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the prompt(s):

1. Boarderline Personality Disorder (BPD)
2. Dialectical Behavior Therapy (DBT)
3. Genetics and BPD
4. Adverse Childhood Experiences (ACEs) and BPD

I confirm that I have not presented any AI generated text as my own work. I confirm I have copies of my drafts, notes, and other resources I used before, and after the use of AI tools which I may be asked to provide in evidence.

Introduction to the theoretical framework:

This theoretical case formulation will take into consideration a biopsychosocial approach in the determination of the presenting, predisposing, precipitating, perpetuating and protective factors of the clinical case of patient, Roberta Henderson. This case formulation aims to draw possible links from the client's Adverse Childhood Experiences (ACE's) of childhood abuse, suicidal motivations, self-mutilation and symptoms the present symptoms of Borderline Personality Disorder (BPD). Further aiming to provide a secure treatment to help resolve her difficulties and for long-term better management of her symptoms and behaviour.

Basic demographics of client:

Roberta is a married, 30 year old, Caucasian, female. Roberta has continued association with a psychiatrist, whom has been treating her with antidepressant medication for over 18 months. Within this time, Roberta has had suicidal ideation and self-inflicted penance, with periods of dissociation, memory loss and problematic relationships. With a past of having difficulties with depression, alcohol abuse and bulimia nervosa (BN).

Diagnosis: Borderline Personality Disorder (BPD).

Client background summary

Roberta was an only child, with a past of Adverse Childhood Experiences (ACEs) receiving abuse from her mother and father, whom both have a history of depression and alcohol misuse. Abuse from her father was initially not violent (beginning at age 5 but became sexual when Roberta was 12 years old) this was initially not made clear when therapy had started, although indicated a troubled and unsupportive home environment and upbringing as the abuse continued into secondary school. Roberta has a past of difficulties with alcohol misuse and bulimia nervosa (BN) although not much is disclosed upon this, only that she had met her husband at present at an alcoholics anonymous (AA) meeting while in college. These two disorders resumed up until her visit to the clinical psychologist (CP). Indicating that she had upheld these struggles for a long time. Despite these difficulties, she achieved a degree and completed 2 years of medical school. At age 27, Roberta deteriorated upon the news that a classmate that she knew of had committed suicide. This had triggered an immediate deep depression within Roberta over the following months and induced severe suicidal ideations. Although Roberta did not know what had inclined her to feel this way. She left education within weeks and became increasingly depressed with continuous suicidal ideations.

She sees a psychiatrist, who has prescribed her with antidepressants medication for over eighteen months. The psychiatrist has now referred her to a clinical psychologist (CP) after several suicide attempts (predominantly over this eighteen month period since having medication for depression (could be a query of being a trigger in her behaviour). Roberta was hospitalised more than ten times : one stay lasting for 6 months. She has also inflicted extreme self-harm; numerous cuts and burns, drinking bleach and injecting dirt into her leg (to convince the GP to show her more attention). Her husband attended the first appointment with her, highlighting that him and the family were strongly thinking about long-term inpatient care due to growing concerns of Roberta's welfare. Contradictory, Roberta had an inclined preference for outpatient treatment and inpatient care (a wish previous CPs had

declined). The CP agreed to provide therapy on the condition that she is committed towards behavioural changes and no suicide attempts for at least a year.

Her behaviour appears in a chain, starting with a social interaction which leads to her feeling threatened/unloved (with no clear cause) usually by an encounter with her husband. This is accompanied by urges to hurt herself (kill herself or self-mutilate). Dependent on how she felt at the time, it will be accompanied by an infatuation of emptiness and a desire to end her emotional pain forever. She also has issues maintaining strong interpersonal relationships, often isolating herself, acting erratically upon feelings of abandonment or plans getting cancelled. Roberta takes a strong all good or all bad attitude towards people and herself, also evident when others commented on her success – reacting in a way to show that she needed more support.

