

Psychological Case Formulation: Robin

Introduction to theoretical framework:

This psychological formulation will use an integrated biopsychosocial approach, making use of theory and research based on the etiopathogenesis of borderline personality disorder (BPD), in order to hypothesize a prognosis in the case of Robin, who displays strong symptoms of borderline personality disorder (BPD), major depressive disorder (MDD), as well as characteristics of bulimia nervosa (BN) and alcohol misuse. This formulation aims at drawing connections with the client's adverse childhood experiences (ACE), and the symptoms of BPD.

Basic demographics of client:

Age: 30

Sex: Female

Ethnicity: Caucasian

Marital status: Married

Present bio-psycho status: Ongoing involvement with psychiatrist. Recent episodes of suicidal ideation and self-harm, with periods of disassociation and memory loss. Intermittent alcohol binges and food restriction/binges. Displayed symptoms of major depressive disorder, and in receipt of pharmacotherapy (antidepressant medication). Troubled interpersonal relationships. Polarization of self and others (all bad vs all good).

Diagnoses: Borderline personality disorder (BPD), major depressive disorder (MDD), with cooccurrence of alcohol misuse, and intermittent episodes of behaviors associated with bulimia nervosa (BN).

Client background summary:

Robin, a 30-year-old, married, Caucasian, female, with no children, living in a middle-class urban area, has been referred to a clinical psychologist by her psychiatrist, following multiple suicide attempts (predominantly over the past 18 months, since receiving medication for depression).

Needing hospitalization on more than 10 occasions: one stay lasting for 6 months) and has inflicted extreme forms of self-mutilation and harm; numerous cuts and burns, drinking bleach on more than 10 instances, and injecting dirt (in an attempt to demonstrate to her medical team that she needs more attention), ultimately this required reconstructive surgery on her leg. Her family have grown increasingly concerned for her welfare and have suggested that she is admitted to hospital to receive treatment as an in-patient. However, Robin has expressed her wishes to remain at home as an out-patient for the duration of her treatment, something that has so far been declined by previous clinical psychologists (present clinical psychologist has agreed to out-patient care on the strict basis that Robin adheres to treatment and makes no suicide/self-harm attempts).

Robin has a history of problems with bulimia nervosa (BN), and alcohol misuse. Issues surfaced around age 14 and have continued throughout her life (alcohol binges and food restriction/intake). Having said this, Robin has functioned well throughout her education and employment, achieving a college degree, and completing two years of medical school. It was during the last of these two years that a classmate (who was little known to the client) committed suicide, triggering a deep depression in Robin over the following months, and inducing suicidal ideations.

Robin has struggled in her interpersonal relationships with her 'few' friends and family members (pushing them away with erratic behaviors, then proceeding to go out of her way to keep them close), which has been a common theme in her life. Her husband (whom she met during an Alcohol Anonymous meeting) is often the main-focus of her behaviors. Robin will threaten to commit suicide or inflict serious harm to herself should one of these individuals reduce or eliminate contact with her, or she will be the first to cease contact on the assumption that she is disliked and unloved by them, or that they are bad and unkind (illustrating a polarization of self and others). Robin often displays erratic changes in her behavior: from calm and reasonable, to angry, paranoid and irrational, often with no clear cause of affect.

Robin's childhood was turbulent, with experiences of severe sexual abuse at the hands of her father (beginning at age 5, and becoming more aggressive by age 12), and physical abuse by her mother, continuing throughout her childhood and into her first years of high school. Both parents have a history of depression and alcohol abuse, further indicating to a chaotic and unsupportive home environment.

Table of the 5 P's

	<u>biological</u>	<u>Psychological</u>	<u>Social/environmental</u>
<u>Predisposing</u>	• Family history of depression and alcohol misuse. • Psychopharmacotherapy (primarily antidepressant medication). • Bulimia nervosa (BN) (age 14+). • Depression. • Alcohol misuse (age 14+). • While there is no one definitive gene believed to be responsible for BPD, an accumulation of genetic influences could be at play (observed in twin studies).	• Brain development (amygdala, hippocampus, orbital-frontal cortex brain regions). • Suicidal ideations and self-harm. • Dissociation and memory loss (during episodes of self-harm). • Issues with attachment and abandonment. • Fluctuations of mood. • Problematic coping mechanisms. • Unhelpful interpersonal skills. • Erratic and unstable behaviors. • Polarization of self and others. • Feelings of emptiness.	• Limited social network. • Only child. • History of physical and sexual abuse by parents. • Mental health and alcohol abuse within the home environment during childhood. • Neglect. • Adverse childhood experiences (ACE). • Troubled interpersonal relationships. • Not in work or education. • Husbands possible alcohol use. • Suicide of classmate.
<u>Precipitating</u>	• Antidepressant medication. • Alcohol misuse.	• Problematic coping mechanisms.	• Family disputes.

