

drowned. A spouse is either worthy of adoration or of the most severe condemnation. Life is perfect or life is hopeless.

Katrina behaves in ways that alienate, even frighten, those close to her. Her standards for others are as unrealistically high as her standards for herself, and this contributes to a sense of hopelessness and helplessness and, consistent with Seligman (1974) and Beck (1967), a generally depressed, periodically suicidal frame of mind.

Assessment Plan

My assessment would not likely include the tests described in the case material, most particularly the projectives. What is reported from them seems to me no different from what was already known about the patient, and represents, to my mind, time and expense not well spent. I find it interesting and a tad disconcerting that the case material contrasts her seeming to be motivated and cooperative during the four intake sessions with her reluctance to complete the various assessment measures. Perhaps Katrina has the kind of skepticism about some of the tests given to her that I do, so her difficulties completing them may not have pathognomonic significance (unless it be judged that I am defending on behalf of the patient!).

Rather than rely on psychological tests of dubious validity and utility, I would probably use clinical interviews and perhaps some situation-specific questionnaires like the Dysfunctional Attitudes Scale (Weissman & Beck, 1978) or the Fear of Negative Evaluation Scale (Watson & Friend, 1969). In sessions with both the patient and her husband, I would conduct a functional analysis of the clinical complexities of her case; that is, I would conceptualize her problem according to the familiar cognitive-behavioral SORC model (Kanfer & Saslow, 1969), to wit:

- S: What are the situational determinants of her maladaptive cognitions, emotions, and behaviors?
- O: What internal factors, from cognitions to biological variables, have to be included for a useful understanding of the patient?
- R: What overt responses or behaviors does the patient engage in?
- C: What are the consequences or payoff for her behaving or thinking or feeling in a particular way?

The hope is that a careful functional analysis (cognitive behavioral assessment) of Katrina would yield information that would allow a construction of her psychological distress that would in turn imply a treatment plan possessing some measure of empirical support.

Initial Treatment Plan

My overall treatment plan would probably be modeled after Linehan's dialectical behavior therapy (DBT; Line-

han, 1993). I would first of all establish a relationship marked by acceptance of the patient that is a thoroughgoing validation of her fears, concerns, and destructive impulses. I would assume that she is doing the best that she can at any given moment. This could take a number of sessions and would be a leitmotif throughout treatment.

The challenge, at the same time, is to persuade the patient to refrain from self-harming behaviors. Necessary also is teaching the patient better control over her emotions, perhaps by training in deep muscle relaxation.

This dialectical feature of DBT has always been for me the most difficult—balancing the validation that seems to be particularly necessary for a borderline patient against the need to reduce the frequency/intensity of destructive behaviors and increase the frequency of behaviors that will improve the clinical situation. Given the exquisite sensitivity that Katrina is likely to exhibit to any signs from the therapist that she is not behaving as well as she could, it seems of the utmost importance to work towards a synthesis of acceptance and change. In contrast to what a Rogerian would hold, I would not assume that acceptance without specific change efforts would improve the clinical picture in Katrina or, for that matter, in most patients, regardless of their clinical diagnosis.

Linehan has asserted many times that DBT is essentially cognitive behavior therapy within a dialectical context. I agree with this conceptualization. The core change aspects of DBT are social skills training and other cognitive behavioral procedures.

There is much to work on with Katrina. She seems to use alcohol in an effort to control her stress. BPDs are said to abuse drugs often. She also is said to have had periods of anorexia and bulimia. The latter has been linked to the kind of dichotomous thinking that is a core feature of BPD, in this case something like "It is absolutely essential that my physical appearance measure up to the ideals I see around me in this society, and so I must be very careful about weight gain and therefore have to get rid of any food I eat" (Fairburn, 1985).

Her taking two psychoactive drugs would require my working with a physician, hopefully a psychiatrist knowledgeable about the risks and the benefits of medications. The side-effects of the SSRI Effexor, for example, include increases of 10 to 15 mm. in both systolic and diastolic blood pressure, (hypo)mania, seizures, headaches, dizziness, insomnia, anxiety, and anorexia. One has to consider whether this patient can afford these possible burdens on top of what she is already trying to cope with. Indeed, one wonders how much of the symptom picture is a result of the drugs she is on.

The "stated beliefs regarding self, others, and the world" that are included in the case material certainly describe a person with a very low opinion of herself and with little hope that things will ever get better. Reflected

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