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UNDERSTANDING BORDERLINE PERSONALITY DISORDER AND DEPRESSION: A CASE FORMULATION

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ABSTRACT

The co-occurrence of depression and borderline personality disorder (BPD) complicates the formulation thus it must be comprehensive to accurately inform an effective treatment plan. The case is TSN, 22-year-old Malay woman who sought psychological help for having recurrent depressed mood and self-harm. Mood assessment indicated high severity of BPD symptoms, moderate depressive symptoms, and mild anxiety. We formulated the case based on 4P biopsychosocial model, Crowell's biosocial development model of BPD, and Beck and Bredemeier's unified model of depression. TSN was temperamental and impulsive as a child. Parental invalidating responses and neglectful environment were reported. The loss of close friend had precipitated BPD traits, which exacerbated by multiple interpersonal losses thereafter. Coping with losses using ineffective strategies have gradually resulting depressive symptoms in TSN. We concluded that BPD traits, rather than depression, had triggered and maintained her depressed mood, thus it is important to focus on treating the BPD psychopathology.

Keywords: *borderline personality disorder, depression, case formulation*

BACKGROUND

The symptoms of emotional sensitivity, impulsivity, low mood, and self-harm are commonly reported in individuals with depression as well as borderline personality disorder. The symptoms co-morbidities between the conditions complicate the formulation, diagnosis, and treatment focus. Although individuals with co-occurring BPD and depression do not significantly differ from those with only one of the two disorders in terms of overall severity and impairment, they have poorer treatment prognosis and more suicide risk (Levy et al., 2007;

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Newton-Howes et al., 2013; Soloff & Fabio, 2008). They are also significantly more sensitive towards rejection, experiencing greater sadness when rejection is encountered (Hepp et al., 2017). We aim to formulate a case from a client who presented with these multiple co-morbidities to better inform treatment planning

ETHICAL CONSIDERATION

We addressed the ethical issues in publishing this case report via consent signed that we obtained from the client at the beginning of the therapy which stated amongst others that the client agreed that this case may be published for academic purpose anonymously.

CASE PRESENTATION

TSN is a 22-year-old Malay lady, the third of 5 siblings who was born with no complications and had achieved normal developmental milestones. Academically, she performed at the above average level and currently pursuing a bachelor's degree in Law. Her mother was 53 years housewife whom was described as good-hearted but strict and firm towards her children. Her father was good-hearted, helpful, and knowledgeable, yet was also said to be hot-tempered, explosive, and enjoyed teasing others. TSN described her family relationship as quite tense with many arguments over trivial matters since childhood.

TSN spent most of her time completing study tasks, sleeping, and engaging in leisure activities such as playing mobile games, watching YouTube videos, and reading books alone in her bedroom. She had only two close university friends she occasionally chatted with over the phone. She perceived herself as a "highly sensitive person" who "overthinks" situations and is easily overwhelmed by emotions. She realised that her mood changes between predominantly dysphoria and chronic emptiness. The mood was triggered by various interpersonal stressors such as bullying at school, family conflicts, isolation, and recurrent absence of a romantic interest.

TSN reported shifted between idealising her loved ones to feelings of dislike and suspicion. She lashed out or left the loved ones when she perceived that they were being unsupportive or neglectful towards her. TSN shared that she severed more than 10 close friendships to avoid abandonment. Her feelings towards her romantic interest also vacillate according to whether he was present or absent in her life.

When TSN began to dissociate from her feelings and cut herself when she felt overwhelmed, she started to seek medical treatment at the age of 21. Initial assessment using BDI-II, BAI, and BSL-23 indicated high severity of BPD symptoms, severe to moderate depressive symptoms, and mild anxiety.

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DISCUSSION

Case Formulation

The case is formulated based on biosocial developmental model of BPD (Crowell et al., 2009), 4P biopsychosocial model, and a unified model of depression (Beck & Bredemeier, 2016). The first explains how biological factors predisposes an individual to temperamental vulnerabilities often exacerbated by emotionally-invalidating environment. This leads to increasing emotional dysregulation and maladaptive behaviours. The second model conceptualises depression symptoms as adaptations to conserve energy and protect the self from potential threats in response to significant losses. The last model categorises the predisposing, precipitating, perpetuating, and protective factors that contribute to a presenting problem. Integrating the three models enables better comprehension of how the various factors in TSN's life contribute to her BPD and depression symptoms. Figure 1 illustrate the complex interactions between multiple factors which develop, trigger, and maintain the BPD and depressive symptoms in a patient – TSN.