	• Depression.	• Polarization of self and others. • Unhelpful interpersonal skills. • Attachment and abandonment issues. • Unstable mood.	• Families wish for treatment as in-patient. • Suicide of classmate.
<u>Perpetuating</u>	• Alcohol misuse. • Depression. • Antidepressant medication, as a singular treatment option.	• Problematic coping mechanisms. • Polarization of self and others. • Unhelpful interpersonal skills. • Unstable mood.	• Ability to inflict harm. • Mistrust of family and friends. • Husbands possible alcohol use. • Limited social circle added to lack of job or college course.
<u>Protective</u>			• Adherence to her wishes. • Attention from medical staff/family/friends. • Education/employment, or some other form of structured activity.
<u>Presenting</u>	• Intermittent alcohol use. • Eating disorder (BN).	• Suicidal ideations and infliction of self-harm.	• Troubled interpersonal relationships. • Limited social network.

	• Antidepressant medication.	• Problematic coping mechanisms. • Polarization of self and others. • Unstable mood.	
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Genetics:

BPD carries an increased risk of suicide during adolescence and early adulthood. It is estimated that almost 10% of those with the disorder commit suicide before they reach adulthood. It is therefore imperative that more research is conducted on the biological formulation of BPD. As of yet, there is no one singular gene known to be responsible for the symptoms of BPD, it is however suggested that an accumulation of hereditary traits may be responsible (aggression and impulsivity are highly heritable). One study involving 92 pairs of monozygotic twins (identical), and 129 pairs of dizygotic twins (nonidentical), found a 35% concordance with the monozygotic twin sets, and a 7% concordance with the dizygotic twin sets (Lis, Greenfield, & Henry, et al. 2007), indicating that genes play an important role in the development of BPD.

Differences have also been observed on a neuroanatomical level in individuals with and without BPD. Positron emission tomography (PET) scans have shown that the hippocampus and amygdala can be as much as 16% smaller in those with BPD, these changes in brain structure are believed to be related to early experiences of trauma or adverse childhood experiences. Furthermore, hypoactivity of serotonin metabolites in the cerebral-spinal fluid (CSF) of monkeys, coupled with the presence or absence of a loving nurturing environment is closely associated with self-destructive behaviors, and increased impulsive aggression (Lis, Greenfield, & Henry, et al. 2007).

Childhood abuse:

As previously discussed, the client has had experiences of physical and sexual abuse throughout her childhood, and into adolescence. Adverse childhood experiences such as these are believed to be contributing factors in the etiopathogenesis of BPD. The prevalence of childhood sexual abuse (CSA) reported among BPD patients is believed to be between 16% and 71%. In a two staged semi-structured interview (stage one – confirming BPD diagnosis and collecting

sociodemographic data/ stage two – collecting data on CSA), conducted by two interviewers, and involving 36 BPD patients, found that 44.44% (16), of the patients (36) had a definitive history of reported CSA (Mennon, Chaudhari, Saldanha et al. 2016). In another similar study involving 290 BPD inpatients, more than 50% of those who had reported experiences of CSA, had done so during childhood or early adolescence, at least once a week, and by a parent or other person in close proximity. More than 50% of all sexual abuse reported involved the use of force, violence, and/or penetration. Findings after the use of ‘multiple regression modelling’ suggest that the presence and severity of CSA, neglect, and other abuse, appears to contribute to the severity of symptoms of BPD (Zanarini, Yong, & Frankenburg, et al. 2002).

The symptomatic characteristics of BPD that are significantly associated with CSA are; recurrent suicidal/self-harm behaviors, stress related paranoid/dissociative symptoms, and identity disturbances, while unstable interpersonal relationships were strongly associated with the absence of CSA. Never the less, the developmental milieu of BPD patients, suggest that adverse childhood experiences may have a role in the development and severity of BPD (Mennon, Chaudhari, & Saldanha, et al. 2016). This correlates with the client's experiences of CSA and help to explain the etiology of some of her symptoms.

Parenting styles:

Reinecke, and Ehrenreich (2004), suggest that the interaction of factors including; genetic vulnerabilities, personality variables, childhood trauma, and familial psychopathology can contribute to the risk of developing BPD. According to the cognitive developmental model of BPD, parenting styles that are inconsistent, unsupportive, unresponsive, and un-nurturing, while also being unhelpful in the development of affect regulation skills, further raise the risk of developing the disorder. Parenting styles such as these interact with the individual's impulsivity, temperamental vulnerabilities, and affect dysregulation, attributing to the development of disorganized attachment styles. These disorganized attachment styles are believed to cause the individual to become vulnerable to developing maladaptive schemas regarding rejection, abandonment and self-worth, as well as contributing to a deviation of self-efficacy (Reinecke, & Ehrenreich. 2004).

