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Borderline Personality Disorder: Two Case Reports

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Case Report

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Abstract

Two patients of Borderline Personality disorder are reported and the condition is briefly discussed. A 24 year old female patient presented with aggressive behavior, suicidal attempts, emotional instability, and poor interpersonal relationship. Poor adjustment in the school and with siblings was reported. Father is very dominant and strict in nature and becomes aggressive and irritable on minor issue. There is history of sexual relationship with multiple partners and two abortions. There is history of multiple suicidal attempts and sexual abuse by her boss. Mental status examination showed increased speech productivity, labile affect with no features of psychosis. A 24 year old male driver was referred with history alcohol consumption and cigarette smoking since 6 years, cannabis consumption since 3 years and occasionally taking opioids. Since school time he has noticed that he gets irritable very easily. Whenever he would get into any fight he would feel like ending his life and has had multiple suicidal attempts in the past. He has had three relationships in the past 6 years. He feels distressed as he doesn't know who he is and what he wants to do in his life. Mental status examination showed mild depression without features of psychosis.

Keywords: Borderline Personality Disorder; Suicidal Attempts; Emotional Instability; Multiple Partners; Irritability; Dialectical Behavior Therapy

Abbreviations: BPD: Borderline Personality Disorder; IPDE: International Personality Disorder Examination; DBT: Dialectical Behavior Therapy.

Introduction

Borderline personality disorder (BPD) is a fairly common, chronic, and debilitating psychiatric disorder. The disorder presents with emotional lability, poor impulse control, angry outbursts, high suicide risk, repeated self-injury and chaotic and self-defeating interpersonal relationships. The disorder is commonly associated with other psychiatric and personality disorders, places a high burden on care givers, and high treatment costs [1-3]. Because of the characteristic mood swings, BPD is often mistaken for bipolar disorder. It was

found that 41% of the patients in emergency department who had attempted suicide with history of multiple suicide attempts met the criteria for BPD [4]. Fortunately, most patients with BPD improve with time [5]. About 75% will regain close to normal functioning by the age of 35 to 40 years, and 90% will recover by the age of 50. Though suicidal threats and attempts are common, 90% of persons with BPD improve even after threatening to end their lives on multiple occasions [6]. Sadly, however, about 10% subjects commit suicide. The mechanism of recovery in BPD is not yet known. However it is established that with age impulsivity gradually reduces, and patients discover over time ways to avoid the most troublesome situations and find stable positions that provide the structure they need [7].

Case Report

Case 1

This 24 years hindu, unmarried female hailing from urban, upper middle class background was brought to psychiatric OPD by mother with the complaints of aggressive behavour, suicidal attempts, emotional instability and poor interpersonal relationship of 8 years duration and feeling of aloofness for three years. Her aggressiveness came into focus when her elder sister got married to a boy of other caste with the permission of patient's mother. Her father was ignorant about it and patient lied to her father at the time of marriage of her elder sister that all people in her house had gone to place of pilgrimage. Later when the above matter was revealed in front of father, he got angry on the patient. At the same time her high school results had come and her father sent her to Orissa for further studies against her will. After this her aggression went on increasing, she was found to be ignoring simple instructions given by her father. At times she would be found to throw flowerpots or any household articles.

Even at times she slapped her mother on minor issues. When patient was in 10+2 she used to live with her father and a maid servant. Her mother was staying in a different town. At that time patient had several arguments with her maid servant on minor issues. She used to scold the maid using abusive language and had even beaten her several times. On one occasion the patient had even beaten her maid for not following her order. She had dragged the maid out of the house and beaten her in presence of the neighbors. Later on she repented her actions. During that period once her father had gone to her tution place, and didn't find her. So when she returned home, her father scolded her. After that she got very distressed and attempted suicide by trying to hang herself with a sari to the ceiling fan.

However, her father, suspecting something, broke open the door and saved her. She felt guilty about the event and she promised that she would never do that again. However, she had made several suicidal attempts. She had fallen in love with a boy in her neighborhood but had not expressed her feelings. When the boy went to Kolkata for further studies, the patient obtained his phone number and used to call him regularly for almost two years. She felt that she had got emotionally attached to him, so she proposed him but he declined. After that event patient had several episodes of anger towards her mother and servants on minor issues which, as per patient, was out of control and she used to accept her guilt about that event later on. Patient had made many boyfriends and used to get emotionally attached to them very soon and used to propose them but they used to decline. During that period also patient had got physical relationship with them and had to undergo abortion twice. According to her, she could never find a true love and everyone tries to cheat her and blackmail her emotionally.

