

Rowan University

Rowan Digital Works

Theses and Dissertations

5-1-2007

Effectiveness of a treatment approach for comorbid major depressive disorder and borderline personality disorder: a case study

Jo Anne Esfahani
Rowan University

Follow this and additional works at: <https://rdw.rowan.edu/etd>



Part of the [Counseling Psychology Commons](#)

Recommended Citation

Esfahani, Jo Anne, "Effectiveness of a treatment approach for comorbid major depressive disorder and borderline personality disorder: a case study" (2007). *Theses and Dissertations*. 783.
<https://rdw.rowan.edu/etd/783>

This Thesis is brought to you for free and open access by Rowan Digital Works. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of Rowan Digital Works. For more information, please contact graduateresearch@rowan.edu.

EFFECTIVENESS OF A TREATMENT APPROACH FOR COMORBID MAJOR
DEPRESSIVE DISORDER AND BORDERLINE PERSONALITY DISORDER: A
CASE STUDY

by
Jo Anne Esfahani

A Thesis

Submitted in partial fulfillment of the requirements of the
Masters of Arts Degree
of
The Graduate School
at
Rowan University
June 16, 2007

Approved by _____
Dr. Janet Cahill, Ph.D.

Date Approved 5/1/07

© 2007 Jo Anne Esfahani

ABSTRACT

Jo Anne Esfahani

EFFECTIVENESS OF A TREATMENT APPROACH FOR COMORBID MAJOR DEPRESSIVE DISORDER AND BORDERLINE PERSONALITY DISORDER: A CASE STUDY

2006/2007

Dr. Janet Cahill

Masters of Arts in Counseling Psychology

This case study evaluates the effectiveness of psychopharmacology and psychotherapy with a focus on Cognitive Behavioral Therapy in the treatment of an adult female diagnosed with Major Depressive Disorder and Comorbid Borderline Personality Disorder in a community based mental health agency. The client's psychosocial assessment is presented and the empirical treatment literature related to the client's diagnosis is reviewed. A variety of outcome measures were used. Results indicated the treatment was effective: the client experienced significant reduction in the severity of her symptoms. However, further treatment is needed to improve parenting skills, maintain healthy interpersonal relationships and to reduce residual symptoms of depression to prevent relapse. Comparison of the normative practices versus best practices is reviewed with a summary and suggestions for improvement of treatment.

ACKNOWLEDGEMENTS

A Master's thesis in psychology is a huge endeavor that can only be accomplished with the help and support of many people. I would like to thank my academic advisor, Dr. Cahill who displays a great commitment to the field of counseling psychology. She is able to model her knowledge of therapeutic techniques and teaches with patience, respect, humor and enthusiasm.

I would also like to thank the professors that provided me with a high quality of education in all areas of psychology which will guide me through my professional life. Dr. Haugh's persistence, determination and high expectations forced me to think critically and challenge and improve my standards. Dr. Maschler's knowledge of theory and technique of group therapy has influenced and improved my present professional work. Dr. Chapell's knowledge of social development demonstrated the importance of identifying the special needs of individuals in various stages of their lives. Dr. Perez-Rivera respectfully taught the importance of considering the diverse cultural needs of clients and its impact on therapy. Dr. Lo Mastro's expertise in the area of career development helped me to see that a thorough assessment includes a person's stage of career development.

In my professional career, I have had the opportunity to be clinically supervised by many experienced and empathetic clinicians in the field of mental health counseling. Their knowledge has impacted me in my professional career. They took their time to patiently share their experience and knowledge, modeling clinical skills, and teaching the importance of reflection and self care. My sincere

thanks go to Derry Holland, LCSW, Gail Bresnahan, LCSW, Michael Adornetto, LCSW, Frank Diak, PhD., and Charles Graham, LCSW.

Most importantly I would like to thank my family for their support, endless love, and encouragement, especially my parents who helped me through my recovery after a recent life threatening surgery which enabled me to return to school and complete this thesis.

My husband's strength and love knows no boundaries. He pushed me past my limits on days I thought I could not take another step. He also supported me emotionally, listening to my fears and concerns during my darkest hours. He is the driving force behind me returning to complete my degree.

My sister is my best friend and confidant. When my confidence was low, she took the time to help me see that I can complete any task if I take it one day at a time.

Finally, I want to thank my sons Michael and Adam, who are a great source of happiness, joy and pride. They keep me young and laughing. Thank you.

TABLE OF CONTENTS

Acknowledgements	ii
Chapter 1. Psychosocial Assessment	1
Chapter 2. Literature Review	36
Chapter 3. Normative Practice and Outcomes	67
Chapter 4. Normative Versus Best Practice	81
Chapter 5. Summary and Conclusions	84
References	87
Appendix. Informed Consent	92

Chapter 1: Psychosocial Assessment

Psychosocial Assessment

Name: Ms. Janeen Smith

Presenting Problem

Ms. Smith is a 23 year old African American, single parent female self referred for individual counseling, reportedly at the recommendation of her mother. At intake, Ms. Smith reported, "My mother tells me that I have been angry for the past 2 ½ years" since the birth of her son, "my mother says that I am moody and I yell at my son all the time." Ms Smith agrees with her mother's assessment, admitting that she had been experiencing mood swings for about 2 ½ years. Ms Smith reports daily bouts of sadness stating she cries, is unmotivated and is unable to feel happy about anything. Ms. Smith states she is "frustrated" and feels "stuck" in her situation. Ms. Smith attributes this fact to being financially unstable, unable to commit to her job, unable to continue her education and the fact that she has limited support raising her son. She reports waking up every morning "in a really bad mood". She is usually very tired because she has bouts of insomnia. She is either unable to sleep or she falls asleep only to wake up after an hour or two of sleep. At other times, she tends to sleep excessively, attributing this to being tired from the night before. Ms. Smith denies any prolonged periods of a decreased need for sleep. This is problematic because she is presently employed as a customer service representative and frequently

calls out of work. On the days she does go to work, her mornings are very stressful, getting son ready and driving him to day care, then spending the rest of the day working directly with customers while feeling agitated and tired. For the past two weeks, Ms. Smith has not been going to work due to a sprained foot. She states “my mother thinks I sprained my foot on purpose”. She is unsure if she agrees with this assessment. She did report that her boss had been giving her a hard time. Her boss recently questioned her change in mood and her poor attitude when dealing with customers. She responded by openly saying things about her boss to her co workers, like, “she is so phony”, “she thinks she knows everything.”

Since she has been out of work, Ms. Smith reports getting out of bed before her mother, Ms. Jackson, goes to work to dress herself and her son, Sammy, who has already been fed breakfast by her mother. After Ms. Jackson leaves for work, Ms. Smith admits to lying on the couch for the rest of the day, leaving Sammy to fend for himself, ignoring his requests for attention or something to eat. Although Ms. Smith recognizes this is neglectful, she lacks the motivation to attend to Sammy. This was not noticed by Ms. Jackson until Ms. Smith was hospitalized by the fifth session of treatment at the counseling center. She was hospitalized for severe depression with psychosis at a local hospital’s psychiatric unit for one week, (this hospitalization will be described in detail later in this assessment). Thereafter, Ms. Jackson made sure that she would randomly check on Ms. Smith to see if things were OK. She would not leave Ms. Smith and Sammy alone for too long. Ms. Jackson would ensure that Sammy was fed lunch daily. After Ms. Smith’s hospitalization, she agreed to attend the Agency’s parenting program. As a result, the Division of Youth and Family

Services (DYFS) was not notified because Ms. Smith and Sammy would be monitored weekly at the program.

Ms. Smith states that when she was working, Ms. Jackson and Sammy wanted her full attention when she returned home in the evening. Ms. Jackson complained that she should put Sammy to bed or in another room so they can talk. At the same time, Sammy wanted Ms. Smith to play with him. Ms. Smith felt torn between the two of them. This was reportedly the precipitant of daily arguments with Ms. Jackson. Ms. Smith states that when she attempts to put Sammy in another room or to bed, he cries and/or acts out. This reportedly agitates Ms. Jackson who tells her that she does not know how to raise her son. They argue, while Sammy attempts to get Ms. Smith's attention by screaming, throwing his toys, running around, or crying. This leaves Ms. Smith feeling "overwhelmed" and "trapped". Although Ms. Smith describes her mood as sad, with crying spells, she reports she mainly becomes angry and yells at Ms. Jackson and Sammy. Until her fifth session, Ms. Smith denied thoughts of suicide/homicide towards herself or others.

At first Ms. Smith reported that she was unable to move out due to financial constraints but later admits that she does not want to leave her mother alone in fear that something bad will happen to her while she was away. Ms. Smith fears that if she left Ms. Jackson alone, she may become sick and fears nobody will be there to help. She also reports feeling guilty about leaving Ms. Jackson since she did so much for her while she was growing up.

History of the Complaint

Ms. Smith reports experiencing bouts of depression since childhood but her symptoms would wax and wane over the years stating, "I just dealt with it". Anger, impulse control, substance abuse and promiscuity were reported to be an issue during adolescence. Ms Smith stated that in the past she attributed these behaviors to the fact that she was raped when she was seven years old. Ms. Smith believed that she was "stripped of her innocence" and frequently asked "why did this happen to me?" Now, however, she reports she believes her behaviors are the result of Ms. Jackson leaving her alone as a child and tends to minimize the rape, making excuses for the rapist's behaviors, "he would never have done this to me if he was not high."

She states that her angry outbursts are the result of an accumulation of a number of incidents that may happen over a period of time. She states that she usually does not react until she reaches her "boiling point". Once she reacts she cannot stop. When she is in this state she can not be comforted and has difficulty gaining composure. She works really hard to hide what she is truly feeling and to maintain control because she fears that she will lose Sammy to the system if she acts on her feelings.

Ms. Jackson has numerous medical problems such as diabetes, high blood pressure and unspecified cardiac problems. Ms. Jackson takes Prozac for depression. According to Ms. Smith, Ms. Jackson tends to exaggerate her symptoms when they occur and needs a lot of attention. Ms. Jackson works as a professor at a local community college. Although Ms. Jackson reportedly makes enough money to support the household, Ms. Smiths states she continuously complains about not being

able to pay the bills and needs financial help. This results in Ms. Smith feeling like she should be contributing financially to “earn her keep”.

Household Composition

Ms. Smith resides with her 46 year old mother, Ms. Jackson and her 2 year old son, Sammy in a private residence in Burlington County

Family of Origin:

Ms. Smith was raised by her biological mother. Her father, Joe Johnson, was absent most of her childhood because he was incarcerated when she was eight months old for raping and kidnapping a woman. Mr. Johnson got caught when someone heard the kidnapped woman in the trunk of his car and called the police. When Ms. Smith was 10 years old, Mr. Johnson was released from prison. At this time, Mr. Johnson remarried and resided with his new wife and their children, Ms. Smith’s half brother and two sisters. Ms. Smith has no relationship with Mr. Johnson because she states that shortly after he was released from prison she went to his home for a visit. While there, she witnessed Mr. Johnson beating his new wife and decided to break all ties with him and her paternal family.

During Ms. Smith’s childhood, she spent a lot of time alone because Ms. Jackson was always working. Ms. Jackson had a boyfriend, Mr. Jones, who was out of work and needed a place to stay. Mr. Jones resided with them and babysat for Ms. Smith daily. Ms. Smith states, “I trusted him”, “He was like a father to me”. Ms. Smith stated she really cared for Mr. Jones and enjoyed being with this man because

he took good care of her while her mother was away at work. When Ms. Smith was seven years old, Mr. Jones was babysitting while high on cocaine. Without warning, Mr. Jones raped Ms. Smith. She reports that Mr. Jones took her forcefully into the bedroom, laid on top of her and began fondling her. She states he began breathing heavily while staring wildly into her eyes. This eventually ended in full penetration. Ms. Smith states that she realized that he was high because his eyes were “weird” and he would not listen to her frequent cries to stop. Ms. Smith reports that this was very painful and it caused her to bleed. Shortly after the rape, she reports, quietly getting up, cleaning herself up, straightening up the bed, and throwing away her blood stained underwear. She did not tell anyone. Mr. Jones threatened that if she told anyone, he would kill her and her mother. When Ms. Smith’s mother returned home from work that night, Mr. Jones secretly waved a closed fist at Ms. Smith reminding her of his threat. Ms. Smith stated that, at the time, she made a conscious decision not to tell her mother. She feared her mother would kill this man and go to prison, “like my father”, and then “I would have no parents”. He never touched her again. About one year after this incident, her mother and Mr. Jones broke up and he moved out of the apartment. Thereafter, Ms. Smith was left alone for long periods of time without anyone to talk to, preparing her own meals and caring for herself until her mother would get home late at night. Ms. Jackson worked two jobs to help to pay the bills and was out of the house from early in the AM until after 6 PM most days. Although Ms. Smith had maternal family members, they were not involved with her and her mother when she was a child.

Ms. Smith's maternal grandmother, Ms. Hattie, presently resides in the same county and is a psychiatric nurse. Ms. Smith has a very strained relationship with her maternal grandmother. She refuses to talk with her or spend time with her on a regular basis. Ms. Smith recalls how unsupportive Ms. Hattie was during her childhood when her mother struggled financially and was never offered help. When Ms. Smith was 11 years old, she and her mother relocated from an economically deprived area of Washington, D.C. to reside with Ms. Hattie in New Jersey. Ms. Hattie would constantly verbalize how Ms. Smith and her mother are disrupting her life. Ms. Smith told a story about Ms. Hattie to explain how she feels about her. She stated that when she and Ms. Jackson first moved in with Ms. Hattie, Ms. Smith got a dog. Two weeks later and without warning, Ms. Hattie gave her dog away, stating the dog made too much of a mess in the house. Ms. Smith and Ms. Jackson resided with Ms. Hattie for five years until Ms. Jackson got a Master's Degree in English and became gainfully employed at a local community college, enabling them to move into their own home.

Ms. Smith's maternal uncle, Mr. Talley resides in the area. Ms. Smith has a very strained relationship with Mr. Talley and tends to keep a safe distance from him. He has been diagnosed with Bipolar disorder and refuses to take medications. He is usually at family functions and often times displays irrational and aggressive behaviors. Ms. Smith reports that one summer she was the target of Mr. Talley's behaviors. Ms. Smith described an incident where her uncle got upset with her while the family was swimming in her grandmother's pool. Mr. Talley reportedly became angry and a verbal argument turned into a physical altercation. Ms. Smith stated that

Mr. Talley held her face down in the water, attempting to drown her. After freeing herself from him, Ms. Smith grabbed her son and while still wet, abruptly left the family function. Mr. Talley never apologized for this incident and all family members ignored his behavior because they know that he is mentally ill.

Ms. Smith's maternal grandfather is an alcoholic and her maternal uncle holds a diagnosis of bipolar disorder and substance abuse. She presently has a very strained relationship with all of her maternal family members. Ms. Smith feels that they are "all phony" because they did not help her or her mother when she was a child. She does however, use them when she needs a babysitter or if she needs to purchase large items such as her son's bedroom suite, which she cannot afford.

Ms. Smith states that when she was a child, her maternal grandfather would occasionally baby sit for her while mother and grandmother were out working. Ms. Smith described an incident when she was about 12 years old and her grandfather took her for a walk in Philadelphia. He stopped at many local bars while she waited outside alone. Since he was drunk, they got separated while walking. She reports that she was lost in the middle of Philadelphia, left to find her way home. Although she eventually found her way home, she has never forgotten this incident.

