challenging. Avoidant/dependent BPD patients such as Anna can be noncompliant with homework assignments, present difficult challenges with regard to crisis management, often attempt to cross therapeutic boundaries, and frequently display significant deficits in managing their everyday lives. For these reasons, they may elicit negative emotional reactions from their therapists. Nevertheless, it is useful to approach treatment planning with BPD patients in a systematic yet flexible fashion, planning for these therapeutic challenges.

Even with a clear conceptualization and treatment plan, it is not uncommon for therapists to feel ineffectual, and perhaps even hopeless, in response to the BPD patient's chaotic and, at times, emotionally overwhelming presentation. Hence, in addition to treatment planning, developing effective coping skills on the part of the therapist is essential. Given the emotional toll that can accompany treating BPD patients, it is recommended that therapists limit the number of BPD cases they treat, seek formal and informal support, and modify any unrealistic or perfectionistic tendencies they might have with regard to treatment outcome with BPD patients.

Stages of treatment. It is useful to distinguish three stages of treatment that are applicable to any patient: assessment/conceptualization, intervention, and maintenance/consolidation of treatment gains. Assessment and conceptualization should ideally precede intervention, but are best seen as ongoing processes rather than as fully completed at any given time. Additional data will become available during the intervention stage, allowing the clinician to revise and refine the conceptualization as necessary. It is also likely in working with BPD patients like Anna that there will be a need for crisis intervention before there is enough time for a full assessment or conceptualization. It is crucial that the clinician remain flexible and be able to juggle several therapeutic balls at once. Since we have already largely discussed issues relevant to assessment and conceptualization, we will proceed to a discussion of intervention.

Intervention. The formal intervention stage of cogni-

دریافت فوری ← متن کامل مقاله

ISIArticles
مرجع مقالات تخصصی ایران

✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
✓ امکان دانلود نسخه ترجمه شده مقالات
✓ پذیرش سفارش ترجمه تخصصی
✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
✓ دانلود فوری مقاله پس از پرداخت آنلاین
✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات