CASE CONFERENCE

Anna: A 26-Year-Old Woman With Major Depression and Borderline Personality Disorder

Willem Kuyken, University of Pennsylvania School of Medicine

This issue of Cognitive and Behavioral Practice presents a case conference of Anna, a 26-year-old woman with major depression and borderline personality disorder. The format for this case conference is the description of the assessment of Anna's presenting problems (this paper) and a series of response papers written by cognitive-behavioral therapists from a variety of clinical-theoretical perspectives.

This case conference presents the challenging case of Anna and invites psychologists with a range of cognitive-behavioral perspectives to conceptualize Anna's presenting problems and respond to the particular challenges she brought to therapy. The purpose is to consider a case that illustrates the challenges of working with people who suffer from major depression and personality disorders and try to understand and intervene using one of several cognitive-behavioral perspectives. It is hoped that this will provide a forum in which to overview the cognitive-behavioral theory, clinical experience, and clinical research in the area of depression and personality disorders. The response papers consider the case from a traditional cognitive therapy perspective adapted for people with personality disorders (Beck, Freeman, & Associates, 1990; Fossel & Wright, 1999), dialectical behavior therapy (Linehan, 1993; Robins, 1999), a schema-focused cognitive therapy perspective (Ratto & Capitano, 1999; Young, 1994), constructivist cognitive therapy (Ramsey, 1999), and a developmental psychopathology perspective (Kuyken, 1999).

Willem Kuyken saw Anna for therapy. The therapy and outcome are described in the second paper by Kuyken (1999). The closing paper reviews the issue as a whole, approaching the case from a pragmatic cognitive therapy perspective to offer guidelines for working with the particular challenges presented by people with personality disorders (Newman, 1999). Participants were asked to (a) conceptualize Anna's presenting problems, (b) outline their treatment plan, (c) anticipate the likely stages of therapy, (d) conceptualize and suggest ways of addressing three problems that arose during therapy, and (e) predict the likely outcome. With this outline in mind, the authors read the following case description and then wrote their response papers.

Cognitive and Behavioral Practice 6, 50–53, 1999
1077-7229/99/50–53/$1.00/0
Copyright © 1999 by Association for Advancement of Behavior Therapy. All rights of reproduction in any form reserved.
just could not adjust, I just could not cope.” She could not identify any specific situational triggers to the onset of her problems. However, one night she had been unable to sleep and sat in the bathroom staring at her husband’s razor blades thinking about cutting her wrists. Several times in the previous days she had thought about deliberately driving her car into a wall or into oncoming traffic. The client explained that the only deterrent had been thinking about her husband and children. After she told her husband about these thoughts and impulses, he contacted a psychiatrist and arranged for an appointment the next day. The psychiatrist prescribed Zoloft and an anxiolytic medication (Klonopin PRN) and referred Anna for therapy.

Anna said that her difficulties had significantly affected her both socially and occupationally. She reported that she was no longer the amiable and open person that she typically had been. Instead, she found herself being unfriendly to colleagues and irritable at home. Anna had taken several days sick leave from work, stating vaguely that she could not “face it.” She said that her husband had become concerned when she disclosed her suicidal thoughts.

Anna said that she had “coped” with difficult life events in the past by escaping the situation (e.g., changing jobs), keeping busy at home, or by working toward “something positive.” She blandly noted that she did not feel emotionally supported by friends or family. Anna described considerable hopelessness, which had made her current difficulties more difficult to manage.

Anna feared she would be stigmatized if she discussed her personal problems with people in her community. She said that within her community there was a need to present a highly functioning public face. Anna feared that people would label her as mentally ill if they knew about her need for treatment. This had also prevented her from talking to her family about her difficulties. She said, “I always try to make it seem to my parents that everything is perfect. They seem so negative and would otherwise focus on the negative.” Anna went on to say, “I almost wish that I had a physical illness so that I could talk to people.” Consequently, she felt lonely and “desperate to talk to somebody.” Besides her husband, she had told no one about her difficulties, and had continued to convey a high-functioning public façade.

**Current Life Situation**

Anna lived with her husband and two children. She described no particular problems with her living arrangement, although she noted that she liked to be in total control of the children’s schedules and the household chores. Anna’s husband was a lawyer in a prestigious firm. She denied any marital difficulties, although she explained that he worked long hours and was rarely home. On further questioning, Anna disclosed considerable loneliness and irritation with her husband. Most significantly, often after marital conflict she would become angry and distant and retire to another room where she would self-harm. She was able to recognize that the anger was out of proportion to the situation, but found that her reactions tended to be intense and immediate. A functional analysis of several such episodes suggested cognitive triggers such as “He doesn’t understand,” “He is so thoughtless,” “I can’t tell him what I think and feel, and even if I did, he would say something stupid.” Consequently, she would become intensely angry and frustrated and find it difficult to manage her feelings. She stated that self-harming enabled her to relieve feelings of frustration.

Anna had two young children (ages 2 and 1). She said that her children gave her much pleasure, although in the last few months she had found interacting with them more stressful than pleasurable. Anna had regular contact with her parents but felt unable to talk to them openly about her struggles. Anna’s account suggested that her husband and parents did not always get along. Consequently, Anna worried that if she talked to her parents they would blame her husband.

Anna reported that she had many social ties in her neighborhood through her religious community and through running a small business the previous summer. Indeed, her account suggested that she had a high profile in her community, although she described these relationships as “completely superficial.” Her family was religious and attended religious services each week. She had a close friend from high school with whom she spoke regularly on the telephone. Her two older sisters had moved abroad, and she kept in contact with them via the telephone.

Anna had two part-time jobs. She did not enjoy her work because of a perceived incompetence and lack of commitment to her chosen career. Her account was suggestive of a resentment that she had pursued a “second-choice career” and that she held her family of origin at fault for not supporting her in her first career choice. She said that she had always wanted to start her own business because she enjoyed organizing and working toward goals.

Anna described herself as “friendly,” “open,” “sweet,” and “fun” in public, but that her private side is of someone who likes routines, schedules, and can be “uptight” and “irritable.” She added, “I have an I-can-do-it-all complex.”

**History**

**Family and Social History**

Anna was born in the Midwest, and her family moved several times during her childhood. Anna described her
mother (aged 54, a teacher) as supportive and their relationship as close: “I told her everything growing up.” However, she described her mother as overly involved, particularly at times of crisis. At other times Anna thought that her mother had overemphasized independence. Anna described her father (aged 56, a consultant) as “difficult to live with,” “irritable,” “uptight,” and “obsessional about time and details.” She said that he tended to be “controlling” and allowed no room for discussion or responses to his demands. Anna said that when she was 7 her father had a “nervous breakdown” and was hospitalized. The family did not openly discuss this, but she recalled seeing tablets (“lithium, I think”) in his medicine cabinet. Anna said that throughout childhood her father would playfully make fun of her and, as part of a game, would say, “You’re dumb” or “You’re ugly.” While aware that he intended these statements playfully, Anna said that she recalled taking them to heart. Anna denied any childhood or adult sexual or physical abuse.

The client reported that her parents argued a lot, and they discussed divorce, sometimes with the children. Anna was the third of three sisters (ages 34 and 32). She remembered that she was jealous of her older sisters and that they sometimes “picked on” her. She described one older sister as a rebel and the only child who “stood up to” their father.

Throughout school and high school Anna said that she had achieved good to excellent grades. However, Anna revealed that in elementary school she had felt “like the dumbest.” She said that her experience of feeling overwhelmed by schoolwork led to anxiety and frustration, which in turn led to self-harming (biting). She attended a boarding school between the ages of 13 and 17. In high school Anna dated someone for 3 years (10th to 12th grade), and this relationship had been serious. However, the relationship ended acrimoniously when her boyfriend became romantically involved with one of Anna’s friends. She described a considerable animosity toward her friend, but not her ex-boyfriend.

In college, Anna changed her major from business studies to a vocational degree in health care because she was experiencing significant academic difficulties, felt unable to manage, and was experiencing “anxiety attacks.” She said that she had always regretted this decision as she did not value or enjoy working in her health care specialty. She also expressed disappointment that no one had encouraged her to persist with business studies. After graduating, she worked in schools, which she found undemanding and unrewarding.

Anna married 6 years ago while she was still in college. However, soon after getting married, her husband was diagnosed with a potentially serious health problem. Although the health problem was successfully treated, it influenced their decision to have two children earlier than previously planned. Anna reported features of postpartum depression after her second child, lasting approximately 2 months. However, she attributed this to the fact that her husband was working as a junior lawyer at the time and she was alone in hospital for 2 days after the birth, as well as when she returned home.

Two years previously, Anna and her family moved to their current home. She initially sought work in her specialty, but was unable to secure a position. She then looked for employment in a related specialty. Following that she set up and ran a small business. She said that this was successful and gave her great satisfaction: Anna remarked, without a trace of irony, “Life was perfect.” She said that throughout the summer she was very happy and for the first time in her life, “I felt very good about myself.” She added that during this period several people had remarked on her energy, and her mother-in-law had expressed concern about her energy and some weight loss. Anna denied any other features of mania or hypomania.

**Psychiatric History**

Anna believed that she had had no major psychiatric or psychological problems until several months before the assessment. Her psychiatrist had prescribed Zoloft and Klonopin, and Anna had found these medications helpful, attributing her initial improvements to the medication. She said that since starting the medications she had continued to have thoughts about death as an end to her suffering, but had no further suicidal impulses. In her family Anna noted that her father had been diagnosed with bipolar disorder, and her paternal grandfather suffered from major depression.

**Observations and Mental Status**

Anna was distressed and tearful during the early part of the assessment interview, and she reported that she had been too distressed to complete the inventories that had been mailed to her in advance of her initial assessment. She appeared calmer and less distressed as our meeting progressed. Anna’s dress suggested good self-care and meticulous attention to detail. Indeed, there was dissonance between her good self-care and the nature and severity of her affect. She was cooperative and willingly gave a full account of her difficulties. Though her distress could be intense, the client’s account tended to be nondescript, impeding a precise assessment and suggesting limited insight. Anna’s thought processes were intact, and there was no evidence of hallucinations or delusions. Her intellectual level appeared to be in the significantly above-average range.

**Standardized Assessments**

Anna’s scores on the Beck Depression Inventory (Beck & Steer, 1987), Beck Anxiety Inventory (Beck & Steer, 1990)
Anna’s scores on the Minnesota Multiphasic Personality Inventory-2 (Graham, 1993) suggested a valid profile and a balance between self-disclosure and self-protection. There was some suggestion, however, of a possible good impression bias. In terms of the clinical scales, Anna’s profile of scores was in the subclinical range (no spike above T score of 65). Anna’s only spiked score on a clinical scale (one standard deviation above the normative sample mean) was on the social introversion scale, suggesting insecurity and discomfort in social situations. In terms of supplementary scales, Anna’s scores were significantly elevated on the following scales: social avoidance, narcissism (easily hurt), somatization, and social introversion.

Provisional Diagnostic Impressions (Diagnostic and Statistical Manual of Mental Disorders; American Psychological Association, 1994)

The following diagnoses were based on the assessment and consultation with the psychiatrist who had also assessed Anna. The Axis-II diagnostic impression was given on the basis of: (a) identity disturbance, (b) suicidal threats and self-harming, (c) affective instability due to a marked reactivity of mood, (d) chronic feelings of emptiness, and (e) inappropriate, intense anger.

Axis I: 296.23. Major Depressive Disorder, single episode, severe, without melancholic features.
Axis II: 301.83. Borderline Personality Disorder.
Axis III: None.
Axis IV: Problems with primary support group (little emotional support).
Problems related to the social environment (overwhelmed with taking care of two young children, in addition to two part-time jobs). Occupational problems (job dissatisfaction).
Axis V: GAF: (current) 65
GAF: (highest in last year) 90

Problems Arising During Therapy

Three problems arose during the course of therapy that required thoughtful conceptualization and cautious intervention. These are described briefly for each of the response papers.

Problem 1

In the first stage of therapy, Anna threatened suicide to her husband. Her husband then telephoned the therapist, leaving a voice-mail message in which he insisted that Anna be given electroconvulsive therapy (ECT) immediately. It emerged that after searching the internet, Anna’s husband had concluded that her depressive symptoms were completely biological and should be treated through aggressive physical interventions.

Problem 2

In the second stage of therapy, Anna declared her love for the therapist. She described this as being similar to the relationship she had had with her boyfriend in high school, and not an artefact of the therapeutic relationship.

Problem 3

In the final stage of therapy, Anna tended to become activated within session (tearful, angry, distant). Once activated, she found it difficult to leave the therapist’s office. However, she said that between sessions she tended to avoid therapy issues and homework. Anna stated on several occasions, “When I don’t think about it, I am fine,” and “When I come here I have to think about my problems and that makes it worse.”

References


This work was supported by the Center for Cognitive Therapy, University of Pennsylvania Medical School. I am grateful to Cory Newman, Halley Cohen, and Sarah DeMichele for their comments on an earlier draft of this paper. Correspondence concerning this article should be addressed to Willem Kuyken, Center for Cognitive Therapy, Department of Psychiatry, University of Pennsylvania, 3600 Market Street, Philadelphia, PA 19104-2648.

Received: November 5, 1998
Accepted: November 10, 1998