At the age of 12 years, Ms. Smith reported experiencing "flashbacks" of the rape, in addition to feeling the same throbbing pain in her groin that she experienced at the time of the incident. Although she still did not tell Ms. Jackson, she was reportedly acting very strange, fearful of everything, crying and withdrawing from her friends and family. As a result, Ms. Jackson took her to counseling. She did not tell her mother or her therapist about the incident at the time. It was not until the age

of 16 years old that she decided to write Ms. Jackson a letter about what happened. She called her on the phone at work and read her the letter. Ms. Jackson immediately returned home and for days was upset, sitting in a dark room crying and staring. After about one week, Ms. Jackson went to therapy and began taking Prozac. Ms. Smith also went to a therapist but never reported this incident. She states she discontinued therapy after her therapist diagnosed her with anxiety disorder. Ms. Smith was never treated for the rape.

When asked how she was disciplined as a child, she describes Ms. Jackson as an authoritarian parent, mainly yelling when she was upset. Ms. Smith reports that she was well behaved as a child and never really needed to be disciplined. For the most part, Ms. Smith believes Ms. Jackson was not abusive but was neglectful, leaving her alone while she went to work. Ms. Smith does not blame her mother for leaving her alone with the man that raped her. Ms. Jackson reports that until two years ago, she was always working really hard and was very worried about not having enough money to support her family. Ms. Jackson admits that when came home at night, she would “rant and rave” about how hard she worked and that she never had enough money. This would be the topic of daily arguments. Ms. Jackson reports that recently, she has made a concerted effort to remain calm when she is home and not to yell all the time. Ms. Smith agrees that Ms. Jackson has changed but reports she can not forget some of the things Ms. Jackson said in the past. Ms Smith is always worried that her mother is thinking that she is a burden, even though she no longer expresses this.

Growing up, Ms. Smith did not experience any real structure during the work week. Ms. Smith would return home from school daily to an empty house. Most times, she would make something to eat, do her homework and stay home watching television. She did not go outside because it was a “rough” neighborhood. Ms. Jackson would return home late into the night and would go to bed. Ms. Smith reports that Ms. Jackson was always tired and complained a lot about having to work so hard, spending most of her evenings yelling about something. Ms. Smith always felt guilty about Ms Jackson having to work so hard and that there were times that her mother would not eat so Ms. Smith could eat. Although Ms. Smith reports she recognized that her mother had to work to pay the bills, she states she felt lonely and neglected.

Ms. Smith admits that she and her mother had good times together usually on weekends when Ms. Jackson was not working. They lived in a one bedroom apartment and when Ms. Jackson was home, they reportedly did everything together, “like Thelma and Louise” or “Mutt and Jeff”. Ms. Smith states that for years she had an imaginary friend which was a vision on her wall that looked like the “monopoly man”. She states that she would talk to him and he would talk back. Ms. Smith reports that her mother knew about this imaginary friend but was not concerned; in fact Ms. Smith states they would talk and laugh about this.

Current Relationships

In terms of her current relationships, Ms. Smith describes a very dependent relationship with her mother. She reports frequently wanting to move out of Ms. Jackson’s home but will not for fear that her mother may need her help. Ms. Smith

describes a scenario of what may happen to Ms. Jackson if she did not reside in the home. Ms. Smith stated that Ms. Jackson may wake up, feeling shaky because of her diabetes. Needing something to eat, Ms. Jackson would prepare oatmeal in a glass dish. During this preparation, the dish may fall and break and Ms. Jackson may pass out, falling on the glass dish, possibly severing her jugular vein. The next day, Ms. Smith would find Ms. Jackson in a pool of blood, really hurt or dead. As Ms. Smith reported this fabricated scenario, she was smiling with embarrassment because she realized that this was not very probable but states she can not help thinking the worse case scenario.

While concerned for Ms. Jackson, Ms. Smith reports a highly conflicted relationship with her mother. She believes Ms. Jackson is untrustworthy. Ms. Jackson reportedly agrees to provide support for her to go to school and become more independent; however, when Ms. Smith makes the commitment to go back to school, Ms. Jackson complains about babysitting or that there is not enough money to run the household. In fact, during the initial intake session, Ms. Jackson called Ms. Smith to inquire when she was coming home because Sammy was misbehaving.

It is noteworthy to state that some of Ms. Smith's reports of her mother contradict my face to face meeting with her. Ms. Jackson appeared to be a healthy and vibrant woman, very concerned about Ms. Smith and Sammy. In fact, Ms. Smith agreed to pay for Sammy's daycare expenses so Ms. Smith can have time home alone to work on her recovery. Ms. Jackson was able to provide insight about Ms. Smith's behaviors and her concern for Sammy. She identified a number of Ms. Smith's unhealthy behaviors that she believes needed to be addressed, including her lack of

motivation, her inability to complete tasks, like cleaning up her room or maintaining her physical appearance, her lack of patience and extreme agitation with frequent bouts of yelling and arguing. Ms. Smith denied any evidence of abuse or neglect by Ms. Smith towards Sammy. Ms. Jackson recommended that Ms. Smith seek counseling mostly out of concern for Sammy.

Drugs, Alcohol and Addictive Behavior:

Ms Smith reports that during her High School years, she had a lot of friends. She began “hanging out” with them and drinking. This began at the age of 14 years. At first she would drink to be “part of the crowd”. Later she drank alone. She reports that she would begin drinking in the morning before school. While at school, she would sip on a water bottle filled with one pint of Hennessey whiskey or Mad Dog. By the time she got home in the evening, she was usually drunk. She reports that she never got caught drinking in school. She admits that drinking was very much a part of her social life. She would go to parties on the weekends and drink until she was drunk and not return home until Monday morning in time for school. She states that during that time, she was also very promiscuous, sleeping with both men and woman. She also reports that some of her other behaviors included fighting and/or getting verbally aggressive with others, at times for no reason. She reports that she was given the title, “the protector” because she would fight her friend’s battles. She stated that her friends would tell her that they were mad at someone and she would argue with them or beat them up.

Ms. Jackson became aware of Ms. Smith's drinking after a she got caught having a wild party in Ms. Hattie's house, leaving the house a mess. She also stated that her friends stole some items from her grandmother's home. Ms. Hattie was very upset with Ms. Smith but she reports that she did not care. Ms. Jackson eventually became aware of her frequent drinking binges and asked her on numerous occasions to get help, without success. Ms Smith reports Ms. Jackson audio taped her while she was drunk. When Ms. Smith was sober, Ms. Jackson played it back for her. Ms. Smith states it was then, "I realized that I sounded like a drunk". This helped Ms. Smith stop drinking and reports she never drank to that extent again. Ms Smith also admits to using marijuana at the time, but denies using any other drugs. Ms. Smith reports that during High School she would use marijuana daily, about one to two blunts per day and up to four on weekends. Ms. Smith admits to recent use, which consists of a joint one time a month with her mother to relax or at parties if it is available. Ms. Smith denies using marijuana or alcohol to excess at this time and does not believe that she has a problem with alcohol or drugs. Ms. Smith never received treatment for this issue and was never involved with the law as a result of drug or alcohol use.

Ms. Smith reports in High School she was very promiscuous, having unprotected sex with both boys and girls. She recognized this was not good for her but she states she was unable to stop. Ms. Smith was considered the "life of the party" always ready to have fun. However, she did have three unwanted pregnancies and unprotected sex with unknown partners. She reported that this behavior began in 10th grade and continues to date.

She reports that she has “threesomes with friends”. On the night of the threesome, her friends call her up and tell her that they “got a room”. If she chooses, she will meet them knowing that the evening will end in an orgy. She usually does not know who is going to be waiting in “the room” and therefore does not know her sexual partners. She reports she knows that this behavior is risky because she can get pregnant, get a STD or just become involved with dangerous people, but she does not seem to be able to stop. She also admits that alcohol and marijuana is always involved with this behavior.

Ms. Smith reports that although she has sex with men and women, she is heterosexual. She reports that when her son’s father returns home from his incarceration, she will reside with him and continue a monogamous relationship with him. She reports that her son’s father is the first man that she really loved and when he comes back, she believes that things will be better. Having multiple sexual partners is something she does to pass the time.

Prior Efforts to Address the Problem:

Ms Smith reports she went to a psychiatrist at the age of nine years old for having episodes of unexplained crying and being fearful of being alone. She was reportedly prescribed Zoloft and took it for about 3 weeks, then stopped. Ms. Jackson did not insist that she continue with this medication. Ms. Smith was unable to provide the name of the doctor she was seeing, therefore no records could be sent for to verify this information.

In High School, Ms Smith reports experiencing flashbacks of the rape she sustained at the age of seven years old. As a result, Ms. Smith reports seeing a therapist briefly but after she was given a diagnosis of Anxiety Disorder, she discontinued treatment. Again, Ms. Smith was unable to provide the therapist's name; therefore, no records were obtained for this treatment.

It is noteworthy to state, that by the fifth session with this client, she went into crisis and was hospitalized by commitment at a local hospital in their psychiatric unit. Prior to her hospitalization, Ms. Smith had a routine psychiatric appointment with the counseling center's consulting psychiatrist. During the assessment, Ms. Smith reported passive suicidal and homicidal ideations towards herself and Sammy. Ms. Smith also verbalized bizarre and psychotic thoughts. Ms. Smith believed that her 2 year old son, Sammy, was actually older than two and should be acting more maturely. She was unable to understand that his behaviors were age appropriate and not a personal attack. She kept referring to Sammy as someone else, stating "so you think you are a big man with all those kids living across the street." She was referring to times when Sammy would pretend to live across the street and would state that he had been the father of the children who reside across the street. Ms. Smith could not differentiate what was pretend from what was real. She did not have an actual plan to harm herself or Sammy but had passive ideations that both of them would be "better off" if they were not here. The psychiatrist insisted that she go to the nearby screening and crisis unit where she was evaluated and committed to their mental health unit for a one week length of stay. While there, she was placed on three medications: Zoloft, an antidepressant for depression; Trileptal, an anticonvulsive

medication used off label as a mood stabilizer; and Trazadone for sleep. It is important to note, that she has already been prescribed Trileptal for migraine headaches therefore the medication remained as part of her regime with an increase in dosage. She was discharged with these medications and returned to the Individual Counseling Center for counseling sessions and medication maintenance. Ms. Smith was also referred to a Partial Care program for parents and children where she and Sammy attended together weekly to for parenting and social skills training. Ms. Smith discontinued this program after three weeks because she stated that she could not relate to the other parents since they were court ordered to treatment. However, after talking with the counselors, it was reported that Ms. Smith did not like the fact that she was confronted after disciplining Sammy inappropriately. She was seen yelling loudly in her Sammy's face. It was reported that Sammy was crying which agitated Ms. Smith all the more. When the counselors attempted to intercede, Ms. Smith became very upset and stated she was not returning. Since this is a voluntary program for Ms. Smith, she chose not to return.

Early Developmental Neurological History:

Ms. Smith reports that when she was born, she aspirated meconium, in-utero, and as a result sustained a heart attack and two strokes. This is by client report only and there was no way of validating this statement. Ms. Smith does not appear to be physically disabled and her memory and cognitive abilities appear to be intact. Ms. Smith graduated from High School. She was in regular classes. All developmental milestones were reportedly achieved in the appropriate time frames.

Medical and Psychiatric History:

Ms. Smith came to her first meeting stating that she had a sprained foot, something that happened at work and she was going to see an orthopedic doctor for the problem. Ms. Smith also reported having high blood pressure, two herniated disks in her back and migraine headaches. She reports that she takes ultrasette for the back pain and trileptal for the migraine headaches. Ms. Smith was scheduled for knee surgery for an unspecified congenital problem in both of her knees that causes them to pop out all the time, resulting in a loss of balance. She was scheduled in mid-August to undergo knee surgery to rectify this problem. She did not attend session during this time and remained at home recovering with the help of physical therapy for weeks after the surgery. Ms. Jackson cared for Sammy during this time.

Ms. Smith states that when she was 17 years old, she began having “flashbacks” of the rape she sustained at the age of 7 years old. She saw a therapist briefly and states that although she really connected with him, she discontinued treatment after he told her that she suffered with anxiety disorder. She refused to return, stating, “I hated that he gave me a diagnosis”. She would not elaborate on this. She was unable to recall his name therefore no records could be obtained.

Ms. Smith was never hospitalized psychiatrically until two weeks after she started therapy session for 4 days. She was committed to the mental health unit of a local hospital for depression with psychosis. Prior to the hospital stay, Ms Smith reported passive suicidal ideations to hurt herself and Sammy. Ms. Smith did not

specify a plan but made references that she and her son would both be better off if they were not here.

Ms. Smith had four unplanned pregnancies and one live birth. She had three previous abortions. Her fourth pregnancy resulted in the birth of Sammy two years ago. Her pregnancy was normal but her son was reported to be “sickly” after he was born and required a lot of attention. Ms. Smith was unable to provide a diagnosis for Sammy.

Ms Smith was assessed for symptoms of mania which she denied.

Education and Job History

Ms. Smith went to regular classes and graduated from High School. She was recently enrolled in the community college working towards an AA degree in Human Services. Her goal is to become a social worker. She took a brief leave of absence from school to work as a customer service representative to help her mother pay bills. Prior to that time, she worked in a battered woman’s shelter but found that to be too difficult to manage emotionally and left. She said that she felt really sorry for the women and would go home feeling sad for them daily. At present, she quit her job as a Customer Service Representative at a major bank because she became upset at her boss who asked her why she was so moody. She reports that she did not want to deal with this issue so she quit her job. She planned to return to either work or school in September. If she does not do one or the other, she will be cut from Medicaid and will stop receiving her monthly stipend. It was the opinion of the staff psychiatrist that Ms. Smith remains out of work for 3 to 6 months to work on her recovery. This

was relayed to welfare and Ms Smith will receive benefits until January 2007.

Thereafter she will be required to return to a work.

Ms. Smith's was never gainfully employed. Most of her income was from minimum wage jobs. She worked as a cashier, salesperson, and customer service representative and had clerical positions in non profit organizations. She admits that it is easy for her to get jobs but has difficulty keeping them. She tends to have problems with her co workers or her bosses. She has a hard time taking directives from her boss and tends to quit before taking constructive criticism. Most of her jobs do not last longer than 6 months.

Social Supports and Pattern of Relationships:

Ms. Smith has a pattern of unstable relationships with marginal men and showed a pattern of poor judgment with partners as far back as High School. During High school, Ms. Jackson had a boarder in their home that was more than ten years older than Ms. Smith. After about 6 months of residing in their home, Ms, Smith engaged in a sexual relationship with him. She reports that they would have sex daily while her mother was away at work. Eventually, Ms. Jackson found out about this relationship and asked the man to leave. She stated that she was having unprotected sex with this man. Ms. Smith continuously engages in risky sexual behaviors.

She reports having one good friend Renee who she sees weekly. Renee is also a single parent and has two young children around the same age as her son. At times they get together and go to nightclubs. Renee is also involved in the threesomes.

Ms Smith gets support and confides in a woman Ms. Tina she calls “aunt”.

Ms. Tina is a family friend who has been reportedly providing guidance and support to Ms. Smith. Ms. Tina takes care of Sammy when she feels overwhelmed and provides guidance on how to parent. Ms. Smith feels she can relate to Ms. Tina because she is also a single parent and knows “first hand” what Ms. Smith is going through. Recently, Ms. Smith informed Ms. Tina of her promiscuous behaviors and that she had three abortions in the past. Ms. Smith fears that this Ms. Tina may tell her mother if she gets upset with her. To date Ms. Tina has maintained this secret.