When triggered via life events, maladaptive schemas attributing to personal worth, abandonment, and loss are believed to be central in the behavioral and emotional symptoms of BPD. For those

with a natural vulnerability to be impulsive, or neurotic, inconsistent parenting is believed to contribute to maladaptive belief systems. Other risk factors associated with a vulnerability to developing BPD are; behavioral impulsivity, familial history of substance abuse, depression, and impulse control disorder, a chaotic home environment, severe or chronic abuse and/or neglect, neuroticism, and dysregulated attachment (Reinecke, & Ehrenreich. 2004). Because the client has suffered severe abuse at the hands of both parents, it is highly suggested that a loving, nurturing environment was never attained by her, therefore this theory on parenting styles strongly correlates with the pattern of symptoms and behaviors it sets out.

Treatment plan:

Community based care

As earlier discussed with the client, outpatient care will be implemented, on strict conditions of: adherence to treatment, and that there is to be no attempts to cause physical self-harm. In order to achieve successful community-based care, a community mental health team (CMHT) will be tailored according to the needs of the individual. These may include: a social worker or key worker, psychologist/psychiatrist, and counsellor/psychotherapist (NHS. 2016). A personalized care program approach (CPA) will be utilized in order to address the best needs and wishes of the client. This will consist of four components; an initial assessment of care and social needs, a tailored care plan, a key worker (who will provide support in activities such as attending meetings and appointments or accessing services), and regular revision of the efficacy of treatment (NHS. 2016). By adopting to these strategies, it is aimed that the individual will be supported with the structure of her care in all situations.

Dialectal behavioral therapy

Developed by Dr Marsha Linehan for the purpose of treating the main characteristics associated with BPD, dialectal-behavioral therapy (DBT) is a structured form of outpatient treatment, based primarily on the principles of cognitive behavioral therapy (CBT). Made up of four components; individual psychotherapy, telephone consultations, a therapist consultation team, and skills group training. Aimed at working on specific symptoms, such as; fear of abandonment, emotional lability, an unstable sense of self, and unhelpful/chaotic relationships. The development of skills, such as; emotion regulation, distress tolerance, interpersonal, and mindfulness all contribute

toward effective changes in behavior and learned coping mechanisms. DBT has also been proven to be an effective addition to treatment of other psychiatric disorders such as: bipolar disorder, eating disorders (bulimia nervosa, anorexia, binge eating, ect), and post-traumatic stress disorder (PTSD) (May, Richardi, & Barth. 2016). This is suggested to be a beneficial treatment for the client with her symptoms of BPD, depression, and bulimia, hopefully providing her with the skills that she needs in order to adapt to situations in everyday life.

Telephone consultations allow for the client to access urgent, in-the-moment advice from a qualified therapist, trained in parasuicidal techniques. Weekly therapist consultations in an individual or group setting, aiming to maintain commitment of treatment and motivation of each individual with BPD. Distress tolerance is involved at helping the individual to accept that pain and distress are a normal and sometimes unavoidable part of life. A number of skills are worked on, such as; self-soothing, and techniques for distraction, as well as adjusting their thought processes during the moment that is triggering unhealthy behaviors. Emotion regulation strategies work on enhancing the individual's control over personal emotions. Firstly, by identifying the problematic emotions and their meaning. Individuals are taught to increase activities that illicit positive feelings, and to avoid those that are associated with the negative thoughts and behaviors. By using other skills, they have learned such as mindfulness, the individual can work on raising their tolerance to emotional pain and distress, in a positive, and productive way (May, Richardi, & Barth. 2016). It is also encouraged that Robin seeks to enroll on a small college course that will integrate some structure into her week.

Psychopharmacology:

According to the National Institute of Health and Clinical Excellence (NICE), medication should not be used for the specific treatment of BPD. For this reason, only the symptoms of MDD will be treated with medication. This is to be the current antidepressant medications in use. Suggested dose is to be increased and reviewed in 8 weeks, in order to compensate for additional depressive symptoms (May, Richardi, & Barth. 2016).

Case discussion:

Robin is at a vulnerable stage in her life, experiencing excessive depressive episodes, coupled with strong feelings of emptiness. Therefore, it is important to implement structure into her week, as she achieved so well previously in the completion of her education. However, there are concerns on her ability to refrain from dysfunctional behaviors that involve self-harm. Therefore, this formulation will be open to regular review and reformulation should treatment not be working accordingly.

References

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