Response Paper

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

Gerald C. Davison
University of Southern California

Comments are made on case material firms 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 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.

Cognitive and Behavioral Pract(ce 7, 497-500, 2000
1077-7229/00/497-500$1.00/0
Copyright © 2000 by Association for Advancement of Behavior Therapy. All rights of reproduction in any form reserved.

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
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; 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 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
also is the dichotomous thinking that is part of the “dialectic failure” that Linehan describes for patients with BPD. A general cognitive goal is to teach the patient about dialectics as a way to move her away from black-white thinking. Of course, Aaron Beck has a central place in this kind of cognitive distortion in his widely known and practiced cognitive therapy (Beck, 1976). I would see Beck’s approach as applicable with this patient, but I would blend it with Albert Ellis’s (1962) focus on unrealistic beliefs—imperative thinking or demands for perfection and approval from everyone, and demands that the world be as the patient wants it to be.

I would also take a problem-solving approach with Katrina, focusing especially on encouraging her to construe her seemingly impossible predicament in terms of difficult problematic situations that are amenable to a solution. This general problem orientation, considered but the first stage of social problem-solving therapy by D’Zurilla and Goldfried (1971), may itself be helpful to a person like Katrina, who is easily overwhelmed by perceived catastrophes. I have for some time related this problem orientation to Robert Pirsig’s classic Zen and the Art of Motorcycle Maintenance (1974), in which he uses the metaphor of fixing and maintaining his motorcycle (a complex problem) to convey the idea that one is well advised to adopt a certain attitude toward life’s inevitable challenges, a stance that expects life to serve up problems—that we need not be paralyzed by them; rather, that we can view them as problems amenable to solution.

Would I design therapy as conjoint or individual? I don’t believe the research literature is a sufficient guide. But if the couples therapy she has been in for several months has been at all useful—and in the case of this kind of patient, “useful” can mean little more than her not killing herself or otherwise acting in self-destructive and socially aversive ways—then I would be inclined to keep the husband involved in her treatment. In fact, I would think that it would be necessary to teach him how to deal with his wife’s thin-skinned nature and to provide the kind of support and acceptance that the therapist tries to provide in those few hours each week that he or she is in direct contact with an outpatient. The fact that Katrina has complained that her husband has raped and physically abused her also supports the notion that he should be involved in the therapy.

A Comment on the Patient’s History of Sexual/Physical Abuse

The issue of the patient’s recollections of sexual and physical abuse by her father must be examined. From the case material I see the very real possibility that the patient’s memories are not veridical, to wit: “... it was only in recent years that Katrina began to infer that she have been [emphasis added] sexually abused by [her father] because of ‘impulsive and dangerous behaviors’ she engaged in.” The report goes on to say that her various clinical records contain inconsistencies in the time and nature of the alleged abuse incidents. One is struck by the statement that her father’s abuse of her continued until a month into her marriage, which means that he has allegedly been abusing her for perhaps 20 years, from childhood until adulthood, including during a time when she was living with another adult. While this pattern and extensiveness of abuse are not impossible, I believe they are very rare.

Whose inference is it that she was abused as a child? Is it possible that one or more of her previous therapists led her to believe that she had been abused, based on their own theoretical or political beliefs in childhood abuse as a key etiological factor in a range of adult mental disorders, especially BPD? Did a previous therapist assume that someone with a pattern characteristic of BPD must have been sexually abused as a child? This is not a comfortable question to pose, but I believe it is important to do so, especially when the alleged offender is still alive, as is the case with Katrina.

We have all read about the lawsuits, the court trials, and the broken lives occasioned by the alleged uncovering of repressed memories of child abuse (Lazo, 1995). The problem, of course, is making an accurate appraisal of a given situation: Did or did not abuse occur in Katrina’s childhood? When inferences are made on the basis of theory and, perhaps, also personal, politically driven biases, we, as clinical scientists and practitioners, have reason to worry. The way this case is written up, I am worried. Take note of the observation that the patient’s father had recently become a “distinguished community leader.” Does this make his alleged status as a child molester of his own daughter more or less likely? Are we to assume, a la psychoanalytic theory, that the father has tried to compensate for or expiate his guilt about having molested his daughter by throwing himself into selfless community activities? This is a very slippery slope.

That Katrina’s psychological state worsened when she began “intensive outpatient therapy that focused on exploring issues related to abuse” does not necessarily mean that these memories are veridical. I should think that anyone who comes to believe that her father sexually molested and beat her and who is encouraged by her therapist to talk about these (putative) past events would become psychologically unhinged.

Note, I am not saying that Katrina was definitely not sexually or physically abused as a child. I am suggesting only that the presence of this finding in her clinical records be dealt with cautiously and with scientific skepticism.

Furthermore, we know that a characteristic of post-traumatic stress disorder is intrusive and frequent memo-
ries of the past traumatizing events (American Psychiatric Association, 1994). So sometimes people cannot forget their traumas. Coupled with what we know about the constructive nature of human memory — we do not record our memories the way a camera takes a picture (Bransford & Johnson, 1973) — there is reason to be wary of according validity to all reports by patients of having been sexually abused. Social scientists as well as the legal system share a heavy responsibility in deciding whether a given recovered memory of abuse is a reflection of an actual (and criminal) event. Erring in either direction creates an injustice for either the accused or the accuser.

References

Address correspondence to Gerald C. Davison, Ph.D., Department of Psychology, University of Southern California, Los Angeles, CA 90089-1061; e-mail: gdaviso@rcf.usc.edu

Received: August 25, 1999
Accepted: September 30, 1999

Response Paper
Radical Behavioral Help for Katrina

Robert J. Kohlenberg, University of Washington
Mavis Tsai, Independent Practice, Seattle, Washington

Our treatment plan for Katrina is guided by the principles of functional analytic psychotherapy (FAP; Kohlenberg & Tsai, 1991), an approach derived from radical behaviorism. The fundamental assumption is that we and our clients act the way we do because of the contingencies of reinforcement we have experienced in past relationships. It then follows that clinical improvements, which are acts of the client, also involve contingencies of reinforcement that occur in the relationship between the client and therapist. Thus, our treatment of Katrina emphasizes the use of the client-therapist interaction as an in-vivo learning opportunity. It is for this reason that FAP views a caring, genuine, sensitive, and emotional client-therapist relationship as the most important element in the change process. We describe a FAP case conceptualization form designed to help the therapist achieve a curative therapeutic relationship. Our case conceptualization of Katrina involves an account of how Katrina’s history resulted in her current daily life problems, identification of Katrina’s cognitive phenomena that might be related to her current problems, and most importantly the prediction of how Katrina’s clinically relevant behavior—daily life problems, dysfunctional thinking, and improvements—might occur during the session within our therapist-client relationship.

Our comments about this case are from the perspective of practicing radical behavioral clinicians. The theory that guides our clinical work is deceptively simple. It is that we and our clients act the way we do because of the contingencies of reinforcement we experienced in past relationships. Biological variables such as genetic predispositions are also influential, but since these givens cannot be changed, our emphasis in treatment is on contingencies of reinforcement. These contingencies are current and are always happening during the give and take of treatment—whenever we interact with our clients. Based on this theory, clinical improvements, healing, or psychotherapeutic change, all of which are acts of the client, also involve contingencies of reinforcement that occur in the relationship between the client and therapist. The treatment based on these principles is called functional analytic psychotherapy (FAP; Kohlenberg & Tsai, 1991), and stems from the functional analysis described by B. E Skinner. In contrast to popular misconceptions about...