Ms. Smith recognizes that her promiscuity is very risky and fears that she will get pregnant, a STD or AIDS. She also worries that people in her community will find out and that may make it uncomfortable for her mother and son. However, she states that even though she understands this behavior is not healthy, she shows impaired judgment regarding her sexual behavior, stating she does not want to stop it. She reports, “it is something to do.”

Daniel Anderson, Sammy’s father is about 6 years older than Ms. Smith and is an African American male who is presently incarcerated for possession of cocaine with intent to sell and for forging checks. Mr. Anderson was reportedly up for parole which was denied in August 2006 for “bad behavior”. He will come up for parole again in March 2007. Ms. Smith states they were together for 10 years prior to becoming pregnant 2 ½ years ago. She describes Mr. Anderson as her “first love.” He left her without warning when she was seven months pregnant to evade warrants for his arrest. After Ms. Smith gave birth to their son, she found out where Mr. Anderson was and contacted him. He had been residing with another woman in

Florida. Ms. Smith informed him that if he did not return, she would deny him custody rights to Sammy. As a result, Mr. Anderson returned to New Jersey when Sammy was 2 months old son. At the time, Ms. Smith's grandmother insisted that the couple marry and agreed to pay for all the wedding arrangements. Twelve hours before the wedding, Mr. Anderson was stopped by police for going through a stop sign. He was arrested for outstanding warrants, charged and convicted of the above mentioned crimes. Ms. Smith believes Mr. Anderson purposely went through the stop sign so he would not have to get married. Ms. Smith maintains a strained relationship with Mr. Anderson, visiting him at the jail occasionally on weekends with their son. Mr. Anderson informed her that he has friends "on the outside" who keep an eye on her and Sammy, informing him of their whereabouts and who she is seeing. Ms. Smith is not in fear of him. She is angry at him for leaving her when she needed him the most.

When Ms. Smith began therapy she had been seeing another man, who resides in north Jersey. He provided comfort to her because she was able to tell him everything. She told him about the rape. She reports they talk a lot on the phone. For reasons she can not explain, this man is 32 years old and continues to reside with his mother, and is not gainfully employed. She was unable to report whether or not this man has mental health issues, however, she does not want to continue in a relationship that has no future and broke ties with him.

Ms. Smith recently started a romantic relationship with another woman named Jane. At first she was reluctant to tell me about this relationship, fearing that I would think that she was a lesbian. Ms. Smith came to session, with her forearms exposed.

On the inside of each forearm were "S" shaped burn marks. Ms. Smith reports that she and Jane were having what she termed, "a lover's quarrel" and that Jane held her arms above her head and lit a lighter resulting in the lighter becoming hot, then branding her numerous times. Ms. Smith reported that she could not get away from Jane. This was difficult to believe, because Ms. Smith admits to being much larger in stature and heavier than Jane. Ms. Smith admits to retaliating by punching Jane in her head causing red welts. She admits to keeping her arms exposed for her mother and Mr. Anderson to see during a visit at the jail. She states that this is not typical behavior but that they were just having some fun. She is conflicted about the fact that she is in this relationship. She does not think that she is a lesbian and reported at first it was not sexual in nature and that Jane gave her comfort and friendship. She reports that she was impressed by the fact that Jane did not expect anything from her, especially sex for the first few weeks, something Ms. Smith believes could never happen with a man. Ms. Smith states that when Mr. Anderson gets out of jail, she will break off this relationship and resume her relationship with him.

On the other hand, Ms. Smith is concerned that Mr. Anderson will not be able to provide for his family when he gets out of jail and is unsure about whether or not she will continue their relationship when he is released.

Ms. Smith states she has limited social supports. She believes that her peers, who are also single parents, have support and babysitters and can go out to and do age appropriate activities. Ms. Smith feels that she is deprived of this because her mother refuses to baby-sit and she has no money to pay babysitters. This is in direct conflict

of what she has been telling me during session (e.g. Renee and Jane are very supportive and they are single parents and they spend a lot of time together).

Situational Stressors:

Ms. Smith reports that the lack of financial security is a major stressor. This disables her from getting a babysitter to socialize with her peers, and keeps her dependent on her mother. She and her mother argue a lot due to the lack of finances. Ms. Smith also has limited support/help with her son. Although her maternal family members offer help, she refuses, because she feels any help comes with a condition. She feels unfulfilled and wants to return to school to complete a degree in order to obtain gainful employment. Ms. Smith recently found a program in Michigan that takes in single parents and offers babysitting while she goes to school. She would have to leave the area to go to school and commit to three years away. Ms. Smith reports she will think about this but is unsure if she can make the commitment.

Coping Mechanisms and Strengths:

Ms. Smith can not take any type of criticism from her family telling her she is not parenting appropriately. She also has a difficult time taking directives from previous employers. Typical responses to these situations include Ms. Smith becoming extremely angry which includes threats and yelling, or she becomes withdrawn and isolative and abruptly leaves the situation. As a result of this behavior, Ms. Smith cannot maintain gainful employment or long term relationships. In the past, Ms. Smith abused alcohol as a way of self medicating to cope with depression

and anger. At present, she reports that this is not an option for her because she fears her son will be taken away from her. Ms Smith has been prescribed an antidepressant and mood stabilizer and has done well on these medications. She reports adherence to this medication regime and the side effects experienced at first have subsided.

Ms. Smith recognizes that she has a difficult time managing her anger. She states she can handle day to day stress but reports an accumulation of incidents over time, tends to result in her “blowing up” and becoming extremely angry. She reports her maternal family can provoke her to become angry just by their presence. She tends to lash out verbally at them when they call to ask how she is or when they come to visit her mother. Ms. Smith believes they are “phony” because when she was younger she and her mother went days without food, and they refused to help. She often times states, “where were they when my mother did not eat for weeks just so I can eat!” She and her mother reported, maternal family threatened to get custody of Ms. Smith when she was a child but never followed through with this. Ms. Smith is angry at them for this. She copes by staying away from them and if she does visit, she leaves early, stating she has someplace to go.

On some occasions, Ms. Smith uses her sense of humor to talk about what she is upset about. She recently told me a humorous scenario about what it is like during a family holiday dinner party. She described each person at the table, how they looked and what they talked about. She was very humorous and was able to laugh about this.

When she is upset, she tends to yell and exaggerates what is happening to her. She reports that she maintains a tough exterior when she is around others to protect herself and others from being hurt.

Ms. Smith practices the Baptist faith and goes to church on Sundays and sometimes during the week. When she is feeling anxious, depressed or needs guidance, she states she prays and this helps her. Most times, she spends hours talking with her mother or her aunt about her mental health issues.

Ms. Smith has been disappointed often throughout her life by her family, friends and in her relationships. As a result she is untrusting of others and remarkably minimizes what has happened to her in the past as evidenced by her making excuses for her rapist, "he was high on cocaine or he would not have raped me". She also minimizes what Mr. Anderson has done, by stating that it was not his fault that he was incarcerated or that he was unfaithful with other woman because he was lonely.

Self Concept and Motivation for Treatment:

Ms Smith has a poor self concept. She tends to be very affected by other people's opinions. She also gives credit to others for her accomplishments and expresses how she feels in terms of how others see her. For example, Ms. Smith states that it is difficult for her to live up to Ms. Jackson's standards. She believes her mother has a "near genius" IQ. I am surprised by this statement since; I did not get this impression after a meeting with and talking to her mother. In addition she tends to give others credit for her accomplishments. Since she has been in therapy she has been able to obtain benefits, get food stamps and register Sammy in a daycare

program on her own. Ms Smith tends to give me credit for what she has accomplished, stating "if it was not for you"; "I could not have done these things." Although I pointed out numerous times that I did not tell her to do these things, she insists that I did. Ms. Smith has poor judgment regarding other people and is a poor historian.

She tends to think that no one will believe her accounts of things or that what she has to say is important. This is seen by Ms. Smith relaying her feeling in terms of how others see her, "My mother says I am depressed" or "my aunt thinks I am a bad parent". Other times, Ms. Smith fabricates outrageous stories about her life, like the scenario of her mother falling on glass and dying if she moved out. She does this so that others will find her interesting and will want to listen to her.

Miss Smith also has issues of dependence. Giving others credit for her successes makes her obligated to them. Even though she reports feeling stuck in her mother's home, she will not leave, because she feels she must stay to help her.

She appears to be very motivated for treatment and attends regularly. She has numerous trust issues always thinking that others have ulterior motives for their behaviors. She oftentimes tells me that the therapy sessions are helping, but continuously does not complete homework assignments that may assist in her treatment. On some occasions, Ms. Smith brought Sammy to session, keeping her preoccupied with his behaviors, disabling her from talking freely. She also tends to withhold pertinent information.

Conceptualization:

Ms. Smith's paternal and maternal family members suffer with depression and substance abuse. Her maternal grandfather and uncle hold a diagnosis of Bipolar disorder and substance dependence. Ms Smith's mother is prescribed antidepressants and sees a therapist. Her father was incarcerated for raping and stuffing a woman in the trunk of his car while under the influence of drugs and alcohol. Ms. Smith may be genetically predisposed to depression and substance abuse. Since being prescribed anti-depressant medications, Ms. Smith's depression and agitation have been lifted providing further evidence to the genetic link to her depression.

Ms. Smith sustained neglect and abuse as a child which may contribute to her diagnosis of Borderline Personality Disorder. Her environment was not nurturing and most times invalidating. She was raised by a single parent since her father was incarcerated for most of her childhood. Her mother was reportedly absent for most of the day and when she was home, she spent a lot of time yelling and complaining about not having money. Ms. Smith's maternal family was not helpful when she and her mother needed money for food. When they did help they were verbally abusive and reportedly made comments that made Ms. Smith and her mother feel like they were a burden. When she was 12 years old, Ms. Smith sustained sexual abuse from her mother's boyfriend.

Ms. Smith cannot trust anyone and believes that others have "ulterior motives". This may be the result of the abuse and neglect she sustained as a child. Mr. Anderson, abandoned her to evade the police but was eventually caught and incarcerated. Ms. Smith tends to isolate herself from others, and minimizes what has

been done to her. She reportedly does this to protect herself and other around her. She reports that at times, she finds it difficult to control her anger displacing it on others because they are not trustworthy.

Ms. Smith also reports feelings of guilt that contributes to her depression and dependency on her mother. She feels guilty for her mother's tough life. She recalls times during her childhood, when her mother would go without food, so she could eat. Ms. Smith continues to feel guilty about being in her mother's house but is unable to leave because she cannot maintain interpersonal relationships or gainful employment.

Symptoms of her depression include severe fatigue a lack of motivation, a poor sense of self, helplessness and hopelessness. Instead of the typical reaction of crying, Ms. Smith tends to become sad, feels worthless, frustrated, angry and lonely.

All of the above mentioned issues combined with being a single parent, contribute to feelings of inadequacy and reinforces her beliefs that she is not a good person. Ms. Smith feels like a failure because she is not able to remain focused on anything that can assist her in becoming independent. Her recent attempt at school was cut short because she felt she needed to work to "earn her keep". Working is difficult for Ms. Smith because she is unable to interact with her coworkers and misinterprets her boss's directives as threats, responding to them with defensive and threatening remarks. This keeps her very dependent on her mother for financial and emotional needs and makes her avoid committing to make changes in her life. Since Ms. Smith tends to mistrust a lot of people, she has a limited amount of social support when it comes to caring for her son, Sammy. This keeps her home a lot with her son

and increases her feeling of being “stuck”, frustrated and overwhelmed by the responsibility of motherhood.

She reports she cannot do what other girls her age are doing which is in direct conflict of what she does when she does have free time for herself. She tends to engage in risky behaviors like orgies instead of going out to the nightclubs to dance.

Some of her behaviors may be the result of what she was exposed to when she was a child. Ms. Smith comes from a family/culture of people who are single parents. Women are expected to maintain a strong façade, remain tough and suppress their emotions. Ms. Smith reports that when she becomes upset with her situation she feels guilty because she feels her mother had it worse than she presently does. Anger was modeled by her mother during her childhood and adult years and as a result, Ms. Smith handles a lot of her problems using anger. There is secondary gain to this behavior. When she gets angry people listen to her, which provides power and gets her what she needs.

Ms. Smith has a poor sense of self and trust issues. Most times, she creates who she is; telling me only what she believes will sound good. At times she withholds or exaggerates information so her story sounds good or interesting. Other times she attempts to state that her behaviors are due to others or tries to convince me that she is interesting in fear of abandonment. As the therapeutic relationship developed she became more trusting and honest about her behaviors and feelings.

Ms. Smith appears to be impulsive and does not have realistic expectations. She tends to want quick answers to her problems. She and her mother spend a lot of time discussing the origins of her depression. They reportedly believe that if they

found a major trauma Ms. Smith sustained, then they would understand why Ms. Smith is depressed and this would resolve her problems. Ironically both know that she was raped but tend to minimize this experience.

Ms. Smith did not have any positive parenting role models. Her mother was an authoritarian disciplinarian and would oftentimes complain about her situation, making Ms. Smith feel like a burden. Ms. Smith uses the same parenting style as her mother. Ms. Smith tends to yell at Sammy when she feels he is doing something wrong. Prior to her recent hospitalization, Ms. Smith was verbally abusive and neglectful towards Sammy. When she was in a deep depression, she was unable to manage her day. During this time, Sammy would wake up and have breakfast with his Ms. Jackson before she went to work. Thereafter, Ms. Smith would return to bed or lay on the couch neglecting Sammy by ignoring his requests to play with him or give him lunch. This went on for weeks until Ms. Smith was hospitalized. Since that time, Ms. Smith's mother monitors her behaviors to ensure that Sammy is not at risk. However, much of Ms. Smith's reported stressors are a result of Sammy's behavior. She constantly reports that he is "acting out". She recently requested a referral from his pediatrician for an evaluation to determine if Sammy has ADD or ADHD. The doctor refused to give her the referral, stating that Sammy was fine. Sammy tends to react to his mother's constant demands, her lack of attention, insensitivity and unresponsiveness to his needs. He reacts by throwing toys or yelling loudly while running around. This infuriates Ms. Smith and she does not know what to do with this so she yells and spansks him, reinforcing these negative behaviors. Ms. Smith spent one month in the Agency's parenting program but left after being confronted

about her yelling directly into her son's face. She refused to return even after we discussed the need for this at length.

Diagnosis:

Based on the information gathered during the assessment, Ms. Smith appears to have symptoms that satisfy criteria for Major Depressive Disorder with psychotic features, severe and recurrent; and Borderline Personality Disorder.

The diagnosis of Major Depressive Disorder, severe and recurrent with psychotic features, is given as the primary diagnosis. The diagnosis is designated as primary due to the severity of the current symptoms. Ms. Smith's symptoms are consistent with her having currently been experiencing a major depressive episode for more than a two week period where she had a depressed mood, a loss of interest or pleasure in nearly all activities, decreased energy and fatigue. She reported feeling sad, hopeless, and discouraged. She exhibited increased irritability with persistent angry outbursts, and tends to blame others for how she feels. She has an exaggerated sense of frustration which was evidenced before she was hospitalized. In addition, Ms. Smith symptoms satisfy Criterion "B" for Major depression in that she denied the presence of manic symptoms required to make a diagnosis of mixed episode. Criterion "C" was satisfied because Ms. Smith's depression caused significant distress and impairment as evidenced by her report that she had difficulty maintaining self care and caring for her son. Criterion "D" was satisfied because Ms. Smith's symptoms were not due to physiological effects of substances or a medical condition and Criterion "E" was satisfied because it was not due to bereavement.

Ms Smith was also given the specifier, severe with psychotic features because along with meeting the criterion for Major Depressive Disorder, there was a presence of a delusion. Ms. Smith has a history of episodic irrational, illogical and delusional thinking, manifested in childhood as the “monopoly man” on her wall. Most recently, prior to her only hospitalization she exhibited passive suicidal and homicidal ideations and the delusional belief that her 2 year old son was “a big man who lived across the street with all his kids” and should behave as such.

The additional specifier, recurrent, was given because this was not the first time that a Major depressive episode was experienced.

With the exception of irritability, Ms. Smith did not display an elevated or expansive mood, flight of ideas, pressured speech, racing thoughts or labile mood. During session, Ms. Smith’s mood was typically calm and her speech was an appropriate rate and she was able to think clearly and articulate what she was thinking during sessions. Even when Ms. Smith exhibited psychotic and delusional thoughts they did not appear manic. Therefore a rule out, of Bipolar Disorder was given since she does not meet all the criterion set for this diagnosis.

Most of her behaviors can be attributed to her diagnosis of Borderline Personality Disorder. According to the DSM-IV, Ms. Smith meets the criterion for this Disorder. Beginning in her young adulthood, she exhibited poor impulse control, a pattern of instability of interpersonal relationships and moods, and a poor self image. This has been evidenced in many areas of her life. She has a history of substance abuse during High School drinking daily in and out of school and has been engaging in risky sexual promiscuity since that time. She reports that her girlfriend

will call her up and state that “she has a room”. This means that after going to a night club, they will both go to a hotel room where a man and/or other people are waiting there to have group sex. She does not know who will be there until she gets there. There is also drugs and alcohol involved. She admits that she has unprotected sex during this time.

Ms. Smith also displays a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation. Ms. Smith fluctuates between hating her mother and loving her mother. One week she idolizes her, stating that she is very supportive, loving and her best friend and the next week she hates her. This tends to be reflected in all of her relationships. She always ambivalent about her relationship with her son’s father, reporting that she took her son to the prison to see his father after telling me the week before that she has decided never to see him again and that she is breaking all ties. .

Ms. Smith tends to have identity disturbances which are marked by persistent and an unstable self-image or sense of self. Ms. Smith would continuously tell me about herself in reference to how others see her, for example, “My mother says that I am depressed”. In addition, although she reports that she not a lesbian, she has sex with woman when she is involved in an orgy and is also intimately involved with a female friend but will not admit to it. She remains conflicted by this.

Ms. Smith is very impulsive in two areas such as sex and substance use which are potentially self damaging. As stated earlier, Ms. Smith used alcohol excessively during her High School years and presently engages in unprotected sex with

numerous partners at the same time. Although she recognizes that this is risky, she reports she cannot stop.

Ms. Smith's affect is unstable due to marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours). Ms. Smith tends to get really angry at her mother and her son at least one time weekly. Most times, she cannot explain what triggered this irritable mood but it usually results in her yelling at her son or fighting with her mother where everybody is upset with one another for a few days.

Ms. Smith reports chronic feeling of emptiness. Ms. Smith tends to report that she is frequently bored and feels that she does not have a focus for her life or a purpose. She feels that she does the same thing each day and has nothing to keep her going.

Ms. Smith reports bouts of inappropriate, intense anger and at times, difficulty in controlling anger. In High School Ms. Smith was given the name "the protector" because she would get into physical altercations with others to defend her friends. Recently, she reported that she wanted to hurt another child for hitting her son. She also loses her jobs after becoming upset with her bosses after they give her directives. She tends to become verbally threatening towards them or makes unsavory remarks, getting her fired.

The following diagnosis was given to Ms. Smith:

Axis I: Major Depressive Disorder, severe, recurrent with psychotic features

Rule out Bipolar I

Axis II: Borderline Personality Disorder

Axis III: Migraines, herniated disc,

Axis IV: GAF: 60

Axis V: Parent Child Relationship problems, Single parent; lack of support; financial problems

Chapter 2: Literature review

The purpose of this literature review is to provide a general overview of the empirically supported treatments related to Ms. Smith's diagnoses of Major Depression and Comorbid Borderline Personality Disorder. Treatment approaches include psychopharmacology, various psychotherapeutic approaches and a combination of the two. This literature review is based on professional journal articles and books written or edited by prominent people in the field of psychology. Treatment approaches will be discussed for each diagnosis, separately, and together, since the two diagnoses together represent a separate clinical entity.

Pharmacotherapy

Prior to the 1970's antidepressant medications was the standard treatment for depressed patients. Randomized drug studies showed that two-thirds of over 300 randomized studies on antidepressant medications were superior to placebos and less effective than psychotherapy (Hollon & DeRubeis, 2004). Recent controlled studies have concluded that pharmacotherapy is effective in symptom reduction in Major Depressive Disorder and Co-morbid Personality Disorders.

The Agency for Health Care Policy and Research (AHCPR) designated antidepressants as the first-line treatment for moderate to severe depression (Schulberg, Pilkonis & Houck 1998), restricting psychotherapy as primary treatment

for mild to moderate depression. (Schulberg, Pilkonis & Houck, 1998 p. 932). This was based on the findings by the National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH TDCRP) Elkin et al (1998). In this study, 239 outpatients between the ages of 21 and 60 were randomly assigned to one of four treatment conditions: cognitive behavioral therapy (CBT), interpersonal therapy (IPT), imipramine plus clinical management (IMI-CM) or placebo plus clinical management (PLA-CM). CBT is a structured approach to the treatment of depression in which patients are trained to identify and modify thoughts, beliefs, and assumptions about past, present and future experiences (Sanderson and Rego, Chapter 11 p. 214). In comparison, IPT focuses on four types of interpersonal problem categories that are related to depression and enables the client to develop adaptive ways of relating to others. Each treatment was conducted over a 16 week period. The results indicated that all treatment conditions including PLA-CM were effective in reducing depression; however, IPT and the IMI-CM group were superior to both therapies in the treatment of MMD. (Schulberg, Pilkonis & Houck, 1998). The results also indicated that initial depression severity may be an important factor in considering treatment.

Serotonin reuptake inhibitors (SSRI's) are the most widely used class of antidepressant drugs in the treatment of depression with psychotic features (Krippeke, 2006). Some theories link depression to a lack of stimulation of the recipient neuron at the synapse. SSRI's increase the extra cellular level of the neurotransmitter serotonin 5-hydroxytryptamine or (5-HT) by inhibiting its reuptake into the pre-synaptic cell, increasing the serotonin available to bind to the

postsynaptic cell. This allows serotonin to remain in the synaptic gap to be recognized over and over, and be fully stimulated.

Meyer's (2006) article, focuses on the binding potential of 5-HT in the brain during depressive episodes. His investigation was conducted with the use of positron emission tomography or pet scans. Although this study is beyond the scope of this paper, a significant finding showed that pet scans are able to locate binding potential (BP) of 5-HT in specific areas of the brain. Meyers (2006) was able to determine that during a major depressive episode the prefrontal cortex of the brain is dense with (BP's) which is consistent with findings in post mortem suicide victims. In other patients exhibiting pessimistic thoughts, BP was less dense in the midbrain area of the raphe nucleus where serotonin is most concentrated, showing little activity at the synapses. These finding support the biological aspects of depression and the correlation between too little serotonin and depressive symptoms, the effects of psychopharmacology and the potential for the development of more effective drug treatments.

Three types of antidepressant that are used most frequently are SSRI's, tricyclic antidepressants (TCA's) and monoamine oxidase inhibitors (MAOI's). Although there is no evidence that SSRI's are more effective than MAOI's or TCA's, they are most widely prescribed (Glyn 1994). This may be due to the troublesome side effects of TCA's and MAOI's, which are considered an older class of antidepressants. Side effects for TCA's include cardiotoxicity and death due to overdose. MAOI's have numerous dietary restrictions and a risk of hypertensive crisis. Conversely, SSRI's are well tolerated and safer. Symptoms include nausea

and gastrointestinal side effects (Glynn1994), which tend to subside with prolonged use. Studies have shown that individuals prescribed TCA's are more likely to discontinue their medications within four to six weeks of treatment as compared to patients treated with SSRI's (Olfson, Marcus, Tedeschi & Wan 2006). Although the cost is a 20 to 30 times higher than TCA's and MAO-I's compliance rate is highest among patients who take SSRI's. The initial cost outweighs long term costs since adherence to SSRI's may aid in the prevention of relapse.

Besides tolerance there are a number of reasons patients discontinue their antidepressant medications. Olfson, Marcus, Tedeschi and Wan (2006) conducted a multivariate analysis to characterize the rate and pattern of antidepressant discontinuation among adults in the United States. The data for this study was drawn from the Medical Expenditure Panel Survey for 1996 to 2001 for 829 depressed outpatients. Olfson et al. (2006) categorized the data into three groups according to the length of time it took for them to discontinue prescribed antidepressant medications from initial treatment. The first group of outpatients were patients who discontinued treatment within the first 30 days of initial treatment, the second group discontinued treatment from 30 to 60 days of initial treatment, and the third group from 60 to 90 days of treatment.

An additional longitudinal study over a 2.5 year period was conducted with these same patients. Information was gathered in the form of a structured, in-person interview at the outpatient facility. These patients were asked to complete of the Medical Outcomes Study 36-Item short form questionnaire requiring them to report their perception of their physical and mental health. Additional questions included

the reasons for seeking treatment, health conditions, health events, medications prescribed and involvement in psychotherapy.

Results from this study concluded that approximately 42% of individuals discontinued antidepressant medications within the first 30 days, of those that continued; only half of them discontinued medications during the subsequent 30 to 60 day period with one quarter continuing antidepressant therapy for more than 90 days.

The sociodemographics of the individuals in this study indicated that the highest group of individuals who discontinue medications are low income Hispanics, with less than 12 years of education. In contrast, white educated individuals had the best rate of adherence. Groups that remained on medication were individuals who had success with taking antidepressant medications; individuals who perceived their mental health as poor and individuals that were in psychotherapy. Although the information gathered and analyzed was initially studied to determine the cost effectiveness of antidepressant medications; it can serve as a basis for identifying and tailoring treatment approaches to depressed patients with consideration to cultural differences which may assist in improving adherence and preventing relapse.

Some patients willing to adhere to treatment are resistant to medications and are not able to get relief with antidepressants alone. Treatment resistant patients are patients that had at least two unsuccessful trials of antidepressant medications. A study conducted at Cedars-Sinai Medical Center in Los Angeles (Grohol, 2006) attempted to improve efficacy of antidepressant medications by augmenting them with other psychotropic medications. The goal was to achieve remission in depression. After administering the additional medication, researchers tracked this

group for over a two year period. The results concluded that 60 percent of individuals with psychotropic medication augmentation were in remission after 4 to 6 weeks of starting treatment (Grohol, 2006), with less depressed patients able to discontinue the augmented medication earlier. This study provides evidence for the synergistic effect of adding psychotropic medications to antidepressants, and gives an alternate method of treating depression in treatment resistant patients.

Prescribing off-label medications is another attempt to achieve symptom reduction in a number of psychiatric diagnoses. The FDA's definition of off-label is "the use of a prescription drug for an indication, dosage, form, dose, regimen, population or other use not mentioned in the approved labeling." (Rosack, 2006, p.3). Chouinard's (2006) proof-of-concept study supports the potential utility of new off-label indications of a number of psychotropic medications. For the purpose of this paper, basic conclusions of medications prescribed to Ms. Smith will be discussed. The study concluded that antidepressant medications are used off-label for insomnia, anxiety and panic and anticonvulsant medications, typically used for seizures and epilepsy, are used off-label for treating major depression, psychosis, mood swings and aggression. (Chouinard, 2006). It is important to note that pharmaceutical companies must pass rigorous clinical trials before introducing a drug to the general population. They tend to focus on the efficacy, tolerability and drug interaction of the drug they are promoting. Once approved and used over time, patients report additional benefits which are then reviewed in proof-of-concept studies. In short, this article indicates that there is a recent trend in searching for new off-label drugs in

depression which provide treatment options and symptom relief for depressed patients.

Markovitz's (2004) conducted a meta-analysis of clinical trials for the effectiveness of psychopharmacology in treating personality disorders. His review revealed that although there is a small amount of evidence for the effectiveness of treating personality disorders with medications, it is robust. In fact, the American Psychiatric Association recommends pharmacotherapy as a mode of treatment for BPD (Markovitz, 2004). The success in treating BPD with medications can be attributed to its shared hypothesized etiology and the fact that BPD shares the same set of symptoms as other successfully treated Axis I psychiatric diagnoses such as Major Depression, Schizophrenia, and Bipolar disorder. Markovitz believes that abnormal personality traits are accompanied by neurochemical abnormalities in the central nervous system (CNS). Psychological trauma, physical trauma, or a genetic predisposition results in the notion of a biological vulnerability in these patients. Beck's diathesis-stress model and Lenihan's biosocial theory of Borderline Personality disorder supports this theory (Klosko and Young 2004). Medications work to restore neurotransmitters in the CNS to a normal state, thereby reducing symptoms. In regard to shared traits, BPD shares the affective symptoms of depression, a variety of anxiety disorders, eating disorders, impulsive behaviors, substance abuse and psychosis (Markovitz, 2003). Effective treatment has been seen with antipsychotic medications for the treatment of psychotic symptoms, anticonvulsant medications to treat mood swings and aggression, and SSRI's for

depression. Regardless of the underlying cause of BPD, effective treatments can provide symptom reduction and hope to patients with this difficult disorder.

Bellino, Zizza, Rinaldi & Bogetto (2006) found that combined treatment with psychotherapy and antidepressants is superior in treating MDD with Comorbid BPD than medication or psychotherapy alone. 32 outpatients from the University of Turin diagnosed with MDD and comorbid BPD were randomly assigned to 1 of 2 treatment groups. 15 patients received fluoxetine and clinical management and 17 patients received fluoxetine plus Interpersonal therapy (IPT). All patients were repeatedly assessed, at baseline, week 12 and week 24. The following measures were used. A semi-structured interview to assess demographic and clinical characteristics, a Severity and Improvement Items of the Clinical Global Impressions Scale (CGI) to assess global symptomatology, the Hamilton Depression Rating Scale (HDRS), the Hamilton Anxiety Rating Scale (HARS), the AAT-P, a self administered questionnaire for a daily life satisfaction profile. Results concluded that 75% of combined treatment achieved remission; whereas 62% of medication only achieved remission. Although rates of remission for each treatment group were not significantly different, Bellino et al. (2006) found significant differences in measures of social and relational functioning, quality of life measures and interpersonal inventory.

In summary, there is much evidence for the effectiveness of psychopharmacology in treating Axis I and II diagnoses. Since the 1970's psychopharmacology has been the first-line of treatment for MMD. Studies using pet scans can provide solid evidence for changes in the brain's neurochemistry in the

manifestation of mental illness. Pharmaceutical companies continue to create new classes of medications that are safer with fewer side effects. Doctors augment medications with additional psychotropic medications to provide a synergistic effect, improving the effectiveness of many antidepressant medications providing relief to many patients suffering with debilitating symptoms. Studies comparing the efficacy of psychotherapy against psychopharmacology continue to support the use of medications as superior to psychotherapy alone. However, studies have shown that a combination of psychopharmacology and psychotherapy may improve the patient's quality of life with rates of remission, close if not superior, to psychopharmacology alone. The following section will provide evidence supporting the use of psychotherapy in the treatment of MDD and comorbid BPD.