Since childhood patient had ambition to become a good singer and dancer but her wishes were not fulfilled. So she used to think that she has achieved nothing in her life and there was no one to support her in becoming what she wanted to be. This thought came regularly in her mind. After completing her post-graduation in Mass Communication she was employed but had changed several jobs as she was not able to adjust in the office environment. In 2005 she was working for a newspaper but patient was not able to make friends and was not able to work along with her colleagues, so she left her job and went to Delhi in 2007 and joined another newspaper, but she faced similar problems there also. As per patient the colleagues did not like her, so she again left her job and joined a T.V. news channel where she worked for six months. At that time her superior had misbehaved with her by touching her private parts. (Patient refused to elaborate further). Later patient left the job and complained against the person. As per patient she was regarded as having bad character in that office. Thereafter, unable to get any job in Delhi, she returned to her home town. She had joined postgraduate course in Economics and was also preparing for competitive examinations. Her pervasive and persistent mood was irritable. She was taking minimal interest in doing house hold activities or

in mixing with people. Her sleep was increased. Although she had difficulty in falling asleep but thereafter slept for 9-10 hours and sometimes even up to 12 hours. About eight years back patient had taken medications for one month under the guidance of Psychiatrist but details of medications were not available. She was also treated by faith healer. In both cases only mild improvement was noted.

Personal history revealed behavioral problems in the form of temper–tantrum, rigidity and bed wetting in childhood. She was treated for bed wetting problem. Poor adjustment in school and with the siblings was reported. There is no history suggestive of any mental or physical illness in the family. She often acted impulsively without consideration of the consequences. Out bursts of anger is reported especially when she was criticized. She believed in religious beliefs, believed in God and used to pray. She had overactive way of doing activities. She easily mixed with strangers. She easily got irritable and was rigid in any situation. Mood was irritable most of the time. Resentfulness, impulsiveness and rigidity are the significant traits of her personality. Impression was that she was a slow-to-warm-up child.

Family Assessments were done with following three scales. On Social Support Questionnaire the score was 51 which indicate poor social support. On Family Pathology Scale the score was 89 indicating moderate family pathology. On Family Functioning Questionnaire the score was 159 indicating average family functioning. The disturbed family atmosphere, family functioning, family pathology, poor support as well as the poor interaction have had high influence in maintaining her behaviour. Expressed Emotion in the form of critical comment by other family members and especially father and emotional over involvement by the mother had maintained the psychopathology of the patient. Physical examination and mental status examination showing increased speech productivity, labile affect irritable mood, intact cognitions with fair judgment and insight. Patient exhibited emotional instability, chronic feeling of emptiness, unstable relationships resulting in repeated emotional crises and series of suicidal threats. Her self-image, aims and internal preferences including sexual are often unclear or disturbed. Based on the above she was diagnosed as according to ICD 10 as Emotionally Unstable Personality Disorder, Borderline Type.

On the Stanford Binet Intelligence Test her mental age was 231 months and Intelligence quotient was 120 suggesting that she has above average level of intellectual functioning. On Eysenck's Personality Questionnaire she attained high score on extroversion which suggests she is outgoing, cheerful and friendly in nature. On the International Personality Disorder Examination (IPDE) highest score were found on emotionally unstable personality disorder and histrionic personality disorder. On further assessment nine definite, one probable and one negative diagnostic criteria was found in emotionally unstable personality disorder borderline type. Analysis of the stories on Thematic Apperception Test suggests that the plot of the stories is structured, imaginative, incomplete and inappropriate. There is coherence in her thought process. Reduced productivity may indicate emotional blocking and inhibition. The content of the stories are mostly negative revolving around the family, friends or love. She possesses childlike imagination and dramatically describes the events of life. The hero identification is complete and type of identification is of the same sex and appropriate age. Examination of the patient's imaginal production and her needs suggests that at present the patient's dominant needs are achievement, affiliation, autonomy, counteraction, harm avoidance and aggression. She gave outcomes in most the stories. Some of them are happy and imaginative while others are unhappy and imaginative. This reveals her emotional attitude towards life. Patient's significant conflicts are achievement vs. inadequacy, acquisition vs. lack, affiliation vs. rejection. Main defenses used by the patient are wishful thinking, projection and rationalization.

Majority of emotions and feeling expressed are love and affection, ambition, confidence and anger. In most of the stories expressed feelings are negative like aggression, anger, guilt and anxiety. Negative emotions are more prominent in calculating emotional maladjustment. As present it appears she is more anxious and her anxiety is due to lack of love, deprivation and failure in life. Stories given on card 5 suggest her relationship with her parent is not good she has negative feeling towards them. Her emotional adjustment is not satisfactory. The ego of the patient is weak and it is not functioning smoothly. Anxiety, depression and guilt are present in her inner dynamics. The basic traits of the patient's personality are emotionality, intraception and changing. The TAT revealed emotional blocking and inhibition, weak ego functioning, strained relationship with family, aggression, anger and guilt.

Rorschach Psychodiagnostics revealed impulsivity, extratensive trend of personality, dysphoric emotion

and poor social conformity. She was started on carbamazepine to improve global functioning and risperidone to control aggression. The immediate goals of psychosocial management were to build rapport with the patient and to monitor the patient. The short term goals were to educate the patient regarding illness including high risk sexual behavior, to develop insight about illness, to reduce high expressed emotion in family, to enhance cohesiveness, and to modify home environment. The long term goals of psychosocial management were to enhance communication among family members, to improve family functioning or interaction pattern and regular follow up. Management package consisted of psycho-education including sex education, insight oriented psychotherapy, supportive psychotherapy, family Counseling, environment modification and marital therapy (to patient's parents).

Case 2

This 24 year old male driver, hailing from an urban nuclear family, educated upto B. com, unmarried, Hindu, right handed, was admitted for acute tonsillitis and referred to psychiatry OPD for de-addiction. He gave history of gradually increasing alcohol consumption since 6 years with daily consumption since 3 years. He was consuming 1-2 quarters of whisky daily after work in the evening. Whenever he had money he would drink continuously for a few days till his money would finish. He has history of blackouts after taking alcohol. He has history of jaundice 1 year back and malena 3 months back. He stopped consuming since 1 month as he was admitted in the hospital for tonsillitis. He also reports cannabis consumption since 3 years, daily 6-7 joints along with his friends. There is history of cigarette smoking since 6 years daily 1 pack. He has occasionally taken opioids in the form of injections and "panni" in the company of his friends.

Since school time he has noticed that he gets irritable very easily. He used to get angry with his parents over small issues. He is unable to tolerate loud sounds/people talking around him when he is angry. Whenever he would get into any fight he would feel like ending his life. He has had multiple suicidal attempts in the past-he drank phenol which was present at home and went and sat on the railway tracks many times, all of which occurred after trivial fights. After a fight with his girlfriend in a fit of anger he slashed his wrists. He has had three relationships in the past 6 years: he was very close to all of them but the relation ended abruptly due to repeated fights. He feels distressed as he doesn't know who he is and what he wants to do in his life. Since the past 1 month he feels intense craving for all the substances and also started having low mood which would be present most of the time. His sleep and appetite were normal. His self-care was maintained. Predominantly mood was irritable. There was no history suggestive of epilepsy, head injury, neuro-infectious disease. There was no past or family history of any mental or physical disorder. Physical examination was within normal limits.

On mental status examination patient was well kempt and sitting comfortably. He was co-operative, communicative, rapport established with ease and in touch with reality. Speech was in normal tone and speed. Mood was mildly depressed, affect was reactive and appropriate. Thought was coherent relevant. There were no delusions, obsessions or perceptual abnormality. He was conscious, well oriented to time place and person, attention was easily aroused and sustained. Insight and judgement were unimpaired. On the IPDE highest score were found on emotionally unstable personality disorder. His score on the Borderline Personality Inventory was 11. On Social Support Questionnaire the score was 53 which indicate poor social support. On Family Pathology Scale the score was 86 indicating moderate family pathology. On Family Functioning Questionnaire the score was 147 indicating average family functioning. His score on the Borderline Personality Inventory was 11. On Social Support Questionnaire the score was 53 which indicate poor social support. On Family Pathology Scale the score was 86 indicating moderate family pathology. On Family Functioning Questionnaire the score was 147 indicating average family functioning. He was started on escitalopram 5mg to improve his low mood and Lithium 600mg to control irritability and mood swings. Psychological management package consisted of psycho education, cognitive behavior therapy, supportive psychotherapy, family counseling and environment modification.