Clinical Characteristics through the 5 P's

Presenting factors

Roberta displays several clinical characteristics which could be a strong indication of Borderline Personality Disorder (BPD). **Struggling with her social interactions, evidently with friends and family (pushing them away with unstable behaviours, but processing to go out of her way to ensure she is not alone)** this has been a re-occurring throughout her life. According to the DSM-5 (American Psychiatric Association, 2022) this is a symptom of BPD **with strong attempts to avoid abandonment**. Furthermore, Her husband is often the main start point of her behaviours, with no clear reason. On the urge that someone was to eliminate contact, Roberta threatens to commit suicide/self-harm. Otherwise, she would stop talking to someone, on the first account that she is unloved (illustrating an extreme social dispersion). Roberta's moods are very unstable; from content, to angry, irrational and paranoid. Which often has no clear objective which is associated with **the affective instability due to a marked reactivity of mood symptom** (DSM-5, 2022). Stated in the DSM-5 she showcases an intense all or nothing attitude towards her interpersonal relationships, frequently switching between idealisation and devaluation of herself and others, further **linking to an unstable image of her self** which could be an indication of an identity disturbance and **Inappropriate, intense anger or difficulty in controlling anger**. Roberta has recurrent suicidal idealisations and carries out self-mutilating behaviour which According to the **DSM-5 an individual with BPD will have impulsivity in at least two areas which are self-damaging**. Moreover, **Chronic feelings of emptiness** is also a symptom of BPD according to the DSM-5, which Roberta states is persistent. Roberta also displays **transient, stress related paranoid ideation or severe dissociative** symptoms (DSM-5, 2022) by being threatened by her husband.

Predisposing factors

From a biological point of view, genetic links could be a predisposing factor in this case (Bozzatello et al., 2021). Roberta's mum and father have a history of mental illness and alcohol abuse. Which indicates that Roberta has been exposed to this environment for countless years throughout her childhood. Although, it is not expressed that the family had symptoms of BPD, familial and twin studies support the potential links of vulnerability in heritability BPD at almost 40% (Skoglund et al., 2021) with strong links between gene-environment interactions (Amad et al., 2014). However, BPD has a complex multifaceted etiology, deriving from both these genetic and environmental influences. Proposing that due to the two predispositioning factors that could play in the role in the pathogenesis of the disorder, there is not one definitive gene responsible for its development (Nia et al., 2018) which makes it difficult to determine the root causes of BPD (Skaug, 2022) due to the wide range of risk factors that could be apposed. BPD is thought to be linked to impaired neurotransmitters (Thornton et al., 2023) which are 'messenger chemicals' used to deliver information in the brain between different brain cells (Hussain et al., 2023). Due to these being impaired, it results in altered levels of serotonin. This has been linked to depression, aggression and the ability to control destructive actions sufficiently (Leichsenring et al., 2023). Fatimah et al (2020) conducted a study determining BPD risk factors, in which the use of alcohol substantially predicted child BPD traits (Roberta's dad was a user of alcohol). Perental disputes and unconcern, perental externalizing psychopathology and others BPD and poor parenting contributed to environmental risks (Fatimah et al., 2020). Early trauma and childhood abuse has been associated with the onset of Borderline Personality Disorder (Bozzatello et al., 2021) with Adverse Childhood Experiences (ACEs) affecting different biological systems, such as neurotransmission mechanisms which persist into adulthood (Precious, 2025). Childhood adversity has been strongly linked to several negative outcomes, such as the increased risk of suicide attempts and developing depression (Leichsenring et al., 2023). The biosocial model suggests that there is a link between childhood abuse and increased vulnerability to emotional dysregulation (McDaniel, 2022) which is a prime feature of BPD. Due to Roberta's early experiences of abuse from her mother and father, this could have contributed to her now struggles with attachment and fear of abandonment (DSM-5, 2022). BPD has been associated with being co-morbid with other disorders. Describing the stimulanious accourance of more then one disorder (Kohne et al., 2021) As Roberta has a past of having depression, issues with alcohol use and Bulimia nervosa (14+) these could be predisposing factors in the onset of the disorder. The psychological predisposing factors is Roberta's consistent suicidal thoughts and self-mutilation, as well as not being mentally present while self harming. Her issues with attachment, alternations of mood (high and low), troublesome coping mechanisms of behaviour. Issues with interpersonal skills, erratic behaviour and feelings of emptiness.

Comparably, from a social/environmental perspective there are multiple predisposing factors that could be involved. Roberta has a limited social network, which according to (Liebke et al., 2017) reports of loneliness is persistent with patients with BPD, although they have impairments of interpersonal communication. Being an only child does not have a direct effect on the development of BPD. However, employing a secure parenting style within a single-child family has great importance, and could become a risk factor if not managed well (Winsper et al., 2012). Considering Roberta has a history of ACEs from her parents, this was

not granted. Indicating experiences of neglect during her younger years and growing up surrounded by parental issues with alcohol and mental health. Roberta is also no longer in work or education suggesting a lack of a routine or sense of purpose. According to Miller et al. (2021) having a sense of routine and belonging can help lessen the symptoms of BPD, especially those associated with chronic emptiness (DSM-5, 2022). The use of alcohol by her husband should also be questioned.

