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Abstract

Borderline personality disorder is frequently encountered in psychiatric practice though it is reported to only affect one to two percent of the population. An estimated 10% of patients seen in the outpatient psychiatric setting, and about six percent patients within family practice meet criteria for this disorder (Biskin & Paris, 2012). The American Psychological Association (2013) has clear-cut criteria set for establishing diagnosis requiring the presence of five or more symptoms indicating a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in multiple contexts.

This paper explores the treatment course of a 38-year-old woman who is currently separated from her third husband and diagnosed with borderline personality disorder in her teens. The patient has co-existing mental health and substance abuse diagnoses ranging from bipolar disorder, depression, generalized anxiety disorder alcohol and marijuana abuse. She has extensive suicidality profile with significant attempts requiring instant resuscitations. She once jumped off the third floor of the parking ramp, and within a year, she overdosed on medications requiring intubation in the emergency room.

This patient has been engaged in cognitive behavioral therapy (CBT) for over a decade, and recently dialectical behavior therapy (DBT) while anticonvulsant and mood stabilizers were used to manage symptomatology of the co-occurring disorder (bipolar disorder). This is in line with major treatment guidelines for this disorder. The effect of psychotherapy over the years have been marred by classical dysregulation of interpersonal relationships. A constant change of therapists has shortened psychotherapy treatment to less than three months at a time hence, making the effect of therapy sub-par recommendation. This paper will also state the implications for practice and research.
Background

This case study is focused on the management of a 38-year-old Caucasian female patient who has a long history of borderline personality disorder. The symptoms exhibited include a pattern of instability in family relationships evidenced by third marriage within 12 years. She is currently separated from estranged husband, she has the inability to care for her kids and often neglect self-care, she had burned some therapeutic bridges through assaultive/aggressive behavior, and self-injurious behavior to seek attention.

She was brandishing scissors in front of the provider who refused to prescribe narcotics prior to inpatient psychiatric hospitalization. She has scars from previous superficial cuts, and a history of suicide attempts via jumping from the third floor of the hospital’s parking lot. She has a remarkable history of near-fatal overdose on prescription medications. Her recent drug-seeking behavior include intentional falls to get narcotics, and an established history of prescription shopping to enhance polysubstance abuse.

This study seeks to examine what treatment options were explored, the rationale and effects of these treatment approaches, and comparison with established guidelines for practice. A psychosocial intervention was initiated early after diagnosis was made. The patient engaged in dialectical behavior therapy (DBT) weekly for up to 10 weeks but, was terminated due to recurrent canceled appointments. The treatment plan was made flexible to accommodate likely changes per patient’s compliance history.

Case Report

The patient presented to the emergency department (ED) requesting to have oxycodone hydrochloride and acetaminophen (Percocet) prescribed for a toothache. She had a tooth extraction less than a week ago and was prescribed Percocet 5/325mg Q6hr PRN (12 tablets with
no refill) by the dentist which lasted her for three days. She presented with an elevated mood and began disrupting the milieu when denied her request. This caused her to be transferred to the Acute Psychiatric Services (APS). She has been a frequent user of the hospital.

The APS clinician refused to her request, necessitating the use of security to keep her outside of APS for threatening behavior towards staff. She left for a moment and returned, brandishing new long scissors stating, “I will use this to stab my heart on this property”. She also claimed to have been to the third floor of parking ramp where she jumped from in an apparent suicide attempt.

She has had 32 psychiatric hospitalizations over a period of four years, with five chemical dependency treatments. The patient has co-occurring disorders including borderline personality disorder (BPD), major depressive disorder (MDD), substance use disorder (SUD)-for cocaine, narcotics, alcohol, and marijuana. Her management of psychiatric symptoms/illness started 24 years ago when she was 14 years old. She has a past medical history of hypothyroidism, chronic pain, and asthma. She verbalized inconsistencies in treatment compliance for medical issues.

She was placed on medication to target presenting symptoms of anxiety, aggression, hostility, and occasional depressed mood but, as soon as a medication starts to take effect, she either stops taking it or claims she is allergic to it. This repetitive pattern of behavior has seen her tried olanzapine, haloperidol, ziprasidone, hydroxyzine pamoate, diphenhydramine, zolpidem, aripiprazole, lamotrigine, and perphenazine enanthate with no tangible result. She currently takes Gabapentin 300mg three times a day (TID) and Depakote ER 500mg daily for the past two weeks (last follow-up appointment).
Similarly, she has been engaged in substance abuse counseling (1998), and cognitive behavior therapy in 2004 with improvement in social function as documented in therapy notes (able to care for a child at that time). She has been in and out of dialectical behavioral therapy sessions since 2016. She claimed her relationship with the therapist wasn’t great because she gave ‘many assignments; my job is to talk while she listens’. She reported notable improvements in symptoms during court-ordered electroconvulsive therapy (ECT) sessions between 10/18/2017 and 5/9/2018 but, stopped as soon as court order ran out.