Psychotherapy

The recent practice guidelines for treatment of MDD emphasize the importance of symptom severity in determining the need for antidepressant medications. The American Psychiatric Practice guidelines (APA, 2000) recommend pharmacotherapy alone or in combination with psychotherapy for patients with severe depression. This is in direct support for the TDCRP study cited in the pharmacotherapy section of this paper which endorses medications as first-line of treatment for MDD. Some researchers believe that the practice APA guidelines and the TDCRC study exclude the benefits and empirical evidence of combined therapy. A meta analysis conducted by Pamapallona, Bollini, Tibaldi, Kuelnich et. al. (2004) supports the efficacy of combined pharmacotherapy and psychological treatment in the treatment of depression. They reviewed data on 1,123 clinical trials of depressed

patients of which 932 were randomly selected to receive medications only, and 910 to receive combined treatment (psychotherapy and pharmacotherapy). Findings indicated that psychotherapy combined with antidepressant medication is associated with a higher response rate than pharmacotherapy alone. Additionally, the clients who remained in psychotherapy for 12 weeks or more, were able to adhere to their medication regime longer.

Another advantage of psychotherapy in combination with psychopharmacology is the prevention of relapse. Thase, Greenhouse, Frank, Reynolds et. al. (1997) examined the correlates of recovery in a meta-analysis of original data of 595 patients with MDD enrolled in 6 standardized treatment protocols. Five outpatient research protocols were conducted between 1982 and 1992. They included the Maintenance Therapies of Recurrent Depression (MTRD), Maintenance Therapies of Late-Life Depression (MTLD), Psychobiology of Recovery From Depression (PRD), Nocturnal Penile Tumescence in Depression Study (NPT), the Social Zeitgebers in Depression (SZD) and the Pittsburgh, Pa site for the TDCRP. The six studies met the same criterion for assessing and confirming a diagnosis of MDD in 600 outpatients. Tools used included the Hamilton Rating Scale for Depression (HRSD) and the global Assessment Scale (GAS). All studies provided 16 week treatment protocols, with random assignments to IPT, CBT, or imipramine plus clinical management. Patients were grouped into severity conditions and compared: less severe and more severe. These groups were also separated into psychotherapy alone or combined treatment groups. Rates of recovery for each group indicated that combined therapy was shown to be superior to psychotherapy alone in

managing more severe depression which is consistent with previously cited findings. Treatments were not significantly different in the less severe group with a 37% rate for psychotherapy alone versus a 48% with combined therapy. Conversely, a significantly different rate of recovery was found between the severe, psychotherapy alone group a 25% recovery rate versus a 48% recovery rate for the severe, combined therapy group. There was little disparity between the psychotherapy groups only in each severity condition. In addition, severely depressed patients in combined therapy had a faster recovery rate and longer rates of remission than with psychotherapy alone. In short, although this study reflects the need for adjunctive therapy for severely depressed patients, future research is needed to identify added benefits of combined therapy in reducing relapse and improving quality of life in depressed patients.

As a result of the chronic and recurrent nature of MDD, Fava, Rafanelli, Grandi, Conti, et. al. (1998), conducted a study to determine the effectiveness of CBT in the prevention of relapse after discontinuation of drug therapy. Forty patients with recurrent MDD who had been successfully treated with antidepressant drugs were randomly assigned to either Cognitive Behavioral Therapy (CBT) or clinical management (CM). CM consisted of monitoring the tapering of medication, reviewing the patient's clinical status, and providing support and advice. During the 20 week experiment, antidepressant medications were tapered and then discontinued. These patients were reassessed for residual symptoms using the Clinical Interview for Depression (CID) after treatment, while drug free, and then assessed 3, 6, 9, 12, 15, 18, 21, and 24 months after treatment. In addition, the researchers conducted a

survival analysis, studying six factors as predictors of outcome: assignment to CBT or CM, age, sex, duration of depressive episode, number of previous episodes, and number of residual symptoms. A final outcome includes an estimated survival curve which refers the relapse rate or to the “relapse-free status”. Results indicated that CBT yielded significant improvement in residual symptoms, with no significant changes in the CM group. During the two year follow-up, 5 (25%) of patients from the CBT group and 16 (80%) of patients in the CM group relapsed. Of the 6 variables selected for survival analysis, only treatment assignment was statistically significant. Finally CBT was highly significant in delaying recurrence.

This study provides evidence to support the efficacy of CBT in abating symptoms of relapse which may assist in the recurrence of depressive episodes. Further studies with larger sample sizes are needed. However, this study indicates the need for maintenance therapies for recurrent depression.

Paykel, Scott, Teasdale, Johnson et. al. (2007) conducted a similar controlled trial study to provide evidence for the efficacy of CBT in the prevention of relapse in residual depression. A common problem after treating depressed patients in partial remission is the presence of residual symptoms which may be a factor in precipitating relapse. Antidepressants alone do not do enough to combat these symptoms (Paykel, Scott, Teasdale, Johnson et. al. 2007). Paykel et al. (2007) hypothesize that CT can abate residual symptoms and prevent relapse. To test this hypothesis, 158 outpatients with a diagnosis of MDD in remission, experiencing residual depressive symptoms from 2 to 18 months durations, were randomized to a controlled trail of CBT. 78

patients received clinical management alone and the other 80 patients received clinical management plus cognitive therapy group. They received 16 sessions of CBT during a 20 week span of time. The patients were assessed regularly throughout the 20 weeks of treatment and at 1 year after the completion of the treatment. All patients were on medication maintenance throughout the trial. They were assessed at baseline, 8 weeks, 20 weeks, and 69 weeks. Assessments at baseline consisted of a history of depressive episodes and treatments received and the Eysenck Personality Inventory to assess for personality disorders. The BDI and HDRS were measures used to rate depressive symptoms. The most important outcome measure was the relapse rate.

Results indicated that the additional use of CBT reduced relapse rates for acute patients with persistent and severe residual symptoms. The cumulative relapse rate was reduced significantly from 47% in the clinical management group to 29% in the CBT group. CBT also increased full remission at 20 weeks but did not improve symptom rating. This study provides evidence for the effectiveness for CBT as an adjunct treatment with pharmacotherapy to reduce residual symptoms and improve relapse rate. Residual symptoms experienced by patients may lead to a depressive episode suggesting a limited response to antidepressants and the need for other treatments. CBT appears to be an appropriate adjunctive therapy for treatment resistant patients.

Scott, Teasdale, Paykel, Johnson et. al (2000) replicated the above mentioned random controlled trial to determine the effects of CBT on psychological symptoms

and social functioning in residual depression. The methodology of this study and assessment tools used remained the same. Additional tools were added, such as: the Raskin Depression Scale(RDS) to measure behavior and secondary depressive symptoms and the Social Adjustment Scale (SAS) which rated vocational, leisure and assessed behaviors across domains such as dependency, interpersonal interactions, and friction in relationship functioning. All subjects were psychiatric outpatients diagnosed with MDD. Although 230 patients met the criterion of the study, 158 patients agreed to participate. 78 patients were randomized to case management (CM) alone and 80 to CBT plus CM. Result indicated that over a 20 week period (acute treatment phase of treatment), both groups had a 20% decrease in scores on the HRSD, BDI, RDS and CID for depression and anxiety, however the follow up phases of treatment (six months) indicated significant differences between groups. The CBT and CM group showed significant decreases in symptoms of guilt, self esteem, hopelessness and pessimism with significant improvements in Social Adjustment Scores for the CBT plus CM group from baseline to 20 weeks. It is important to note that although both groups had similar scores at follow-up (1 year), they did not return to baseline level of functioning.

This study adds to the notion that in patients with partial response to antidepressant medications, adding CT may produce improvements in social and psychological functioning which may decrease the relapse rate. Scott et. al (2003) hypothesize that there may be a potential mechanism in CT that helps to reduce the relapse rate: an overall reduction in depressive symptoms or social impairment, changes in specific symptoms that are associated in relapse and changes in coping

skills (Scott et. al. 2003 p 444). However further investigation is needed to determine the effective ingredient of CT and if it can be generalized to all populations.

Previously cited studies of randomized controlled studies conducted by Paykel, Scott, Teasdale, Johnson et. al.(2000) were able to provide evidence for the efficacy of CBT plus medication in decreasing depressive symptoms, improving social functioning and preventing relapse within a one month follow-up period. To explore the cost effectiveness of CBT and medications in the prevention of relapse Scott, Palmer, Paykel, Teasdale et. al. (2003) replicated this study again using the same methodology. In addition to all the same assessments used in the original study a cost analysis was conducted. The researchers considered the direct care costs using activity data, applying the cost for consultation per unit of service from local providers, and social service agencies. The cost of medications was derived from the British Pharmaceutical Society. Provider's salaries, overhead costs and non face-to-face costs such as note writing and supervision were also considered. This study was conducted over a 17 month period. Results indicated that cumulative relapse rates were significantly lower in the CBT group than in a control group, 29% versus 47% respectively. In regard to cost, CBT plus medications was found to be initially more costly, however it is more effective than medications alone. In this respect, CBT can be more cost effective if providers and consumers agree to pay higher costs in the short term, knowing that they will have better long term outcomes. It is important to note, that this study was conducted in the United Kingdom and costs may differ from the United States in regard to mental health treatment, medications and the social service system. There is little information regarding the cost effectiveness of using

CBT with medications. Further analysis is needed and would be advantageous. The following is an international analysis of the cost effectiveness of using CBT in treatment.

Myhr and Payne (2006) conducted a meta-analysis on the cost effectiveness of CBT for all mental disorders. They used the PubMed, EMBASE, and PsychINFO database and were able to obtain 22 international studies: seven from the United States, eight from the United Kingdom, five from Australia, and one from Germany. Most studies included direct costs and societal costs of mental illness. Results of this study indicate many advantages of CBT over pharmacotherapy, including: fewer drop- out rates, fewer relapses, higher patient satisfaction, and cost effectiveness. Unfortunately it was noted that CBT is underused because it is not as accessible as pharmacotherapy. This is the result of health care policies, insurance issues, public funding and the fact that many providers are not trained in CBT. Although some of the studies reviewed in this analysis were from the United States, the sample size for the U S was very small, indicating a need for future studies and the possibility that this analysis may not be generalizable. It does, however, provide evidence, for the need to train providers in psychotherapy techniques which can be used in conjunction with medications for treatment with MDD and treatment- resistant patients.

Many researchers feel that there is some component unique to CBT that creates change. Jacobson, Dobson, Traux and Addis (2000) conducted an experiment designed to identify the ingredient that creates change and to examine the correlations between changes in specific mechanisms and outcome within and across treatment.

They proposed two hypotheses: the activation hypothesis and the coping skills hypothesis. The activation hypothesis states that the therapist “instigates” the process of change and then helps the client connect with resources that reinforce this activation. The coping skills hypothesis states that the therapist teaches the client new strategies to cope with life stressors and the automatic thoughts associated with the event, thereby decreasing depression. To test these hypotheses, the researchers randomly assigned 150 MDD outpatients to three treatment conditions: Behaviors activation (BA), automatic thought (AT), and the cognitive therapy (CT) condition. CT consists of BA and AT and also schemas or general patterns of thought. 12 weeks of treatment were given to all patients with a manualized approach to each treatment condition. Assessment tools were the HRSD and the BDI given pre and post treatment and at 6, 12, 18 and 24 months of treatment. In addition to the assessment tools listed a 45 items rating scale with six sub-scales was created to rate each condition. Raters listened for each treatment condition used in therapy.

Surprisingly, this study found no evidence that CBT was more effective than either of the other two components. BA and AT were as effective at altering negative thinking and attributional styles as CBT. This indicates that there may be no specific component of CBT but that CBT as a whole is effective. It is important to note that an additional outcome to this study was that most change occurs within the first few weeks of CBT. This change has been studied by others and has been referred to as “sudden gains” (Hardy, Stiles, Cahill, Ispan et.al.2005)

Persons and Miranda (2002) refer to this in their mood- state hypothesis. They propose that the underlying dysfunctional beliefs of MDD are more available for intervention when the patient is in a negative (depressed) state than in a positive mood. In this regard, individuals who begin therapy usually do so in a depressed state. Since treatment of underlying dysfunctional beliefs or schemas is an important goal of CBT, Miranda and Persons (2002) suggest that therapists should work on underlying dysfunctional beliefs early in treatment, while the negative mood is present. Once the depressive symptoms have remitted and the mood is positive, underlying beliefs will not be readily reported. Persons and Miranda tested their hypothesis using a volunteer sample of 43 non-depressed women who reported a change in dysfunctional thinking following mood induction, and with psychiatric patients who reported changes in mood and dysfunctional thinking during spontaneous diurnal mood fluctuation.

Riso, Baldina, Benna, Deacey et. al (2003) provide evidence to support the notion of underlying dysfunctional beliefs in depression. They conducted a cross-sectional study to examine the cognitive factors in chronic depression by studying four cognitive approaches to understanding depression: dysfunctional attitudes, early maladaptive schemas, attributional styles and ruminative responses to depression. Dysfunctional attitudes refer to enduring, underlying negative beliefs that patients use to evaluate themselves. Early maladaptive schemas refer to cognitive themes that develop during childhood and are enduring throughout life. Attributional styles refer to the explanations patients make for the events in their lives, positive or negative. And finally, ruminative response styles refer to a tendency to constantly think about

the causes and consequences of their depression. These thoughts are distracting disabling patients from problem solving, which prolongs depression. This study compares the cognitive differences between individuals, with and without depression. The subjects included 42 outpatients with chronic depression, 27 outpatients with non-chronic MDD and 24 never psychiatrically ill controls.

All subjects were given the following measures. They were assessed for a diagnosis according the DSM-IV using the Structured Clinical Interview for the DSM-IV (SCID). Dysfunctional Attitudes were measured with the Dysfunctional attitudes Scale (DAS). This is a 40 –item scale measuring negative beliefs that affect an individual’s self-evaluation. Early maladaptive schemas were assessed using the Schema Questionnaire, (SQ), a 205 –item questionnaire that measures 16 clinically relevant schema clusters that represent core beliefs which are manifested as themes that develop early and are remain throughout life. Attributional styles are measured with the Attributional Style Questionnaire (ASQ) which gives subjects hypothetical events and asks them to rate them as global or stable events. The ruminative response styles was measured by the Ruminative subscale of the Response Style Questionnaire (RSQ). In addition, the depressed mood of each subject was assessed using the Inventory of Depressive Symptomatology (IDS)

The result of this study supports the notion that the underlying cognitive processes of depression are found in both chronic and non-chronically depressed patients. Although this study supports Person’s and Miranda’s mood-state hypothesis; the researchers found that this explanation is too simplistic and it reflects

the cognitive vulnerability model of depression. This model states that negative constructs are present before, during and after a depressive illness but become activated and more pronounced during periods of depression (Riso et.al 2003 p.77).

Several variables were more present in the chronically depressed patients than the patients with a diagnosis of MDD. The chronic group scored significantly higher in the maladaptive schema measure which indicates a higher level of impaired autonomy, overvigilance, and dysfunctional attitudes. According to the researchers, this leads to an excess need for reassurance which was indicated in the rumination and attributional style measures. . The results also emphasized the importance of negative self and other core beliefs in chronic depression. Chronically depressed individuals evidenced rigid internalized expectations of themselves and the belief that they are impaired, unable to set goals, self regulate and are disconnected from others.