Precipitating factors

As previously discussed, Roberta's early experiences of childhood abuse (ACEs) could have been an environmental precipitating factor to her later difficulties with mental health and alcohol use (Leichsenring et al., 2023). Her family wanted her to have in-patient care, which could have initiated feelings of being unwanted/unloved. Suggested by D'Allicandro (2024) a structured/complying support network can help the management of BPD and make an individual feel more accepted. Again, Roberta's fluctuations of mood and being hard to understand by family members, could be an emptiness trigger. The suicide of a class member, also triggered a deepened sense of depression which Roberta could have been concealing since her childhood. Biologically, her antidepressants could be a trigger in her behaviour as well as her current depression (Tomasetti et al., 2024). Psychologically a trigger could be her issues with polarization of herself and others and her ways of coping with her behaviour. Furthermore, Issues with attachment and abandonment (shown by feeling threatened by her husband) could be a trigger, especially if her husband is still a user of alcohol.

Perpetuating factors

Roberta is in a repeat cycle of events, which in turn leads to her to isolate herself from others. However, Roberta determines these actions as she is unloved which encourages her suicidal motivations and low mood, although fluctuating – these psychological factors can reinforce her behaviour to continue to happen as she is not allowing friends/family to help. Although she is not aware of this, which is a key principle of BPD with patients often being unaware of their actions (Moltu et al., 2023). The fact Roberta is taking antidepressants as a single treatment could be encouraging her behaviour as it is being targeted at depression and not BPD and will not improve her impulsivity or emotional regulation (Tomasetti et al., 2024). It is not stated if she is still an often consumer of alcohol, however, this could be encouraging her behaviour and her depression. As well as the possible use of alcohol by her husband. Socially, she is alienating herself from others which indicates a troubled social network and the fact no one is stopping her from inflicting harm upon herself (considering how many times it has happened). Her husband may be supporting her by attending her first CP with her, although still encouraging her to have in-patient care – suggesting that he may not be able to cope himself, especially since how many times Roberta has been hospitalised. Roberta also has no current employment or educational path, which could contribute to the lack of purpose. According to Miller et al. (2021) strengthening a sense of identity and purpose can improve the management of the disorder, eliminating the lack of self-direction.

Protective factors – what will help

Protective factors could include adhering to her wishes of having a certain type of care and enough attention from her family and the medical team. However, due to her past of ACEs her family could also be a precipitating factor, which could make her feelings worse. Support from her husband could be beneficial. Returning into education or taking part in a type of weekly activity could improve Roberta to keep a structured lifestyle and maintain motivation (improving a sense of purpose) (Katsakou et al., 2019). Developing secure coping strategies rather than pushing others away could be beneficial and better ways of stabilising mood (Kramer, 2017). Psychotherapy could be of benefit, such as Dialectical Behavior Therapy (DBT) which is the best known heuristically supportive treatment for BPD (May et al., 2016) which helps people better control intense emotions and reduce self-destructive behaviours (DeCou et al, 2019 , O'connell & Dowling, 2014). Furthermore, Cognitive Behavioral Therapy (CBT) could be a further benefit to help change deep driven beliefs and behaviour (Matusiewicz et al., 2010).

Treatment plan

Dialectical Behavior Therapy (DBT)

DBT was developed by Dr Marsha Linehan on the basis of treating the main characteristics present in BPD. The therapy is a form of out-patient treatment (adhering to the wishes of Roberta) which is based upon the primary principles of cognitive behavioural therapy (CBT). Although being the only empirically supported treatment for BPD (May et al., 2016). DBT involves the patient recalling on past experiences and dealing with underlying trauma by combining behavioural strategies and supportive psychotherapy (Harned, 2022). It incorporates four components; Individual psychotherapy, telephone consultations, therapist consultation team and training skills group (Rizvi et al., 2013). Which aims to work on the prime symptoms of the disorder such as unstable sense of self, troubled interpersonal relationships, fear of abandonment and emotional instability (DSM-5, 2022). This could promote several areas in Roberta's recovery, allowing her to better approach her relationships (with her husband and friends) and build a better sense of self, especially when alone (decreasing the feelings of being unloved and abandoned). The development of skills involved includes emotion regulation, distress tolerance and mindfulness (Sehati et al., 2019) which are all aspects that can contribute to better coping mechanisms for Roberta, which as earlier discussed could be a crucial precipitating factor in the encouragement of her behaviour. With improved coping mechanisms, Roberta has a greater chance of recovery. DBT also holds weekly sessions with a therapist and telephone coaching which provides advice on the use of the previous skill sets. In turn, the improvement of self-harm/suicidal ideations, emotional understanding/stability, social relationships and work towards goals can be obtained. However, this type of therapy is not to be considered lightly, as it needs high perseverance from the patient to want to improve. DBT has also been seen as an effective addition to help bulimia nervosa (BN) and depression which could further promote her other difficulties (Brown et al., 2019).

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