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Response Paper

A Cognitive-Behavioral Analysis of a Patient With Borderline Personality Disorder

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Comments are made on case material from a patient likely to be diagnosable as borderline personality disorder. The author offers an analysis of the case as one reflecting emotional dysregulation and the complex interpersonal consequences of lack of control over turbulent storms of negative emotionality. A tentative treatment plan is outlined that involves a dialectical cognitive behavioral approach aimed at reducing emotional sensitivity and enabling the patient to cope better with her hitherto uncontrollable and frightening emotional lability and self-destructive behavior. Critical observations are offered on the risks of inferring childhood sexual and physical abuse from reports by clients who were treated by therapists whose theoretical or political orientation lead them to assume the presence of abuse in the past histories of people like those with borderline personality disorder.

The case of Katrina raises a number of interesting questions. My reactions to the material are organized around presenting problems and diagnostic impressions, the assessment plan I would follow, my conceptualization of the case, my tentative treatment plan, and finally some concerns regarding the issue of sexual and/or physical abuse in the patient's past.

Patient's Presenting Problem and Diagnostic Impressions

In *DSM* terms, I would probably diagnose this patient as Borderline Personality Disorder (BPD). More specifically, and consistent with Marsha Linehan's formulation of BPD (Linehan, 1993), I would see her as someone saddled with emotional dysregulation, a problem of extreme autonomic lability and an impaired ability to modulate her emotional turmoil. In a sense, Katrina's behaviors can be seen as maladaptive solutions to dealing with overwhelming negative affect. Associated problems that I see caused by this emotional dysregulation include her chaotic interpersonal relationships, suicidal and parasuicidal behavior, periods of depression, and general impulsiveness.

The case report presents the hypothesis that "Katrina's suicide attempts reflect her inability to find alternative strategies toward regulating her intense emotions." I would agree. I am less certain about the hypothesis that "Katrina acts out her overwhelming rage and depression by presenting with extreme behaviors in an attempt to behaviorally 'match' her feelings." Why would she do this? More likely to me is that her depression and acting out are driven by maladaptive cognitions reinforced by her social environment; at least I would assess for these possibilities.

Also apparent in the case material is "splitting," a black-and-white way of viewing the world that is characteristic of patients with BPD. Present as well are what are described as "intrusive memories of abuse" from both her father and her mother, about which I have more to say below.

Case Formulation

Linehan and others hypothesize that a series of nonvalidating experiences in childhood and adolescence can contribute to the development of BPD, most likely in an individual with a biological diathesis of some kind. I believe we see some element of nonvalidation in the case material. For example, we are told that Katrina and her brother were very unhappy as children, but that these feelings were concealed by their parents by dressing them in neat and pretty clothes and teaching them to be pleasant and upbeat in front of others "no matter what." But whether such experiences occurred in Katrina's past is less important than her current low self-esteem and sensitivity to rejection and disapproval.

In addition to her extreme emotional lability, Katrina manifests a tendency to see the world, including herself, in dichotomous terms ("splitting," as just mentioned), Thus, a therapist either walks on the water or deserves to be

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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 diffculties 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; Linehan, 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 possibe 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