

Yalom describes  
problem patients as  
eight different  
subsets



**ASSIGN  
BUSTER**

The boring patient, the help-rejecting complainer, the monopolist, the psychotic patient, the silent patient, the narcissistic patient, the schizoid patient, and the borderline patient (Yalom, 1995). Yalom notes that a non-problematic patient is practically nonexistent. Typically, individuals who seek therapy have some sort type of personality defect or long standing affectual issue. These problem patient are all unique type individuals whom each have their own personal issues that a therapist must contend with. While some of these patients are confrontational, others are just difficult to make progress with. Regardless of the kind of problem patient a therapist is involved with, the experience gained over time is seemingly the best asset one can have.

The boring patient is ostensibly a name you would not directly use in front of patients. However, it does capture the overall picture of the behavior (or lack of) of these individuals. These patients are usually introverted, but at an even deeper level, they are void of an ability engage in pleasurable social intercourse. These patients comment that they have very little to say and are generally stay secluded during social events (Yalom, 1995). An example of this type of individual would be the one who answers in very short phrases, such as “ Yes, No, I’m good, or it was fine.” These responses are not necessarily due to apathy or disobedience, like some other problem patients, but due to a genuine lack of ability to socially interact or a lack of life experiences to reflect and comment on. While this is seemingly not a grave issue, Yalom suggests that this dilemma be taken seriously.

As described by Yalom, the help-rejecting complainer is also called the “ yes, but” patient (Yalom, 1995). Meaning, these patients persistently raise many personal issues and then reject solutions that are presented by the group.

<https://assignbuster.com/yalom-describes-problem-patients-as-eight-different-subsets/>

For example, a group member may say “ Well, when I had that problem I did this.” However, the help-rejecting complainer would respond, “ Well my problem is more severe than yours, so that will not work.” Seemingly, these patients relay their issues as impossibly difficult to solve. They relish in their own misery; they feed on others attempts to help them just so they can shut them down.

In a certain way, they are similar to the narcissistic patient since they both desire attention. However, the narcissistic patient generally is signified by how they adore themselves to the point of excluding others from consideration (Yalom, 1995). They see the world around them as their audience and they have plenty of ego to give out. Others’ problems are insignificant when the narcissistic patient has an issue they need to address. The reality is that the narcissistic patient can be very difficult to work with on an individual basis due to their enjoyment of the focused dyadic interchange that takes place private therapy. Although, the narcissistic patient is not necessarily easy to work with in a group setting either. They could be a silent narcissist who sits with their own grandiose belief that they are better than anyone else in the group. Once again, in either the silent or narcissistic patient, these issues need to be addressed before it impacts the group’s overall ability to progress.

The monopolist-type patient can be simply described as irritating. These patients do not have the skills to sit quietly with their thoughts (Yalom, 1995). Similar to the narcissistic or complaining patient, these individuals also seek attention, but they are even more interested in inserting

themselves into everyone’s business. Their view of the world is not  
<https://assignbuster.com/yalom-describes-problem-patients-as-eight-different-subsets/>

simplistic, therefore they project their interpretation of the world into others. They tend to speak in a pseudo-manic manner with obsessive detail. The problematic nature of these individuals is how their anecdotes and resolutions go into great lengths which removes the ability for others to explore their issues. Generally, all patients are encouraged to speak up in the group (Yalom, 1995). Therefore, these patient's repeated disruptions add a paradoxical problem for the therapist.

Depicted as the opposite of the monopolist (Yalom, 1995), the silent patient is an unexpectedly difficulty. They are observably quiet and withdrawn, with no apparent interest in participating. They may appear to be shy, however, there are usually other reasons these individuals are uninvolved. Silent patients may be scared of judgment, or may be so highly self critical that they are concerned that they will not speak in the way the meant to. A silent patient may be scared of a certain individual or so overwhelmed by their emotions that they are too anxious to speak (Yalom, 1995).

Similarly, the schizoid patients are withdrawn and quiet. They can appear as superficially emotionless and/or currently be repressing internal affect. Yalom notes these patients as having a “ central disturbance in the recognition, desomatization, and management of emotions” (Yalom, 1995, p. 391). Schizoid patients may not feel emotions in the same way as others and, at times, may not feel any empathy at all. They view other patient's emotions as excessive and illogical; they often wonder why people worry about issues they do not have control over. These individuals are difficult to break open and disclose their inner feelings – may not because they don't want to, but possibly because they do not know how.

<https://assignbuster.com/yalom-describes-problem-patients-as-eight-different-subsets/>

While many psychotic patients require extra social skills training and support, the difficulty in providing these resources are, well, because the patients are psychotic. On the extreme side of the spectrum, severely paranoid or actively hallucinating patients are practically impossible to engage in a therapeutic manner. Even when medicated correctly, these patients are still problematic due to the latent psychotic processes. Though, the concern of a paranoid group think situation is also a circumstance that a group therapist should be prepared for. However, it is thought that in a well-regulated and stable group, a psychotic patient can hopefully rely on the others members to support him or her in progressing through their issues.