Her paranoia and dysfunctional pattern of forming relationships stemmed from distrust in people. She stated, “I was raped by a close relative who was older than me and should have protected me if anything”. She believes people don’t have good intentions and hence can’t be trusted. This led to having ‘few friends’ and perpetual loneliness that caused the frequent lashing out behavior, and persistent self-injurious behavior. She maintained that she is still in love with her estranged husband. However, she was unable to state categorically why she will pursue divorce.

Documented reports showed that she is a current one-pack a day smoker for the past 22 years. She uses up to a pint of liquor (vodka) about three times weekly, and daily during moments preceding self-harm or suicide attempt. Her legal history included possession of drug charges and a year spent in jail for malicious assault (2012) on a fellow patient at a chemical dependency facility. She is deemed unfit as a parent by the county court, and her children are split between ex-husband and estranged husband.

She completed the Minnesota Multiphasic Personality Inventory (MMPI) in 1996 and this has been updated. Prior to establishing a diagnosis of borderline personality disorder, she had completed the Beck Depression Inventory-II (BDI-II), and the State-Trait Anger Expression
Inventory (STAXI) in 1998 with subsequent updates in 2017. The regular psychiatric laboratory workup was insignificant except for a urine drug screen positive for marijuana.

The patient met criteria for borderline personality disorder as stipulated by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) based on history of extensive social history indicative of childhood trauma, feeling of emptiness, intense anger at perceived abandonment, emotional dysregulation, mood instability, dysfunctional relationships, self-injurious behavior, and recurrent suicidal threats especially when her requests are denied. Other differential diagnoses include antisocial personality disorder, unipolar depression, or bipolar I disorder, current mixed state.

Outpatient resources were deemed appropriate for assisting the patient in achieving goals of: (a) reduction of self-injurious behavior, (b) correcting cognitive distortion, (c) less frequent hospitalization, and (d) identification of unhealthy behavior and learning coping mechanisms to handle unexpressed feelings. The patient was discharged to continue weekly dialectical behavior therapy in the outpatient clinic with pharmacological management of other co-occurring disorders. She has been consistent with the weekly appointment and has not returned to the hospital for seven weeks.

**Literature Review**

Overview of relevant literature and national guidelines revealed ambiguity in treatment modalities and actual prevailing practices for borderline personality disorder. Main inclusion criteria in this search include a current diagnosis of BPD, age group of 18 to 60 years, researches/articles within the past 10 years, the presence of co-occurring mental health disorders, and ability to give consent to treatment. Exclusion criteria include under the age of 18, inability to give treatment consent, the presence of a guardian, and a sole diagnosis of BPD.
There is currently no medication approved for primary treatment of BPD across the United States, United Kingdom, Spain, and Central Europe (Martin-Blanco, Ancochea, Soler, Elices, Carmona, & Pascual, 2017; NICE, 2009, & Perese, 2012). About 70% to 80% of BPD patients in these regions were prescribed medications (Martin Blanco et al., 2017). The reasons for off-label prescriptive practices ranged from acuity of emotional dysregulation symptoms, a brief intensity of aggression, increase non-suicidal self-harm and suicide attempts, and notably, professional opinion that antipsychotics will relieve morbid symptoms (Shafti & Shahveisi, 2010).

Some management guidelines, however, supported the use of medications to treat the transient state of acuity in patients with BPD, and treatment of identified co-occurring disorders. Clinical evidence for use of antidepressants especially selective serotonin reuptake inhibitors (except tricyclic antidepressants & monoamine oxidase inhibitors) is based on a premise that though it has minimal control of impulsive aggression, it holds decent effect on anxiety, anger, depression, and affective lability (Ripoll, 2012). Other commonly used drug items in BPD management are atypical antipsychotics, mood stabilizers, anticonvulsants, and Omega-three fatty acid ethyl-eicosapentaenoic acid supplementation. Omega-three fatty acid ethyl-eicosapentaenoic acid is reported to be effective for negative affect and antagonism in moderate to severe BPD (Ripoll, 2012).

Since psychopharmacology with antipsychotics is high, up to 70% in the USA (Martin-Blanco et al., 2017) despite FDA disapproval of primary medication in BPD management (Perese, 2012), it is imperative to understand what combination was reported effective. Shafti & Shahveis (2010) opined that both olanzapine and haloperidol were effective when used separately. This was concluded after patients on these medications showed improvements on the
The patient was previously placed on olanzapine, aripiprazole, and haloperidol in November 2017, January 2018, and March 2018 respectively. Metabolic consideration wasn’t so much because her body mass index (BMI) is usually between 17.5 to 18.5. Though there were recorded improvements in her irritability, hostility, aggression, and suicidality over the period of medication use, they were discontinued following a consistent complaint of dystonia to each of them.