Beevers and Miller (2005) examined whether CT alters the association between negative cognition and symptoms of depression. In other words they wanted to examine whether people receiving cognitive therapy report less dysfunctional attitudes after being depressed, and if CT weakened the relation between negative cognition and depression. To study this notion, they recruited subjects from an inpatient unit and a partial hospitalization program of new admits who agreed to continue with treatment up to 6months post discharge. Of the 121 patients who agreed to the study, 22 dropped out. 99 patients were randomized into one of 4 groups: 24 patients received pharmacotherapy plus CT, 29 received pharmacotherapy plus CT plus family therapy (FT), 24 received pharmacotherapy alone, and 22

received pharmacotherapy plus FT. Depression and negative cognitions were assessed during their hospitalization, at 6 months post treatment, 12 months and 18 months. Assessments used were a variation of the Miller HRSD (MHRSD) which is a revised version of the HRSD that includes 8 additional items to rate depression. To assess for depression severity the MHRSD without three items was used. Negative cognitions were assessed by using 4 MHRSD items, specifically, guilt, worthlessness, helplessness, and hopelessness.

Results indicated that as symptoms of depression increased, negative cognition increased more slowly for people who received CT. CT reduced negative thinking as symptoms of depression increased. On the other hand, CT did not influence the association between negative cognition and depression. CT may be able to “unlink” negative cognition from other symptoms of depression. In this regard, cognitive therapy may help patients to relate more functionally to their negative thoughts by not giving credence to dysfunctional thoughts that interfere and disrupt their daily functioning. CT provides an alternate way of thinking, invalidating negative and dysfunctional thoughts and may be the factors that help prevent relapse. Further investigation is needed to determine if this study can be generalized to all populations since this study was conducted in a private hospital in Providence, Rhode Island.

Major Depressive Disorder with Comorbid BPD:

MDD shares many of the same symptoms of BPD. Rogers, Thomas, Widiger and Krupp (1995) designed a study to empirically identify the aspects of depression

most closely associated with BPD. 50 adult inpatients were administered structured interviews and self-rating scales. Structured interviews assessed depression and borderline personality disorder. Interviews included the Structured Interview Guide of the HDRS, Diagnostic Interview for Borderlines (DIB), the Personality Interview Questions, and the Millon Clinical Multi-axial Inventory to assess construct validity of the interviews. Additionally, the BID was used and the Carroll Rating Scale for Depression, the Clinical Psychopharmacology Research Group Scale, the Hopkins Symptom Checklist and the Self Report Inventory of Depression Symptomatology. This study assessed the relationship of BPD and 11 aspects of depression: boredom, emptiness, abandonment fears, self-condemnation, self-destructiveness, cognitive dysfunction, hopelessness, guilt, sense of failure, somatic complaints, and helplessness

Results indicate that the aspects of depression most associated with BPD are self condemnation, emptiness, abandonment fears, self destructiveness, and hopelessness; boredom and somatic complaints exhibited no association. They also found that people with the co-occurring disorder of MDD and BPD have what can be seen as more desperate and disorganizing qualities which makes BPD unique, distinct and its own separate entity (Rogers, Thomas, Widiger, Frupp1995). In addition it questioned the outcomes of measures used in treating depression such as the BDI. They contend that although the BDI may produce scores that are the same for individuals with and without BPD, the test may not be able to account for the phenomenological distinctions between the two. For example someone on medications may have a decreased BDI score which may indicate a decrease in

cognitive dysfunction but may not account for other aspects of the disorder. This study implies the need for a clear understanding and thorough evaluation of the illness and how it manifests to help target the most effective treatment approach for this difficult population.

Support for this idea can be seen in the study conducted by Stanley and Wilson (2006). They attempted to examine the difference in severity of symptoms between patients with MDD and co-morbid BPD from patients diagnosed with MDD alone. 60 outpatients with a diagnosis of MDD participated in this study. 29 had comorbid BPD and 31 had no Axis II diagnosis. The SCID-I was used to determine their diagnosis. The HRSD was used to assess the severity of depression: with a score of 7 to 17 being mild, 18-24 moderated and 25 severe.

Results indicated that the MDD/BPD group reported more severe depressive symptoms on the self report measures than the MDD group. It is important to note that the clinician's rating of both groups did not significantly differ. However, MDD/BPD patients rated themselves as more depressed than the clinicians. These findings do not indicate a problem with the measures or how the measures are scored but may account for the fact that BPD patients tend to feel invalidated, believing that others do not know how bad they feel (Lenihan, 1993). This study compliments the Rogers and Widiger(1995)study which found that MDD/BPD have qualitatively distinct patterns of symptoms. Additionally, Lenihan's (1993) biosocial theory of BPD maintains that borderline patients are predisposed to a vulnerability to negative moods and are extremely sensitive to negative cues and emotional dysregulation. In

this regard, individuals with MDD/ BPD suffer with more severe depressive symptoms. It would be important for clinicians to know that BPD individual's subjective experience cannot be accurately detected using standard tests and measures.

To add to this notion, Benjamin and Wonderlich (1994) conducted a study comparing the social perception of three groups of inpatients diagnosed with unipolar disorder, bipolar disorder and BPD. They intended to study the differences in perceptions between patients with different affective disorders. The Structural Analysis of Social Behavior (SASB) was administered to the three groups of patient. The SASB measured three specific areas: the interpersonal: transitive-focus-on other, interpersonal: intransitive-focus on self, and intrapsychic: introjection. Results indicated that BPD patients were more hostile and autonomous especially towards their mothers, hospital staff and other patients. The results are discussed in terms of an integrative theory which considers the psychobiology of BPD, interpersonal relationships and attachment disruptions

Since most individuals diagnosed with BPD have a 53% to 83% likelihood of a coexisting Axis I diagnosis of MDD, Bellino, Patria, Parsdiso, Lorenzo et. al.(2005) conducted a study to compare the clinical characteristics of patients with MDD alone and MDD with comorbid BPD. 119 outpatient diagnosed with MDD were divided into two groups. Group1 had MDD and BPD and group 2 had MDD with a different Axis II diagnosis. All patients were given a semi-structured interview to determine demographic and clinical features, the SCIDT to determine Axis I comorbidity, the

Hamilton Anxiety Rating Scale (HARS-21) the (HDRS,22) for depression, the Social and Occupational Functioning Assessment Scale (SOFAS,24 and the Sheehan Disability Scale (SDS,25), the Zung Depression self-rating scale (ZSDS-23) and the Revised Childhood Experiences Questionnaire (CEQ-E, 26).

Results indicated that patients with MDD and BPD are more seriously impaired than individuals with MDD and a different Axis II diagnosis. MDD/BPD patients exhibit distinct features which include early onset, more severe depression, worse social impairment, stronger familial association, and self-aggressiveness. Severity of depression was positively related to the ZSDS score, to self mutilating behaviors, and the occurrence of mood disorders in first-degree relatives. Conversely, it was negatively related to the SOFAS scores and age of onset of MDD. These findings may have implications of the overlapping symptoms and etiology of MDD and BPD. A consideration should be made for the need of an accurate assessment of personality disorders in depressed patients to assist in developing the best treatment approach for these individuals.

In addition to the need for an accurate assessment, there is a need for an integrated approach to treatment. Lee and Overholser (2004) recognized a need for an integrated treatment plan that addresses both the BPD and the MDD. They content that BPD influences the presentation and treatment of MDD. .BPD patients tent to experience bouts of negative affect and have a difficult time calming themselves down. Their feelings of emptiness, loneliness and anger are exacerbated by the fact that they also experience depression. Negative cognitions are thought to play a

central role in the emotional overreaction of these patients (Lee and Overholser, 2004), leading to social and occupational impairments. Using a case example, the researchers show how borderline traits influence the assessment and treatment of major depression. As part of the assessment, Lee and Overholser (2004) recommend differentiating BPD from depressive symptoms. They also support the importance of the maintaining a therapeutic alliance that validates the BPD patient, using empathy, openness and instilling hope. Their final recommendation is to stay focused on long term therapy and cope with non-compliance, since working with BPD is difficult, challenging and may progress slowly. The case study conducted by Lee and Overholser (2004) provided an outpatient with 27 sessions of CBT. Treatment included an integrated approach to treatment plan and the above mentioned recommendations. A review of the progress made by this individual resulted in a positive outcome, with the client making a number of strides in reducing symptom severity and improving quality of life. This study was important in that it was not a traditional randomized controlled trail. The researchers were able to effectively transfer theory into practice in treating depression and borderline personality in a clinical setting and get positive outcomes. This approach to research would be a very useful tool for teaching how to apply theory into practice.

Since studies for psychotherapeutic trials in the treatment for BPD are limited, Brown, Newman, Charlesworth, Crits-Christoph et. al (2004) conducted an open clinical trail of Cognitive Therapy for Borderline Personality Disorder. They examine whether cognitive therapy can improve measures of psychopathology of BPD, specifically the risk factors associated with this disorder. Previous studies

found that core beliefs of BPD patients are highly negative and dysfunctional and reflect themes of dependency, helplessness, distrust, fears of rejection and abandonment, fears of losing control, and extreme attention seeking behaviors (Brown et. al. 2004 p. 259). The goal of CT is to identify and modify patient's core dysfunctional beliefs and to emphasize "collaborative empiricism" which is a term used to define the therapeutic relationship between the patient and therapist. In CT, they work together as a team to investigate evidence for and against dysfunctional thoughts and core beliefs. 32 individuals diagnosed with BPD and who reported risky behaviors received weekly cognitive therapy sessions for over one year. They were administered a number of assessment measures at baseline, 6 months, 12 months and an 18 months. Measures consisted of the SCID-II. The 19-item Scale for Suicide Ideation (SSI), this is a semi-structured interview which measures and evaluates the intensity of the patients plan to commit suicide. Two measures used to assess the severity of depression included, HRSD, and the BDI-II.. The Beck Hopelessness Scale (BHS) assessed positive and negative beliefs about the future. The Parasuicide History Interview (PHI) counted the number of intentional self- injurious behaviors. The Personality Belief Questionnaire (PBQ) is a 126 –item self-report measure to assess beliefs endorsed by patients with personality disorders, intended to assist therapists in eliciting dysfunctional beliefs.

Results indicated that patients experienced a decrease in levels of depression, hopelessness, suicide ideation, and symptoms of BPD from baseline interview to termination and at 18 months. 27% were in remission at termination and 55% at the 18 month follow- up. Suicide ideations and self- injurious behavior scores were

low at termination, indicating that CT can be useful in suicide prevention. Improved measures of dysfunctional beliefs indicated that CT can be useful in treating BPD. Although this was a thorough study, there is a need for the replication of randomized clinical trials to examine the efficacy of CT in treating BPD.

Parker, Roy & Eysers (2003) conducted a meta-analysis reviewing original and quantitative analyses of the efficacy of CBT on depression. They argue that the review of the literature challenges the notion that CBT is as efficacious as other psychotherapies. Since improvements associated with CBT occur early in therapy, they suggest that it is difficult to analyze its effectiveness. They cite Gloaguan's meta-analysis of 48 randomized controlled trials comparing 2,765 patients receiving CBT and a number of additional modalities which included behavior therapy, placebo and a waitlist. With the exception of behavior therapy, CBT was seen to be superior to wait list or placebo. Parker et. al. (2003) suggest that this should not be considered proof for efficacy of CBT since it is being compared to a waitlist or placebo and not another evidenced based therapy. Their analysis did however, result in the notion that CBT can be useful as an augmentive therapy for treatment- resistant depressives and that the effectiveness of CBT only reflects non-specific ingredients common to all psychotherapies.

Dialectic Behavioral Therapy (DBT) and BPD

An offshoot of CBT is Marsha Lenihan's (1993) Dialect Behavioral Therapy (DBT). DBT is an innovative method of treatment that had been developed specifically to treat BPD patients. Lenihan (1993) devised this treatment to deal

specifically with this hard to treat population. BPD patients have a difficult time remaining in therapy, frequently fail to respond to therapy, and make demands on the emotional resources of the therapist. DBT is based on Lenihan's biosocial theory of personality. This theory contends that BPD patients are unable to self regulate, react excessively to low levels of stress, and take longer than usual to return to baseline once the stress is removed. (Lenihan 1993) The major premise of this theory is that the client is either "hard wired" towards an unusually emotional temperament or has sustained severe emotional or physical trauma which produced changes in the brain, making it more vulnerable to intense feeling states.

Biological irregularities and "invalidating environments" result in the development of Borderline Personality Disorder, (Lenihan 1993). Invalidating environments are situations in which a child's personal experiences and responses are disqualified or "invalidated" by the significant others in their lives. In these environments the child's personal communications were not accepted as an accurate indication of his/her true feelings, implying that such feelings are not valid responses to circumstances. High values are placed on self control and self reliance and most experiences are met with erratic, extreme and inappropriate responses. A child in this situation will oftentimes be punished, trivialized or disregarded. Examples of these environments include abusive and neglectful environments or mismatched personalities of parents and children, (i.e.: a shy child growing up in a family of extraverts).

Therapy is organized into a number of hierarchical stages, each targeting something specific. The pre-treatment stage starts off the therapy focusing on

assessment, commitment and orientation to therapy. Thereafter, therapists move on to actual modules which are specific to the need of the BPD client and assists in creating change. Various stages of treatment include focusing on life threatening behaviors then moving onto an improved quality of life and acceptance

Efficacy of DBT has been assessed in two major trials conducted by Lenihan et. al.(1993) The first clinical trail compared the effectiveness of DBT in relation to treatment as usual (TAU). The goal of this study was to reduce the frequency of parasuicidal behaviors (self-injurious behaviors); reduce therapy interfering behaviors such as attrition and reduce behaviors that interfere with the patient's quality of life. To examine the efficacy of DBT, 44 outpatients were randomized into two groups. 24 received DBT and 23 patients received treatment as usual (TAU). TAU consisted of individual counseling or attendance at a day treatment program. Patients were assessed at pre-treatment, 4, 8 and 12 months and 6 and 12 months post-treatment. Measures of treatment compliance and inpatient days were recorded.

Results indicated that DBT is superior to TAU. All treatment goals were attained. During the year of treatment, the TAU group engaged in more parasuicidal acts than the DBT group. The DBT group's attrition rate for DBT was 16.7% versus a 50% rate for the TAU group and patients in the TAU group had more inpatient days than the DBT group, 38.6 versus 8.46, respectively.

The second study compared standard community psychotherapy (SCP) plus a group skills component of DBT with SCP alone. Results indicated no difference between the two groups. A second part of this study was a post hoc comparison of stable patients receiving individual counseling in the second study with stable patient

receiving DBT in the first study. The goal was to compare DBT to other psychotherapies. Results showed that the DBT patients did better in all target areas.

Evidence in the first study indicates that DBT may be an effective treatment for this very difficult to treat population. However, additional studies with a larger sample size are needed. The second study was weak in that it was mainly a comparison study and a more rigorous comprehensive study is needed to confidently determine efficacy.

Scheels (2000) believes that the evidence to support the efficacy of DBT on BPD clients is not strong enough. He contends that although we can conclude that DBT is useful in producing initial improvement on relevant variables such as in suicidal behaviors and psychiatric hospitalizations, there is an absence of evidence of follow-up data at intervals appropriate in assessing efficacy.