The final type of patient is the one I consider to be the most problematic in terms of treating (whether in group or otherwise) is the borderline patient. A borderline patient can have a great deal of insight and intellect, and even appear in control of their behaviors at times, but by definition, they are emotional volatile. Incredibly defensive of any criticism and suspicious of others intentions, borderline individuals require a great deal of time and trust building before effective treatment can begin. They have a elevated fear of abandonment - so that when they are finally able to trust a therapist, when any gap in treatment or expectations occur, their anxiety sky-rockets which can lead to a pseudo-psychotic episode (Yalom, 1995). Furthermore, they are also very critical of themselves and others.

Subsequently, if a fault on either end is found, a deluge of overt emotional and self-destructive behavior can follow suit. Due to the high level of instability, progress is slow and relapses are common-place. While it has been thought that group therapy with borderline patients can be more

<https://assignbuster.com/yalom-describes-problem-patients-as-eight-different-subsets/>

effective than individual therapy (Yalom, 1995), multiple borderline patients within a group can be a recipe for a rebellion aimed towards the therapist. Personally, I find these factors to be the most difficult for me to adjust to. Slow (if any) progress, relapses, and a possible patient revolution are concerns of most therapists. I am concerned that if these issues occur when I am a therapist, I will feel as if I have somehow failed at doing my job – even when these problems are expected. In addition, a common fear that I have is making a major error in judgment or logic in front of a patient. I feel that most patients would be understanding that I am just a human who is a psychologist, not an individual with all the answers.

However, I think that a borderline individual would portray my errors as the scapegoat for some of their issues. As if I have somehow made this patient only worse by being their therapist. Though, I do think over time I will become comfortable with not being perfect (although my slightly narcissistic ego has an issue with this). In a group setting, I fear that some borderline individuals will take the opportunity to undermine other group member's needs. Their personalities may consume the time and dispensation of a group's therapeutic processes, comparable to the monopolist patient. Having to be gently confrontational to these individuals in front of other patients also adds to the concern of being undermined as a therapist. With all these issues, in addition to a increased likelihood of dropping out, I consider the borderline patient the most difficult to work with.

2.

Yalom's views death, freedom, isolation, and meaninglessness as the fundamental life concerns in an individual's psyche. Specifically, how an individual decides to confront these parts of life is what comprises the content of the "existential dynamic conflict" (Yalom, 1980, p. 14). Yalom's existential approach is based on how every individual has significantly different views of life experiences. Simultaneously, there are reoccurring themes in life that we all have to face. Everyone knows what death, freedom, isolation, and meaninglessness mean in the objective manner, but objectivity is not the key of Yalom's existential approach. The main tenant of this approach is subjectivity – how we each, as separate human beings, experience and face the world around us. This existential design highlights each person's internal conflicts as they recognize and perceive it.

Within the existential approach of Yalom, I see the theme of personal perspective. From your perspective you may consider pomegranates as the ultimate snack. However, I may view pomegranates as the most vile of all seeded fruits. While we may disagree, either viewpoint may be objectively proved valid. However, explaining the reasoning behind our viewpoint is an essential part of reducing conflict. In the video by Yalom (2000), a group member (let's call him Bob) comments that he felt judged by Alice when she looked at him. Another group member (Allan) defends Alice by noting that he did not feel that this judgment occurred. Yalom redirects the group's topic to Alice and asks her, "How are you feeling about this Alice? Let's check that out." This example shows the importance of an individual's perspective on an issue. Bob felt a certain way that was causing conflict between her and Alice. He explained how he felt, and so Yalom made sure to recognize that

she has her own point of view that needs to be disclosed so that this situation can be subjectively understood from both perspectives.

Yalom views on the ultimate concerns is similar to the premise of a personally accepted truth. This means that accepting a personal truth requires a struggle to internalize your own beliefs. A truth must penetrate into your mind and involve itself into your life. However, these truths can be hindered by the need for interpersonal acceptance and approval (Yalom, 1980). What this comes down to is the knowledge that you can trust another person – that they understand where you are coming from. In the same video, at a certain point, Yalom steers the conversation back to what Bob has previously said about his gay experience when he was younger. Yalom notes that Bob's private admission may have been a "gift" to Allan. Allan responds that he was not aware of this gift. After a brief discussion, Allan eventually thanks Bob for his contribution and also thanks the group for their support.

