

Clinical Case Study: Roberta Henderson

Roberta is a 30 year old married Caucasian woman with no children living in a middle class urban area with her husband. She was referred to a clinical psychologist (CP) by her psychiatrist. The psychiatrist had been treating her with antidepressant medication for over 18 months during which time Roberta had been hospitalised at least 10 times. One period had lasted 6 months for suicidal ideation and near lethal suicide. There were other various suicidal gestures of drinking bleach and self-inflicted cuts and burns.

Roberta was accompanied by her husband to the first meeting with the CP, who stated that he and her family considered her to be too lethal to be outside a hospital setting. Consequently he and her family were seriously considering the viability of securing long-term inpatient care. However, Roberta expressed a strong preference for outpatient treatment, although no therapist had agreed to take her on as an outpatient. The CP had agreed to take Roberta into therapy provided she committed to work towards behavioural change and stay in treatment for at least one year and not to attempt suicide.

Clinical History

Roberta was raised as an only child. Both her father and mother had histories of depression and alcohol abuse. Roberta had suffered severe physical abuse from her mother during childhood, although this was not apparent until well into therapy. When she was 5, her father began sexually abusing her. It was initially non-violent for the first few years, but then became physically abusive when Roberta was about 12 years old. This abuse continued for the first few years of secondary school. By about age 14, she had difficulties with alcohol abuse and bulimia nervosa. In fact, she met her husband whilst attending an AA meeting when she was in college. She continued to demonstrate signs of these two disorders at the time of her first visit to the CP. Despite these difficulties, until the age of 27 she was able to perform well in work and school settings. She earned a college degree and 2 years of medical school. However, during her second year of medical school a classmate that she knew vaguely committed suicide. Roberta reported that when she heard of this she immediately decided to kill herself as well. She did not however have any insight as to why the incident had provoked her inclination to kill herself. Within weeks she had dropped out of medical school and become severely depressed and actively suicidal.

A certain chain of events often appeared to precede her suicidal behaviour. This chain would begin with an interpersonal encounter, usually with her husband, which culminated in her feeling threatened, criticised or unloved (often with no clear or objective basis for this assumption). These feelings were frequently followed by urges to either self-mutilate or kill herself, depending to some extent on how hopeless or angry she felt. Her decisions to hurt or kill herself were accompanied by her thought of 'I'll show you' or her feelings of hopelessness and desire to permanently end her emotional pain and persistent feelings of emptiness.

On occasion, these stressful interpersonal encounters led to Roberta experiencing dissociation. Following her conscious decision to self-mutilate or kill herself, she would immediately dissociate and at some later point, cut or burn herself whilst in a state of 'automatic pilot'. Consequently she had difficulty in recalling the specific details of the act. At one point, she burned her leg so badly and injected it with dirt (to convince the GP to show her more attention) that she required reconstructive surgery.

Although she had been able to function competently in school and work, her interpersonal behaviour was erratic and unstable. She would quickly (and without reason) fluctuate from one extreme to another. She was an enigma to family and friends. At times she was reasonable, personable and behaved appropriately but at others she appeared irrational and enraged. After verbally berating friends and family, she would become worried and frightened that she had alienated them permanently; creating the feelings of being alone- her greatest fear. As a result she would do something kind for them in order to bring them emotionally closer to her.

As expected, she had alienated many people, who tried to distance themselves from her. When this occurred she would either threaten to kill herself or end the relationship first, usually very abruptly. She expected to have all of her needs met, yet was unable to verbalise what those actual needs were. When disappointed by friends, for example having to cancel lunch, she would take this as a personal affront, feel unaccepted and unloved and want to prove how much she needed that person. She viewed all people (including herself) as either all good or all bad. This polarity (splitting) was also evident when others commented on her competency (e.g. school or work proficiency). She would interpret such comments as that she was gifted or self-sufficient and she would react by showing them how incompetent she actually was (demand more study help or seek reassurance for the quality of her work) in order to prove to them that she needed their help.

Diagnosis and clinical characteristics

- Efforts to avoid real or imagined abandonment
- Unstable or intense interpersonal relationships alternating between idealisation and devaluation
- Identity disturbance- unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging
- Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour
- Affective instability due to a marked reactivity of mood
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty in controlling anger
- Transient, stress related paranoid ideation or severe dissociative symptoms