Conversely, Palmer (2000) feels that although this is a costly, elaborate, demanding and expensive treatment, it is one of the few effective treatments for a group of patients who suffer and are at high risk. Other treatments for BPD have less evidence to support any claims for efficacy. He adds that DBT may serve to help people with BPD who are often served poorly by less specific treatments. Routine treatments run the risk of being just as expensive but ineffective or harmful.

Chapter 3: Normative Practice/Outcomes

Sources for this section came from the Agency's Program Manual, an interview with the program supervisor, the therapist's tenure as an employee at the Agency for the past 14 years and her experience as student intern in the counseling program, intermittently since 2005.

Ms. Smith's treatment took place in the counseling program in a community based mental health center. This program is part of a larger not-for profit agency which provides an array of behavioral health and human services across several treatment programs, including outpatient services, adult, children, family, geriatric, MICA and DDD partial care programs, foster care and support, in-home therapy, school based therapy and residential programs. Of the populations served, priority is given to individuals referred from county and state psychiatric hospitals and Screening and Crisis Units. The agency's primary funding source is the Department of Mental Health Services (DMHS); however the counseling program receives additional support from the United Way. Most private insurances, Medicaid, Medicare and sliding scale fee payments are accepted.

All student interns are supervised by a licensed therapist, with the appropriate credentials for supervision. Supervision is conducted a minimum of every two weeks or as needed and is comprised of face to face meetings with the supervisor, to discuss

issues surrounding treatment approaches, interventions, treatment planning and self care.

The Agency's program manual outlines the policy and procedure in regard to clinical practices and expectation of all therapists hired by the Agency, including interns. It is noteworthy to state that all policy and procedure is based on the Agency's major funding and regulating bodies, DMHS and Medicaid. The most recent revision to the clinical pathways section of the manual was completed about three years ago, prior to a DMHS review and stresses the use of best practices in treating specific diagnoses. The manual states that the research conducted to write the manual is based on the Clinical Practice Guidelines (Version III), Harold Bent, Editor (2001). The manual recommends using the empirically based treatment guidelines set forth by the Clinical Practice Guidelines. Treatment is structured by core treatment principals set forth by the agency, which is based on three key factors that contribute to the improvement in therapy. The first core concept is expectancy which is defined as the consumer's hope and belief that the treatment will work, the second is extra-therapeutic change which is the aspects of the consumer, family and environment that impact change, the third is the therapeutic relationship factor which emphasizes the use of empathy and acceptance.

Interventions are based on the individualized needs of each client. The average length of stay for clients in this program is 10 sessions, with the continuation of services assessed at each session.

In addition, the clinical practice guidelines recommend the integration of several theoretical models common to many interventions across populations and

include cognitive-behavioral reconstruction, psych-educational training, interpersonal therapy, psychopharmacology and solution- focused brief therapy.

The manual lists the most frequently seen Axis I diagnoses along with interventions that have been proven effective for these diagnoses. Only four diagnoses were listed, namely: Oppositional Defiant Disorder, Major Depression, Generalized Anxiety Disorder and Adjustment Disorder. The diagnoses listed were provided with a description of the diagnosis and the specific intervention and the desired outcome. Although the therapists are expected to use these intervention approaches for these specific diagnoses there is no oversight of the intervention used. It is important to note that no Axis II diagnoses were listed.

Oversight includes biweekly supervision by the clinical supervisor. Weekly chart reviews by the Program Supervisor to ensure that documentation is completed timely and is clinically sound. Paperwork includes a comprehensive 13 page bio-psychosocial assessment and an initial treatment plan due by the sixth week of enrollment, weekly progress note in DAP format (Data, Assessment and Plan); and quarterly continued stay reviews which are short reports that justify continued treatment. The Agency requires additional oversight by the program supervisor who must conduct additional random chart reviews. He/She selects two charts, reviews them and reports the finding to the VP of Quality. In addition, ten percent of enrolled clients are randomly selected by the Agency's Quality Treatment Review Committee (QTRC) to be reviewed for the abovementioned items. This review takes place at least 11 times a year.

Each quarter a satisfaction survey is completed by each active client in the program and this is sent to the Director of Quality who aggregates the score and sends this information to the Clinical Outcomes Subcommittee. The committee looks for trends and makes recommendations based on the score. This satisfaction survey is also sent to the Department of Mental Health Services for their review. The Survey includes questions regarding treatment, rights, confidentiality, and overall satisfaction.

Treatment consists of weekly sessions and a psychiatric evaluation by the consulting psychiatrist. The doctor is a consulting psychiatrist from a local University Hospital. To save money on cost, a resident provides treatment for the clients at this program. The resident is supervised weekly by the Agency's medical director who is also the Medical Director of Psychiatry at the same University Hospital.

It is mandatory that all Medicaid clients receive an initial psychiatric evaluation within 14 days of enrollment. At this time, the consulting psychiatrist will complete a comprehensive psychiatric evaluation, provide a diagnosis and prescribe medications. This initial meeting is scheduled for one hour. It is important to note that the psychiatrist's diagnosis is primary to the therapist's diagnoses. If however, there is a discrepancy, the therapist is encouraged to talk with the psychiatrist to discuss issues surrounding treatment and diagnosis. The psychiatrist is required to see the client at least once every three months or as needed. On average, however, a client who is prescribed medications sees the psychiatrist once a month. At this time, prescriptions are renewed and diagnoses are updated.

The Zung Self Rating Depression Scale is available for all staff to use. This is a 20-item self report questionnaire that screens for depression and asks the client to rate themselves by checking a box that best describes how he/she feels during the past several days based on the statement provided. For example the first question is: "I feel down-hearted and blue". The corresponding boxes that can be checked include: "A little of the time, some of the time, good part of the time, or most of the time". Each box checked is scored as follows: the first box will score a "1" with the last scoring a "4". According to the scoring key, a total score between 50 and 69 will indicate that the person is depressed. The highest possible score is 80, which would indicate severe depression. Although the scale is available at the program, it is not presented with the key. Therefore the person administering it, really does not score it and uses it more for face value. It is important to note that anyone can get this tool; it is free and available on the internet, there is no requirement to administering it and takes less than 10 minutes to complete. It is effective, in quickly monitoring changes overtime.

For the purposes of this case, alternate tools were chosen to monitor the severity of depressive and anxious symptoms and to monitor progress over time. These included the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI) and the Personality Assessment Inventory (PAI). The BDI, created by Aaron T. Beck, is a 21 question multiple choice self report inventory, designed for adults ages 17 to 80 and is composed of items relating to depression symptoms such as hopelessness, irritability, cognitions and feelings of guilt, punishment as well as somatic complaints. The BDI is reliable and has an alpha coefficient of .86 for the

psychiatric population. It also tests high for test- retest reliability ranging from .48 to .86, depending on the time between each test administered. The BAI is designed to discriminate anxiety from depression. This is a 21 item scale, describing a common symptom of anxiety. The client is asked to rate how much he/she is bothered by the symptom. The items are summed and scored. The reliability of this inventory ranges from .30 to .71. The PAI is also a self administered inventory of adult personality and psychopathology. This contains 344 items with 22 non-overlapping scales. These scales measure a manifestation of clinical syndromes, clustered in neurotic, psychotic, personality disorders and behavioral disorders and can detect malingering, evaluate for aggression and suicide, and motivation for treatment. Reliability for this scale ranges from .75 to .79. Although the BDI and BAI are easy and quick to administer, the PAI is very lengthy and takes 40 to 50 minutes to administer. All tests must be purchased and scored by a licensed person which may be a factor in why this Agency does not invest in tests with high reliability. It is important to note, that it was necessary to obtain special permission from the Agency to use the BAI, BDI and PAI.

Ms. Smith was scheduled within a week of contacting the agency for help. The initial assessment included a risk assessment and information about the treatment provided, confidentiality issues and a rights and consent form that was reviewed and signed at this time. A brief assessment was conducted to determine immediate needs and to see if this was the appropriate level of care for Ms. Smith. This assessment is part of the biopsychosocial assessment required by the agency. The assessment indicated that Ms. Smith was stable at the time was and not in crisis. She was

however, given the phone number to the local Screening and Crisis Center and the number to the agency enabling her to contact the therapist on off hours if she was in crisis which is common practice by the agency. Ms. Smith appeared appropriate for individual counseling. Since the therapist did not have access to the PAI, BDI and BAI they were not administered until the third session. All three were administered at the third session. Thereafter, the intention was to administer the BDI and BAI every other session. By session 5, Ms. Smith was hospitalized therefore the tests could not be administered. During the next few sessions, consumer attended with either her child or her mother so tests were not administered. On the 9th session tests were again administered and then again on the 12, 14, 16, and 18 session. A provisional diagnosis was given and an initial treatment plan was completed. The initial treatment plan addressed depression, aggression medication and is as follows and is broken up into the goal, the objective and the intervention. They are as follows:

Problem No. 1: Depression:

Goal No. 1: Ms. Smith will attend weekly sessions for a minimum of 10 sessions to be assessed thereafter and meet with the therapist for one-on- one counseling to discuss issues of depression and anger.

Objective Ms. Smith will attend weekly sessions and if she cannot attend she will contact the office to reschedule no more that 24 hours of the scheduled appointment.

Intervention: The therapist will schedule weekly appointments

Goal No. 2: Identify distortions in thinking that lead to depressive feelings and behaviors.

Objective: Ms. Smith will journal and complete written assignments on the cognitive aspects of depression and verbalize an understanding of how patterns of thinking affect feelings and behaviors.

Intervention: The therapist will discuss the concept of cognitive distortions in depression and assign written exercises that illustrates the effect thinking has on emotions, and help the consumer become more aware of the negative thinking patterns while reinforcing positive thinking patterns.

Problem No. 2: Aggression;

Goal No. 1: Ms. Smith will identify triggers that cause anger and a lack of impulse control

Objective: Ms Smith will use coping skills such as counting to 10, breathing exercises, walking away, and meditation when feelings become out of control.

Intervention: Therapist will teach coping skills, and use role play in helping Ms. Smith develop new ways to communicate her needs to others without becoming angry.

Problem No 3: Medications:

Goal: Ms. Smith will attend her first scheduled psychiatric evaluation with the staff psychiatrist and take medications as prescribed to reduce symptoms of her illness.

Objective: Ms. Smith will be medication adherent and report side effects as they happen.

Intervention: The psychiatrist will provide medication education on medications prescribed and inform Ms. Smith of their use, her prognosis and side effects of these medications.

Although the treatment plan called for weekly sessions, Ms. Smith attended on average, three times monthly. When she did not attend, phone contact was maintained. According to agency policy, Ms. Smith, was scheduled to see the consulting psychiatrist within the first two weeks of enrollment, monthly thereafter, or as needed for medication monitoring.

Ms. Smith was prescribed an antidepressant Zoloft which assisted in alleviating her depression. Prior to attending counseling, Ms. Smith was prescribed an anticonvulsant medication, Trileptal for migraine headaches. Once she was hospitalized, this medication was continued but increased since it is used off-label as a mood stabilizer for mood swings. Trazadone was prescribed for sleep. Her discharge diagnosis from the hospital was Major Depressive Disorder, with psychotic features, recurrent and severe, in partial remission and Conduct Disorder. Ms. Smith has been very responsive to the medications prescribed but at times solely depends on them to help her, requesting an increase when she feels her anger is out of control. This request was denied by the psychiatrist who informed her that medications were only half of the treatment and the other half consists of working on her treatment issues in and out of session.

The clinical supervisor was not formally trained in Cognitive Behavioral Therapy; therefore, workbooks which included manualized cognitive treatment for depression were relied upon. The text entitled Cognitive Therapy of Personality

Disorders by Beck, Freeman, Davis and Associates was used as a resource for treating the Borderline Personality Disorder. Cognitive Therapy Techniques by Robert Leahy was used to guide and educate Ms. Smith about how her thoughts elicited behaviors. The following topics were discussed in therapy: automatic thoughts, eliciting thoughts and assumptions, evaluating and challenging thoughts, evaluating worries, distinguishing thoughts from facts, negative thinking, and ABC :Activating Event, Belief (thought) and Consequences. To assist with anger management the Weisinger's Anger Workout Book provided a step by step approach touching on the positive and negative functions of anger, how distortion in thinking can lead to anger and recognizing triggers to anger. In addition the therapist used role play to develop better communication skills on how to talk to people to effectively get what she needs without using anger. At first, Ms. Smith was asked to keep a diary of when she felt her emotions were out of control. Her main issue appeared to be anger management. Across all of areas of life, Ms. Smith would become angry at someone or something during the week. At first she was asked to uses techniques to calm herself such as breathing, counting from 10 backwards before responding to the situation, and when needed to remove herself from the situation for safety reasons. Once this was established, Ms. Smith was asked to keep a diary of when she became angry or upset. She was asked to keep a log of the situation and the emotion(s) that went along with the situation, what she was thinking at the time automatic thoughts and her response to the situation. Ms. Smith did this for homework and had no trouble bringing in this diary to review together. This technique was very successful. She was able to read it back to herself and develop and recognize that some of her

thoughts were distorted and her responses at times were irrational. From this we were able to role play and practice better ways of handling the situation. For example, Ms. Smith was very angry at a child in her son's preschool who she felt; intentionally hit her son with a pretend sword, resulting in injury to the skin on his nose. Ms. Smith's initial response was to go to the school and hit this child. We discussed the implications of this behavior, i.e. she could get arrested, and the child could get injured. She then decided that she was going to confront the parents of this child and was ready to have a physical altercation or at least to threaten the parents that she would harm this child if she did this again. We again discussed the outcome of this type of behavior. We then listed a number of ways that would be more productive. We talked about getting the child care provider of the school involved since this incident happened at the daycare center. We discussed who the responsible party was and that the school director should provide a safe environment for all the children. We practiced what she would say to both the parents and the childcare director at a meeting that was scheduled. She was very eager to tell me during the next session that she was able to effectively communicate what we practiced. She felt proud of herself for not overreacting and accomplishing her goal of saying how she feels, being listened to and getting things changed. The child care director reportedly informed Ms. Smith that she was going to have her staff monitor the children more closely. The parents of the other child were reportedly receptive in Ms. Smith's request that they tell their daughter that hitting is not acceptable.

We discussed what Beck terms "dichotomous thinking". This is black and white thinking with extreme reactions and impulsive decisions. Ms Smith became

aware that she tends to resort to this type of thinking and recognizes that it is not productive and that there is another way to do things that produces change. Another example of this is when Ms. Smith believed that her aunt was angry at her since she did not call her for a few days. Ms. Smith believed that her aunt was upset with her after she told her about her promiscuity. She was sure that her aunt was really upset with her and feared that her aunt would tell her mother and never speak to her again. This was discussed at length and we talked about how Ms. Smith tends to jump to conclusions without any evidence to support this claim. We used role play with how she would contact her aunt to discuss how she was feeling. At the next session, Ms. Smith was able to report that she called her aunt and to asked her why she had not made contact with her for awhile and to ask if she was upset with her. During this conversation, Ms. Smith learned that her aunt had been really busy at work and home trying to complete a special project. Her aunt explained if she does not call, it is because she is busy and has nothing to do with her feelings for her. Her aunt asked that if she feels this way again that she should contact her before jumping to conclusions. Ms. Smith was relieved. We talked about this and how sometimes this type of thinking overlaps into other areas of her life. We discussed this and how she can handle this type of situation in the future.