Predisposing Factors

Crowell et al., (2009) highlighted the role of genetic predisposition as well central and parasympathetic nervous systems abnormalities to mental disorder such as BPD and depression. These biological factors may predispose to psychological vulnerabilities such as tendency to experience distressing emotions, impulsivity, and heightened sensitivity to emotional stimuli. Whilst TSN reported no family history of psychiatric diagnoses, she described her parents and older siblings as prone to expressions of anger that range from stern to explosive.

TSN too she described herself as having a "highly sensitive" temperament since childhood. She easily got overwhelmed and tended to lash out at loved ones when upset since childhood. Unfortunately, her temperamental difficulties seemed to be reinforced by her childhood environment. She described her family as emotionally intense surrounding whereby emotions, needs, and expectations were usually expressed and responded in an explosive manner, judgemental, and critical. When she expressed distress, this was usually not accepted or supported by her family members who deemed her reactions as "immature" and overly sensitive. Her emotional expression was often met with aggression and disapproving remarks. Expressing negative emotions thus felt invalidated, confusing, unacceptable experiences, contributing to self-doubt and rejection of emotions.

In short, her psychological vulnerabilities were reinforced by her childhood environment which then further increased her emotional dysregulation. She became increasingly emotionally sensitive, experiencing intense and prolonged reactions towards emotional stimuli. This increases risk for psychopathology including BPD and depression when precipitating or triggering event(s) occur.

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Precipitating Factors

Precipitating factor refers to specific event that first trigger the onset of mental health problem. In TSN case, it is her tendency to culminate relationships despite she is in need of one. She is highly motivated to avoid feeling of abandonment. As early as 8 years old, TSN having a fear of being rejected by significant others. Particularly, when her best friend began a close friendship with another schoolmate, TSN feared that her friend was going to replace her, and she would lose their friendship. Rather than continuing to maintain the friendship she treasured, she decided to end that friendship to avoid any potential pain of being abandoned.

The demise of her father due to stroke when she was 12 years old was another triggering event. Whilst she was coping to the loss, her mother developed close relationship with another man. This triggered TSN's fear that she was losing her mother to this man. Thus, she reacted to that perceived abandonment by lashing out, which was off course invalidated by all family members, resulting her continuously feeling alone and isolated.

While having to continually managing her loneliness that no one is understanding her, she met a romantic interest at the age of 14. This person however was only intermittently present in her life. While his attention and affection gave her relief, he would stop chatting with her at times. This time around, the absence of this person was not only triggered her feeling of being rejected and abandoned, but also had accelerated the mental health symptoms.

Crowell and her colleagues (2009) stated that individuals with BPD have negatively biased views of situations, behave according to their mood rather than long term consequences, and shut down or avoid stressful situations. As these reactions recur in a multitude of situations, it maintains BPD traits, and consequently developing depressive mood symptoms.

Maintaining Factors

Multiple factors including social, cognitive, emotional, and behavioural can maintain mental health symptoms thus they gradually become a stable trait in an individual, such as TSN. Socially, she felt isolated from her family who had difficulty empathising with her emotions and classmates whom she could not integrate with. She experienced bullying and had difficulties maintaining her friendships and a relationship with her romantic interest as well. Continued stern parenting and disapproving remarks from her mother also contributed to a negative, unstable view of herself.

Cognitively, she developed an increasingly hopelessness and critical view of herself and her life, believing that she was unable to effectively control her emotions and relationships. Since 2020, she also began to dissociate from distressing thoughts and experiences to cope with overwhelming emotions. Emotionally, she became increasingly prone negative affect including sadness, anger, and shame. To regulate these distressing thoughts and emotions, she used various maladaptive coping behaviours. She withdrew from people and avoided potentially distressing situations such as confronting and managing her emotions, her schoolwork, and interacting with family members. Since 2020, she also began to cut herself when emotionally overwhelmed. As these strategies helped her regulate or avoid intense emotions, these

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behaviours were reinforced and became increasingly habitual.

Linking BPD to MDD

It is established fact that BPD-related impairments, especially interpersonal skill difficulties, impulsivity, emotion dysregulation, and self-destructive behaviours, increase the likelihood of interpersonal problems, while interpersonal stressors contribute to distressing feelings among BPD patients (Hepp et al., 2017; Koenigsberg et al., 1999). TSN's main stressors throughout her childhood were multiple actual and perceived interpersonal losses.