The complaints of dystonia to all medication that has ever helped is consistent with behavioral symptoms rather than true allergy because sufficient measures to prevent cholinergic effect were put in place with each antipsychotic initiation. Benztropine mesylate and diphenhydramine (anticholinergics) were used concurrently to reduce extrapyramidal side effects (Stahl, 2018).

The patient is currently on Depakote ER 500 mg daily to regulate both negative affectivity and disinhibition better. This is preferred over the use of lithium due to risk profile. The latter often leads to toxicity (especially in a patient prone to prescription drug overdose), and non-compliance with frequent lithium level checks (Ripoll, 2012). Her liver function tests, complete blood counts, and coagulation were considered prior to Depakote ER initiation (Stahl,
She was also notified of the need for valproate level check eight weeks after commencing medication which will later be done twice or once annually.

In contrast, several guidelines and randomized control trials have strongly supported the use of psychotherapy (mainly dialectical behavior therapy) as the primary treatment for borderline personality disorder. Psychotherapy is used to correct the associated symptomatology of: affective instability, immediate reward-driven decision making, dysfunctional emotional regulation, irritability, hostility, persistent self-harm impulses, and suicide rate that is about 50-fold compared to general population (American Psychiatric Association, 2013; Beatson & Rao, 2014; Dixon-Gordon, Peters, Fertuck, & Yen, 2017; Goodman et al., 2014; Martin-Blanco et al., 2017; NICE, 2009).

Goodman et al., (2014) conducted an empirical study to identify the effect of completed 12 months DBT on the reactivity of amygdala, using functional magnetic resonance imaging (fMRI). A consistent finding in the amygdala of patients with BPD suggests less amygdala habituation, increased activation time which expresses affective instability. They posited that emotional hyper-responsivity arise from genetic vulnerabilities, intrauterine assault or early childhood adverse events coupled with invalidating environments. This finding is akin to BPD etiology (Perese, 2012).

Similarities can be drawn between known childhood adverse events (history of bipolar disorder in mother, alcoholism and obsessive-compulsive disorder in father, sexual abuse and physical trauma as a child and adult, early substance use as an adolescent), and the eventual development of BPD in this study. In another study by Nicol, Pope, Romaniuk, and Hall (2015), findings linked childhood physical abuse to the eventual development of mental illness, BPD
inclusive. It was however clarified that childhood physical abuse only produces schizophrenia-like psychotic symptoms in BPD.

Furthermore, it is believed that emotional dysregulation in BPD is linked to the inability of the prefrontal cortex to control amygdala and the erratic interaction between fronto-limbic structures (Goodman et al., 2014). Hence, the effect of DBT is measured/shown by improvement in emotional regulation, acquisition of skills that pronounce cognitive control over maladaptive behavioral patterns. The result obtained after 12 months of DBT revealed a decrease in overall amygdala activation and an improvement in emotional regulation.

Most studies that was reviewed indicated variations in delivery of interpersonal psychotherapy in form of DBT but, recognized four core elements that must be present as: occur weekly for a duration between 60 to 90 minutes, includes weekly skills training within the group for a duration between 120 to 150 minutes, telephone coaching by individual/primary therapists, and supervision by the therapeutic team to ensure treatment compliance (Andreasson et al., 2016; Kroger, Harbeck, Armbrust, & Kliem, 2013; Wheeler, 2014).

For DBT to be considered therapeutic, it must be structured with a duration greater than 12 weeks. Improvement in symptoms profile is noted as early as 12 weeks in some studies while the gold standard for practice is one-year duration (Andreasson et al., 2016; Kroger, Harbeck, Armbrust, & Kliem, 2013; McMain, Guimond, Streiner, Cardish, & Links, 2012; and Reeves-Dudley, 2017). It is reported that women with BPD and co-occurring substance use disorder are more likely to gain full remission from substance abuse provided they complete at least one year of the DBT treatment regimen (Reeves-Dudley, 2017).

Dixon-Gordon et al., (2017) conducted an extensive scientific research on the key points in the management of BPD using DBT. Emotional sensitivity and reactivity are the main bases
for affective instability. This was noticed in situations that BPD patients perceive to be associated with shame, anger, and anxiety. Amygdala reactivity was implicated via laboratory studies as well. These combinations of symptoms have favored the use of top-down processing rather than bottom-up processing. Top-down processing has been linked with patient’s ability to interpret situations before reacting rather than the impulsive nature inherent in BPD.