Discussion

BPD is commonly encountered in everyday clinical practice. Community surveys of adults have shown that the prevalence of this personality disorder is close to 1% which is similar to that of schizophrenia [8]. 10% of outpatients and up to 20% of psychiatric inpatients have this disorder [9-10]. BPD is characterized by long standing pattern of impulsive behavior and unstable interpersonal relationships, affect, and self-image [11]. However, the symptom constellations related to BPD have

varied significantly over time. For example, Stern identified ten clinical symptoms associated with BPD, including narcissism, hypersensitivity, masochism, and disturbances in reality testing. Deutsch highlighted BPD symptomatology in the context of interpersonal functioning [12]. Specifically, she noted that while individuals with BPD appear to function normally in brief social interactions (as if they were normal), they exhibit an underlying pathological style of relatedness with others. Nine specific features of BPD, including the chaotic lifestyle patterns, inability to tolerate routines, difficulties in establishing emotional contact with others and low motivation for treatment, were identified by Schmideberg [13]. Hoch and Polatin described the clinical trial of pan-anxiety, pansexuality, and pan-neurosis [14]. Knight highlighted the lack of achievement, multiple neurotic symptoms, and psychological vacillation between neurotic and psychotic states in these individuals [15]. The "Presumptive Diagnostic Elements," of BPD according to Kernberg included impulsivity, pervasive anxiety, multiple neuroses, and addictions [16]. According to Kolb and Gunderson chronic affective disturbance, a superficially intact social façade, chaotic interpersonal relationships, impulsivity (i.e., chronic self-regulation difficulties, longstanding self-destructive behavior), and quasi psychotic phenomena (i.e., fleeting losses of reality), are the five fundamental characteristics of BPD patients [17]. These clinical characteristics subsequently became the cornerstones for the Diagnostic Interview for Borderlines (original version) [18].

The studies on psychopathology within the families suggest the following: the families of individuals with BPD are likely to be peppered with members who suffer from mood, impulse, substance use, and personality disorders including BPD; their parenting is frequently characterized by behavioral over-involvement (e.g., over- controlling, over-protective) and emotional under-involvement (e.g., lack of empathy/affection, emotionally withholding); mothers may be ego-centric (e.g., use the child for their own ego gratifying needs), less caring, inconsistent, and over-involved; a negative perception of fathers may be present, particularly when they are the perpetrators of sexual abuse; and the children of BPD mothers may be more emotionally and behaviorally disturbed [19]. They are more likely to have psychiatric disorders including BPD. These are consistent with the findings in our patients.

Genetic studies have shown that though heritability of BPD is low, genetic polymorphisms of neurotransmission systems (serotonin, glutamate and its NMDA receptor), may make an individual vulnerable to develop this disorder [20,21]. A meta-analysis of magnetic resonance studies included more than 200 patients with BPD, controlling psychiatric comorbidities and psychotropic drugs, found that the most frequent finding is the bilateral decrease in the volume of amygdala and hippocampus, a feature that would be a candidate for this disorder endophenotype [22-24].

A number of agents, including low-dose atypical neuroleptics, specific serotonin reuptake inhibitors and mood stabilizers all alleviate impulsive symptoms. Benzodiazepines are not of much use in BPD and carry some danger of abuse [25-29]. A form of cognitive behaviour therapy that targets affective instability and impulsivity named dialectical behavior therapy (DBT) is reported to be useful in individuals with BPD since it teaches them the way to regulate their emotions. It is effective in reducing BPD symptoms, hopelessness, depression, suicidal behavior, and suicidal ideation [30-37]. DBT has also been reported to improve adjustment and quality of life, and reduce health service utilisation and/or inpatient psychiatric days. DBT was found to be significantly better than treatment-as-usual in improving general functioning and in reducing ineffective expression of anger and self-harm in a systematic review of randomized studies [31-33,35-37]. Other therapies developed for treatment of BPD including schema therapy, metallization based therapy, and transference focused psychotherapy are being evaluated [38-41].

Conclusion

BPD has historically struggled to attain a dependable diagnostic status. Along the way, opponents have challenged the reliability and validity of various criteria sets in this search for diagnostic legitimacy. Maybe the historic difficulty in ascribing a distinct and valid compilation of symptoms to BPD is that the disorder is, by nature, a proliferative one—both in terms of psychological and somatic symptoms. Probably the current diagnostic criteria of BPD include the most common psychiatric symptoms in these individuals, but fail to identify the clinical nature of the disorder—the propensity to generate multiple psychiatric symptoms. Perhaps this characteristic should be an additional diagnostic criterion, or at the very least a clinical descriptor, for the disorder [42].

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