At home, her emotional vulnerabilities and intense behavioural responses were invalidated by her family members. Her mother criticised her for being "immature". She felt judged for her distress and viewed herself as problematic compared to her siblings who seemed able to accept the new man in her mother's life, for example.

Among peers, her early BPD traits made it difficult to maintain close friendships, including with romantic partners. Her intense fear of abandonment and maladaptive coping through lashing out, withdrawal, and ending relationships resulted in many conflicts and losses of friendships. When romantic partners chose to keep quiet or missing for sometimes for example, TSN could not handle her emotion. It exacerbated her fears of abandonment and triggered depressive symptoms.

Beck and Bredemeier (2016) stated that depression occurs to adapt to losses of one's investments in vital resources, especially when one's ability to recover this resource appears beyond one's control. In her case, she perceived the interpersonal stressors as losses of love, social support, acceptance, and belongingness. These losses accumulated and prolonged, with difficulty to regain and maintain her interpersonal resources despite her efforts. Thus, this contributed to depressogenic beliefs that she is defective, and people hurt, reject, and will continue to leave her. Her beliefs and negative cognitive appraisals fed into one another.

With these accumulated and simultaneous interpersonal losses, she needed to adapt to these and protect herself. Evolutionarily, humans must conserve energy to survive loss of resources while staying vigilant to prevent further losses (Beck & Bredemeier, 2016). This conservation of energy occurs at cognitive, emotional, and behavioural levels. Cognitively and emotionally, as negative automatic thoughts arose, she felt empty and had reduced concentration in her studies. According to Beck and Bredemeier (2016), feelings of emptiness promote withdrawal from activities, thus conserving energy. On the other hand, reduced concentration arises due to conservation of energy in the brain.

Behaviourally, her body also conserved energy through anhedonia, hypersomnia, and anorexia, and promoting vigilance of emotional stimuli. With lack of pleasure and appetite, she reduced energy-expending activities including reduced eating. On the other hand, by sleeping more, she regained energy. Besides that, being vigilant of potentially painful stimuli, such as critical remarks from family members or lecturers, potential abandonment from peers, flaws in her study tasks, protects her from further losses.

Apart from that, maladaptive coping behaviours perpetuated her depressive symptoms. For example, she avoided painful stimuli such as doing her study tasks, withdrew from her family, and ruminated about problems especially past, current, and potential interpersonal

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problems. These behaviours triggered and exacerbated her distress and problems.

Protective Factors

Nonetheless, TSN had several protective factors that have been helping her manage her BPD and MDD symptoms. Since her BPD and MDD diagnoses in 2020, she gained access to mental health resources and learnt coping skills from previous DBT sessions. Her family interactions have slightly improved, and she had two close friends for emotional support. However, she still had high severity of BPD symptoms, moderate depressive symptoms and mild anxiety that require further treatment.

CONCLUSION AND RECOMMENDATIONS

In summary, TSN was born with temperamental vulnerabilities of impulsivity and emotional sensitivity that was exacerbated by an invalidating childhood environment. Fear of a loss of friendship at very early age, combined with multiple actual and perceived loss of significant others have triggered her symptoms, and somehow worsened her emotional dysregulation, Lack of social skills and use of maladaptive coping had put many of her relationships at failure, thus kept validating her negative views of herself, feeling of isolated, disassociated, and worthlessness. She felt like a loser at love, social support, acceptance, and belongingness. As these losses accumulated and prolonged, with difficulty to regain and maintain her interpersonal resources, it contributed to depressogenic beliefs that she is defective, and people hurt, reject, and will continue to leave her. To adapt to her losses, her body conserved her diminished resources via feelings of emptiness, reduced concentration, anhedonia, hypersomnia, and anorexia, and vigilance of emotional stimuli. As maladaptive coping behaviours such as avoidance, withdrawal, self-harm, and rumination helped her regulate her distress, these behaviours became reinforced as her primary responses to stressors but ultimately exacerbated problems and perpetuated her depressive symptoms. Her BPD traits, such as fear of abandonment, impulsive aggression, and withdrawal, simultaneously caused actual and perceived interpersonal losses and greater sensitivity towards interpersonal losses. This highlights the complexity of her co-occurring BPD and MDD.