Proponents for DBT, as the main treatment for BPD, opined that pharmacological treatment only provides the bottom-up approach to resolving emotional cascades (sensitivity and reactivity) but, failed to give the patient a chance at reflecting on actual stressor/trigger. DBT is said to improve the patient’s ability to form perception more positively hence, increase the likelihood of making better a choice in an uncomfortable situation (Dixon-Gordon et al., 2017).

There is a widespread notion that BPD symptoms (hostility, anger, self-harm behaviors, suicide attempt, agitation, aggression, and/or substance use) increase during periods of actual/perceived social rejection. Emotional sensitivity and reactivity threshold tend to be lower during social rejection or situations that provide less than patient’s expectation. This pattern is recurring in the case under study, with behaviors becoming pronounced during episodes of perceived social rejection (Dixon-Gordon et al., 2017).

McMain et al., (2012) conducted a two-year prospective naturalistic follow-up study in BPD patients who have completed one-year treatment with either DBT or general psychiatric management (psychodynamic psychotherapy, case management, and pharmacotherapy). Though findings of improvements across both groups tend to be similar, DBT group had 50% remission within a year post-treatment while it took two years for patients managed by the general psychiatric approach to have 55% remission.
Furthermore, the assessed outcomes (severity and frequency of suicidal and non-suicidal self-injurious behaviors, decreased health service utilization, symptom severity, and general psychopathology) were significant and suggestive of sustained benefits post one-year DBT treatment. This also indicated that the outcome is long-lasting and extends beyond initial symptoms’ relief (McMain et al., 2012). These findings are consistent with other research conclusions that DBT decreases emotional reactivity and improves emotional regulation (Goodman et al., 2014), and that improvements in aspects of emotional regulation are directly proportional to improvements in symptoms, distress, and interpersonal functioning among BPD patients (McMain S. F., 2015).

An important caution to clinicians in the work of McMain (2015) is regarding the selection of psychotherapy type based on patient’s history rather than following one with the widespread report. The patients with the same subtype of BPD won’t respond to treatment alike, clinicians must understand that most randomized controlled trials/experiments have controlled variables which may not be controlled in real life application.

Bowen (2012) concluded that early life experiences of invalidation, excesses of neglect, physical and sexual abuse are directly responsible for BPD patient’s non-trusting stance/behavior with providers, and other significant people in their life as adults. The patient in this study has a similar cause and effect relationship that could have stemmed from immense childhood adverse events.

After comparing both commonly practiced treatment options, psychopharmacology and psychotherapy, no conclusion can be made about which approach to generalize despite major recommendations and guidelines to utilize psychotherapy as primary treatment. Martin-Blanco et al., 2017; NICE, 2009; Perese, 2012. There are compelling cases for the use of
Psychopharmacology due to co-occurring nature of BPD, with similar symptomatology (Ripoll 2012; Shafti & Shahveis 2010).

**Implication for practice**

The patients with BPD have been well documented to be a high user of the health care system, between nine percent to 40% of both out-patient & in-patient psychiatric population when compared with other mental health disorders (Comtois & Carmel, 2016). Similarly, the rate of burnout among clinicians and direct-care professional is alarming, creating low job satisfaction (Bowen, 2012).

For clinicians:

1. Maintain a straight-forward approach when forming a patient-provider alliance, define boundaries early.
2. Utilize shared decision making.
3. Encourage the client to engage in a form of social role, job/volunteering. Identify and appreciate the personality of the patient (give positive feedbacks when appropriate).
4. Use peer support as appropriate
5. Open communication with the patient, and other clinicians involved in care.


For research:

1. Further research is needed to determine the direct impact of other forms of psychotherapy on symptoms domain of BPD to serve as a comparison for DBT.
2. Research is needed in areas to test improvements in functioning.
3. Organize large-scale/sized research that seeks to evaluate the effect of DBT in BPD management as the current ones usually have less effect size.
In conclusion, this study revealed that current guidelines and clinical recommendation supports the use of psychotherapy (DBT) as a first-line approach rather than psychopharmacology due to its attending risk of polypharmacy. However, most guidelines under review allowed the use of psychopharmacology to manage acute symptoms in the interim. The ultimate decision of which approach or combination of approaches to utilize when treating patients with BPD will depend on several factors.

These include acute presentation of symptoms, practice orientation of the provider, patient’s history and likely predisposing factors, co-occurring disorders, socio-economic factors, willingness to follow-up, barriers to treatment compliance present for the patient, and to some extent, facility’s influence on care (Biskin & Paris, 2012; Dixon-Gordon et al., 2017; Goodman et al., 2014; Martin-Blanco et al., 2017; and Reeves-Dudley, 2017).
Reference