Since Ms. Smith would bring up how she felt about her mother neglecting her during her childhood and about the abuse she sustained by her mother's boyfriend when she was a child, we used the empty chair technique as a way for her to express her feelings and opinions towards them in a safe environment. As far as her talking with her mother, she was able to do this. Again this was almost like practice, since

she later went home and actually talked to her mother about how she felt about being left alone so much. It was not as effective with talking to her abuser. She felt that she put this behind her and forgave him already. She may not have been ready to broach this issue. In a later session, she did write a letter to this man, telling him how angry she was at him for taking her innocence. After reading this letter in session, she ripped it up and threw it away. After this, she refused to discuss this issue and would make excuses for him by saying that “he would not have done this if he was not high”. She was able to forgive him and insisted that she did not feel any anger or hostility towards him anymore. If the therapist attempted to touch on this issue, Ms. Smith would refuse to discuss this.

Ms Smith was also given the book The Dance of Anger which she was to read at home and we would discuss during session. Although homework was intended to be a big part of her treatment, she would sporadically complete worksheets, doing more in the beginning of therapy, than towards the end. We discussed why she was not doing the homework and she would say that she was too busy at home.

Outcome Measures:

Ms. Smith was given the BDI and BAI five times over the course of treatment. The first tests administered on the third session indicated severe depression resulting in a brief hospitalization by the fifth session. Thereafter, follow up measures indicated symptoms of depression and anxiety which remained in the non-clinical range. The PAI was given on the third session and again on the 18th session. This measure did not change overtime and showed a high level of clinical symptoms including depression, anxiety, paranoia, and aggression which were addressed in

treatment planning and discussed during session. It is noteworthy to state that Ms. Smith has trust issues and a high level of negative impression management which may have resulted in an exaggeration of her symptoms to seek attention. These behaviors are consistent with her diagnosis of MDD and BPD.

Chapter 4: Normative Versus Best Practice

Ms. Smith's symptoms responded favorably to the therapy that was provided to her. The literature states that the first- line of treatment for MDD is psychopharmacology, specifically antidepressants. Ms. Smith was prescribed antidepressants and an anticonvulsive for her mood swings which is common practice for the agency. This treatment goes right along with the literature that has been reviewed. Ms. Smith's depression was alleviated with the used of psychotropic medications. This worked as seen by symptom reduction and the ability to remain out of the hospital, in the community while resuming her daily functioning in caring for herself, and her son. As a result of her symptom reduction, she was able to work on her treatment goals. She developed skills in to decrease anger, recognize distorted thinking, develop and used appropriate coping skills, and was effectively communicated her needs without becoming angry. She did this within 19 sessions even though the average length of stay for a client in this program is 10 sessions. It was recommended that Ms. Smith remain in counseling to continue to practice and develop the skills she already learned and work on issues surrounding parenting and interpersonal relationships. However, Ms. Smith adamantly refused to start over with someone new.

The therapist and Ms. Smith developed a therapeutic alliance based on trust and empathy. At first, Ms. Smith was not truthful in many accounts and at times

The therapist and Ms. Smith developed a therapeutic alliance based on trust and empathy. At first, Ms. Smith was not truthful in many accounts and at times would sensationalize her stories to make them sound important. She would also bring her son to therapy as a distraction so that she would not have to talk about her issues. Over time, Ms. Smith became more comfortable with the therapist and was able to talk freely about herself, including her behaviors of sexual orientation and promiscuity. In addition she was able to practice new skills, recognized and tested evidence against distorted thinking and was able to effectively role play in and out of therapy.

Upon discharge, Ms. Smith was referred to the agency's outpatient program which offers psychiatric evaluations and medication monitoring only. Ms. Smith accepted this referral and one week after she was discharged from therapy, she was enrolled in the outpatient programs. After three months, she has attended all of her appointments and reported that she is feeling fine. She is presently planning a wedding with her boyfriend who was released from jail. She reports that is his managing fine at home and that her she her fiancé and her son are doing fine. She continues to use the coping skills that she developed in her therapy sessions.

In theory, the program is set up to adhere to the best practices for MDD and BPD. The policy and procedure of the program states that the therapist will adhere to the best practice of a specific diagnosis, for example CBT for MDD. In most cases, the therapist may conceptually understand CBT is but may lack the training and skill to use it effectively. In addition, the clinical supervisors are typically not trained in this technique and cannot provide the needed oversight for the use of CBT as a

treatment modality. In most cases, the consumer will receive treatment based on the therapists and the clinical supervisor's orientation. It is certain however, that the client will receive a psychiatric evaluation and medication monitoring.

Chapter 5: Summary and Conclusions

The purpose of the current project was to track progress of one client throughout her involvement with the author who served as her mental health provider. In doing so, the psychosocial assessment was presented, the empirical treatment literature related to her diagnosis was reviewed, her progress over the course of treatment was summarized and a comparison between her current treatment and what might be considered best practices was presented.

The client is a 23 year old African American single parent female. The results of her psychosocial assessment indicated that she was experiencing a variety of clinical conditions. She was diagnosed with Major Depressive Disorder with comorbid Borderline Personality Disorder. Her history indicated abuse and neglect during childhood for which she was briefly treated. She has maintained unhealthy relationships with marginal men and women and becomes involved with risky behaviors of sexual promiscuity to pass the time, while her boyfriend serves time in jail. She is not trusting of many people and cannot take constructive criticism from authority figures, making it difficult to maintain gainful employment. She has no positive role models for parenting and raising her son as a single parent is a big stressor for her.

After completing a thorough psychosocial assessment and coming to a conceptual and diagnostic understanding of the client, a literature review was

conducted to explore the best type of treatment that might be provided to the client. The results of this literature review led to a number of conclusions regarding the best type of treatment for a client with MDD and BPD.

The literature states that psychopharmacology is the first line of treatment in treating both MDD and BPD. With regard to treating MDD with BPD, these diagnoses should be considered together as one distinct entity since many of their symptoms overlap and impact each other.

The literature presents strong evidence for the efficacy of pharmacotherapy in conjunction with psychotherapy. Together they are effective in reducing symptoms and preventing relapse in severely depressed individuals. Although no one psychotherapy has been proven superior over the others, many RCTs incorporating CBT provide evidence for efficacy in symptom reduction and in helping the client recognized, identify and question the validity of automatic, dysfunctional thoughts. CBT provides the client with a set of skills that can be used when needed in dealing with residual symptoms. In this regard, CBT has an enduring effect which can provide additional support in the prevention of relapse.

Overall results of the treatment provided to Ms. Smith, indicates that treatment was effective. The client experienced a significant reduction in severity of symptoms and was able to attain her treatment goals and remain hospital free. Her depression improved as seen by her increase in motivation and her ability to return to her baseline level of functioning, independently completing daily tasks of caring for herself and her son. However, since the PAI indicated ongoing clinical elevations of paranoia and aggression, Ms. Smith would benefit from continued treatment.

Without treatment she may not be able to maintain this level of functioning.

Although ongoing therapy was encouraged, Ms. Smith adamantly refused stating she did not want to start over with someone new. During therapy sessions, Ms. Smith developed skills to cope with anger and aggression which was under control at time of discharge.

In exploring the efficacy of the treatment provided to Ms. Smith, it became apparent that a major factor that could have improved treatment is the use of CBT by a more experienced therapist with a more knowledgeable clinical supervisor. In addition, the client should have remained in therapy longer to provide more time to practice skills developed and to address issues surrounding parenting and interpersonal relationships. Finally more research is needed to determine the best practice for comorbid disorders, specifically MDD and BPD. There is also a need to train therapists in a variety of interventions specifically CBT. This will give clients options when searching for therapists to treat their diagnosis. Based on the literature and this writer's observation of clinical practice, most client's treatment in a community based setting consists of medications plus some type of psychotherapy that is not necessarily based on best practice but on the skills and orientation of the therapist.

References

- American Psychiatric Association. (2000). Diagnostic and Statistic Manual of Mental Disorders (4th ed. rev.) Washington, DC:
- Anonymous (2000). Practice Guidelines for the treatment of Patients with Major Depressive Disorder (Revision). *The American Journal of Psychiatry*, 157, 1-7.
- Beevers, C. G. , & Miller, I.W. (2005). Unlinking Negative Cognition and symptom of depression: Evidence of a specific treatment effect for cognitive therapy. *Journal of Consulting and Clinical Psychology*, 73, 68-77.
- Bellino, S., Patria, L., Paradiso, E., DiLorenzo, R., Zanon, C., Zizza M, et al. (2005). Major Depression in Patients with Borderline Personality Disorder: A clinical investigation. *Canadian Journal of Psychiatry*, 50, 234-238.
- Bellino, S., Zizza, M., Camilla, R., & Filippo, B., (2006). Combined Treatment of Major Depression in Patients with Borderline Personality Disorder: A Comparison with Pharmacotherapy. *Canadian Journal of Psychiatry*, 51, 453-460.
- Blier, P. (2001). Crosstalk between the norepinephrine and serotonin systems and its role in the antidepressant response. *Journal of Psychiatry and Neuroscience*, S3-S10.
- Benjamin, L.S. & Wonderlich, S.A., (1994) Social Perceptions and Borderline Personality Disorder: The relation to mood disorders. *Journal of Abnormal Psychology*, 4, 610-624

- Brown, G.K., Newman, C.F., Charlesworth, S.E., Crits-Christoph, P. & Beck A.T.
An Open Clinical Trial of Cognitive Therapy for Borderline Personality Disorder.
Journal of Personality Disorders, 18, 257-271.
- Celada, P., Puig, V.M., Amargos-Bosch, M., Adello, A., & Artigas, F. (2004). The
therapeutic role of 5-HT_{1A} and 5-HT_{2A} receptors in depression. *Journal of
Psychiatry and Neuroscience*, 29, 252-263.
- Chouinard, G.(2006). The Search for new off-label indications for antidepressant,
anxiolytic, antipsychotic and anticonvulsant drugs. *Journal of Psychiatry and
Neuroscience*, 31,168-177.
- Dobson, D.S., Johnston, C., Johnston, C., Mikail, S., & Hunsley, J. (1999).
Empirically Supported psychological treatments: A natural extension of the
scientist-practitioner paradigm. *Canadian Psychology*, 40, 312-315.
- Elkin, I., Shea, M.T., Watkins, J.T., Imber, S.D., Sotsky, S.M., Collins, J.F., et al.
(1989). National Institute of Mental Health Treatment of Depression
Collaborative Research Program: General effectiveness of treatments. *Archives of
General Psychiatry*, 46, 971-982.
- Fava, G., Chara, R., Grandi, S., Conti, S., & Belluardo, P., (1998) Prevention of
Recurrent Depression with Cognitive Behavioral Therapy. *Archives of General
Psychiatry*, 55, 816-820.
- Glynn, H., (1994).New or Old Antidepressants? New is better. *British Medical
Journal*, 309, 1280-1283.

Grohol, J.M., (2006, August 7). New Hope for Resistant Depression. Psych Central
News from

<http://psychcentral.com/new/2006/08/07/new-hope-for-resistant-depression>

Hardy, G.E., Stiles, W.B., Cahill, J., Ispan, C., Macaskill, N., & Barkman, M. (2005).

Sudden Gains in Cognitive Therapy for Depression: A Replication and Extension.

Journal of Consulting and Clinical Psychology, 73, 59-67.

Hollon, S.D., DeRubeis, R.J., Evans, M.D., Wiemer, M.J., Garvey, M.J., Grove,

W.M., et al. (1992). Cognitive therapy and pharmacotherapy for depression:

Singly and in combination. *Archives of General Psychiatry*, 49, 774-781.

Kanba, S. (2004) Although antidepressants and anxiolytics are frequently used

together to treat depression in the acute phase, how effective is the concomitant

use of these drugs? *Journal of Psychiatry and Neuroscience*, 29, 485.

Kripke, C., (2006) Pharmacologic Treatment of Psychotic Depression. *American*

Family Physician. 73, 1935.

Leahy, R.L., & Holland, S.J. (2000). Treatment plans and interventions for depression

and anxiety disorders. New York: Guilford Press.

Lenihan, .M. (1993). Cognitive Behavioral Treatment of Borderline Personality

Disorder. New York: Guilford Press.

Meyer, J. (2007). Imaging the serotonin transporter during major depressive disorder

and antidepressant treatment. *Journal of Psychiatry and Neuroscience*.32, 86-103.

Myhr, G, Payne, K.(2006). Cost –Effective Behavioral Therapy for Mental Disorders:

Implications For public health care funding policy in Canada. *Canadian Journal*

of Psychiatry, 51, 662-670.

- Olfson, M., Marcus, S.C., Tedeschi, M., & Wan, G.J. (2006) Continuity of Antidepressant Treatment for Adults with Depression in the United States. *The American Journal of Psychiatry*, 163, 101-109.
- Lee, M.M., and Overholser, J.C. (2004). Cognitive-Behavioral Treatment of Depression with Comorbid Borderline Personality Traits. *Journal of Contemporary Psychotherapy*, 34, 231-245.
- Palmer, S., Davidson, K., Tyrere, P., Gumley, A., Tata, P., Norrie, J. et al.(2006). The Cost-Effectiveness of Cognitive Behavior Therapy for Borderline Personality Disorder: Results from the Boscot Trial. *Journal of Personality Disorders*, 20, 466-481.
- Persons, J.B., Mirada, J., (2002) Treating dysfunctional beliefs: Implications of the Mood-State Hypothesis. In Leahy, R.L. & Dowd, E.T. (EDS.). *Clinical Advances in Cognitive Psychotherapy* (pp.62-74). New York, NY: Springer.
- Palmer, R.L.(2002) Dialectic Behavior therapy for borderline personality disorder. *Advances in Psychiatric Treatment*, 8, 10-16.
- Pampallona, S., Bollini,P., Tibaldi, G., Kupelnick, B., & Munizza, C. (2004). Combined Pharmacotherapy and Psychological Treatment for Depression. *Archives of General Psychiatry*, 61,714-719.
- Parker, G., Roy, K., Eyers, K. (2003) Cognitive Behavior Therapy for Depression? Choose Horses for Courses. *American Journal of Psychiatry*, 160, 825-834.
- Paykal, E.S., Scott, J., Teasdale, J.D., Johnson, A., Garland A. Moore, R. & Jenaway, A. (1999). Prevention of Relapse in Residual Depression by Cognitive Therapy. *Archives of General Psychiatry*, 56, 829-835.

Rosack, J., (2006). Off-Label Psychotropic Use Reveals Complex Patterns.

Psychiatric News, 41, 16-20.

APPENDIX
Informed Consent

I am a graduate student in the Applied Masters Program in Mental Health Counseling in the Psychology Department at Rowan University. I will be conducting a case study under the supervision of Dr. Janet Cahill of the Psychology Department at Rowan University. The purpose of this case study is to help evaluate the effectiveness of the treatment being provided for the agency. The outcomes collected for this study will be used to help evaluate treatment of your disorder:_____. I am requesting your permission to participate in this study.

This study will not effect our treatment in any way. You will be asked to fill out some additional tests or measures in order to better evaluate your treatment. The results of the assessments will be shared with you and the program supervisor.

These measures will not leave the clinic and will follow the same confidentiality rules of the agency. The information obtained from this study may be used in any way thought best for publication or education. For example, they me be reviewed by other professionals. However, no information that identifies you will be reported.

There are no physical or psychological risks involved in this study and you are free to withdraw any time without penalty.

Your participation or refusal to participate does not effect any of the services you receive fro the agency.

If I have any questions or problems concerning my participation in this study, I may contact Carol King, my supervisor at (123) 456-7891 ext (1112).

Signature of the participant	date
------------------------------	------

Signature of the Investigator	date
-------------------------------	------

Signature of faculty supervisor	date
---------------------------------	------