Recommendations for Intervention Plan

Research has shown that impairments in BPD contribute to the occurrence of more social and occupational problems, predicting future depressive episodes (Koenigsberg et al., 1999). Presence of personality disorders, including BPD, predicts poorer prognosis for patients treated for depression (Newton-Howes et al., 2013). In treating BPD with depression, improvements in BPD symptoms also predicts improvements in MDD (Dell'Osso et al., 2010). Thus, in planning psychotherapy, it is important to focus on treating the BPD psychopathology unless the depressive symptoms impair motivation and engagement in psychotherapy. Specifically, the patient needs to learn to tolerate and regulate emotions in healthier ways. Therapy goals

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must include managing emotions and unhelpful thoughts. Specifically, techniques in Dialectical Behaviour Therapy and Cognitive Behaviour Therapy skills focused on distress tolerance skills, emotion regulation skills, cognitive restructuring, and behavioural activation are evidenced based treatment option.

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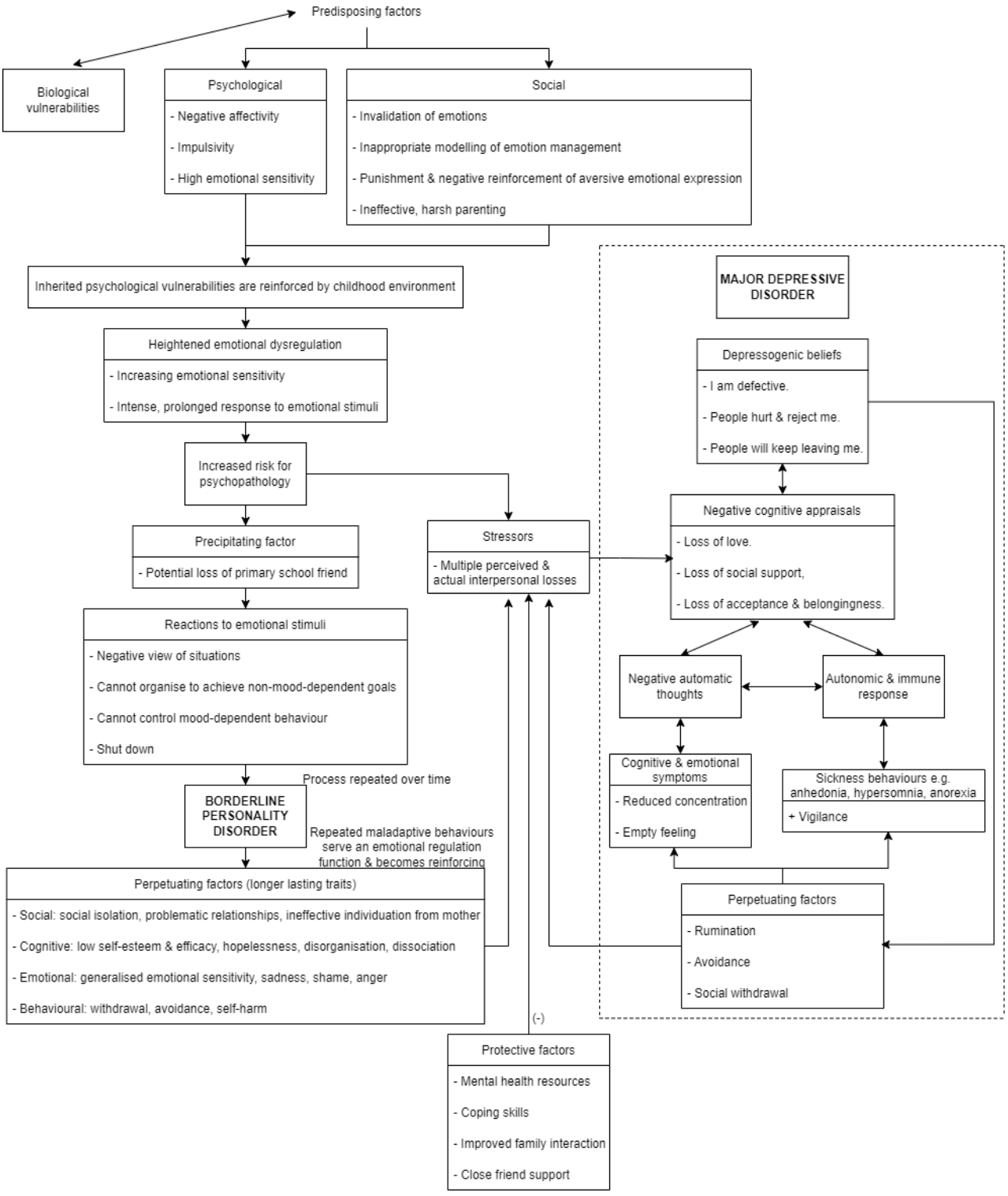

Figure 1: Formulating BPD and Depression via Multiple Biopsychosocial Factors