Initially, when I viewed this excerpt, I thought that Yalom was going to try and discuss Bob's previous homosexual experience. Instead, Yalom points out to Allen that Bob was lending his trust to him, and that this trust was a gift. The real subject of this topic was the resistance of Allan to accept the personally accepted truth of Bob's gift. Overall, Yalom was again trying to emphasize the importance of another's perspective and the basic idea of you don't know what it's like until you imagine yourself in the other person's shoes.

3.



Dialectical behavior therapy (DBT) is a considered a cognitive-behavioral treatment for individuals with mental disorders who are problematic to treat. Originally, DBT was developed for long term suicidal individuals, then DBT was used as a treatment for individuals with borderline personality disorder (Linehan & Dimeff, 2001). Now, DBT has expanded to a wide range of different treatment approaches for many mental disorders. DBT was created on the construct that some individuals are severely lacking in coping skills, motivation, and also have interpersonal, personal, and environmental factors that interfere with the reduction of dysfunctional behaviors. Specifically, individuals with BPD are practically absent in the ability to self regulate emotion and deal with distress.

As a result, DBT is a expansive treatment approach that engages an individual in several important aspects. Dr. Linehan, the founder of DBT, specified 5 different utilities DBT is attempting to insert into individuals: to increase the ability to control behaviors, to motivate individuals to change in a positive direction, to create a treatment environment that both supports the client and the therapist, to maintain these changes in different life settings, and to find ways to improve a therapist's ability to treat individuals in an efficient manner (Linehan & Dimeff, 2001). All of these functions are meant to be used in DBT's multi-modal approach including individual therapy, group and individual consultation, and group skills training. From the clients' point of view, it can be said that the therapist isn't judging them, evaluating them, or trying to "figure out how their mind works". In other words, the focal point of the DBT approach is that the therapist and group is listening, reflecting, and supporting the client with a type of unconditional

positive regard. The therapist places a significant emphasis on the client's current and possible future experiences over the influence of previous ones.

In DBT, the group is where an environment of acceptance is created and specific skills are learned. The group's process involves a validation of the individuals feelings as real, while the therapist and the group provide an environment that accept who they are (Linehan & Dimeff, 2001). This is done by non-judgmentally support of the individual, which may be an unexpected occurrence for the client. Simultaneously, while there is acceptance, there is also a subtle expectation of change that is nudged in. The change strategies within DBT include: behavioral examination of negative behaviors, skills training, management of distressing situations, and exposure based methods (Linehan & Dimeff, 2001). These acceptance methods are meshed with the use of mindfulness.

The use of mindfulness can have a huge positive effect on the therapeutic process. Once the client is open and present in their own emotions and is able to see and trust the sentiments of the therapist, a meaningful dialogue can begin. The client can examine their behaviors with reduced affect. This leads to more proficient insights and better treatment outcomes. Teaching mindfulness within the group may aid clients in identifying their emotions, feeling their emotions without emotional lability, and sharing their experience with their group. By using mindfulness, the client is able to encompass all these personal revelations in a more positive light. However, it is important to note that for an efficient therapeutic environment, a proper therapeutic alliance is required. Both the client and therapist need to view the therapy as significant, positive, and relevant to the agreed upon goal.

<https://assignbuster.com/yalom-describes-problem-patients-as-eight-different-subsets/>

DBT and Yalom existential psychotherapy do have some similarities in their approach to the group therapy model. They both have an aspect of emphasizing an individual's emotional experience as real and relevant. They both examine how behaviors can effect others. However, there are some fundamental differences between the two. Their conceptualization of conflict and their formulated solutions take diverse steps. In the initial example from the video, when Allan came to defense of Alice due to Bob's attack, I feel Linehan would have taken a different approach to dealing with the situation. Instead of redirecting the conversation to how Alice perceived the conflict, a DBT therapist would have accepted pushed for the acceptance of the emotion each person was feeling. I feel that if Yalom attempted to rationalize an individual's behavior to another group member may not have worked out so well in a group of clients with BPD. As a side note, the existential concepts of death, meaninglessness, and isolation probably would not be the best topics in mind for a DBT group.

Yalom has a stronger emphasis in challenging the behaviors and misconstructions of group members. Concurrently, Yalom's approach does not give into the idea that the relationship between patient and therapist requires a deep and meaningful trust to be effective. Instead, Yalom views the therapist's place in the group as the clinical investigator who analyzes the rationale behind the conflict that is occurring (Yalom, 1980). Similar to the psychodynamic model, Yalom consider the past as relevant while DBT looks towards dealing the present and future. Both forms of therapy have their place in the group therapist's arsenal. I learned long ago that you cannot be stubborn in your methodology as a therapist. Every method has

an effective side and yet has an area where it may not be useful. As a side note, this is what I love about this program at Midwestern - the ability and desire to approach psychological issues with multiple perspectives. Those California schools just don't seem to understand that.