Evaluation Studies in Social Sciences (ESSS)
eISSN 0128-0473Vol 5/2024 (106-115)
https://ejournal.upsi.edu.my/index.php/ESSS/index
DOI: https://doi.org/10.37134/esss.vol5.1.8.2024

A CASE REPORT OF BORDERLINE PERSONALITY DISORDER

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Received: 29 April 2024; *Accepted*: 9 July 2024; *Published*: 30 September 2024

ABSTRACT

This case report is about a 37-year-10-month female, AK, who presented with history of self-injurious behaviours, multiple overdose incidents, feelings of emptiness and anger, a lack of interest in all activities, and sleep disturbance. AK was initially referred for cognitive behavioural therapy by a psychiatrist. She reported symptoms consistent with borderline personality disorder. AK has not undergone a standardised psychological assessment previously. Due to the heterogeneity of borderline personality disorder and the potential of comorbidity, a thorough psychological assessment is needed for intervention planning. Psychological assessments (i.e. Beck's Depression Inventory, Columbia-Suicide Severity Rating Scale, Borderline Symptom List 23, and Minnesota Multiphasic Personality Inventory-2) and mental state examination were conducted to better understand her psycho-social, personality, and daily functioning. Following the assessments, a provisional diagnosis of borderline personality disorder comorbid with major depressive disorder was given. Several recommendations were made to help AK improve her overall well-being based on her current problems. Challenges faced in deciding the final diagnosis were discussed. This case report illustrates the importance of applying evidence-based assessments and synthesizing assessment findings in diagnosing personality disorders.

Keywords: *personality disorder, personality assessment, borderline personality disorder, major depressive disorder, comorbid.*

BACKGROUND

Personality refers to the way a person thinks, feels, and behaves (American Psychiatric Association, 2022). Personality is influenced by life experiences, environment, and inherited characteristics (American Psychiatric Association, 2022). Individuals who have experienced adverse childhood events such as physical abuse, neglect, emotional instability, and growing up in a hostile environment are among the predictors for the development of personality disorders (Möhler, 2022). Individuals with personality dysfunction tend to have low frustration tolerance, are aggressive, and often engage in self-injurious behaviour; which affects their interpersonal relationships (Möhler, 2022). Personality disorders are pervasive and have long-lasting impacts on a person's life if left untreated.

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Borderline personality disorder (BPD) is characterised by a pervasive pattern of unstable interpersonal relationship and self-image, intense emotions, as well as impulsivity (American Psychiatric Association, 2022). Persons with BPD may have intense fear of being abandoned, chronic feeling of emptiness, inappropriate intense anger, and repeated suicide attempts (American Psychiatric Association, 2022), that may cause deterioration on persons and the environment.

It is difficult to accurately diagnose BPD as it shares symptoms with other disorders and heterogeneity within personality disorders (Campbell et al., 2020). Furthermore, it is common for patients with BPD to have a comorbid psychiatric disorder (Kulacaoglu & Kose, 2018) and concurrent assessments are needed (Bohus et al., 2021). Hence, this case report aimed to illustrate how diagnostic conclusion of BPD is arrived by integrating comprehensive psychological assessments supported with research evidence.

Individuals with BPD may engage in risky behaviours such as reckless driving, drug abuse, and violating laws (Chapman et al., 2021). In addition, the self-harm and suicidal behaviours increased the likelihood of using hospital emergency services (Campbell et al., 2020). Undiagnosed BPD leads to limited access and referral for treatment, especially mental health services (Campbell et al., 2020). As a result, assessment and diagnosis of BPD is fundamental and necessary for intervention and treatment planning (Campbell et al., 2020).

METHODOLOGY

Case presentation

AK is a 38-year-old Malay female, referred by a psychiatrist for cognitive-behavioural therapy due to major depressive disorder. She presented with an irritable mood and depressive symptoms. She has a history of being treated for major depressive disorder with underlying borderline personality traits in 2018, which included multiple episodes of self-harm. However, AK has never undergone a formal assessment. A thorough intake interview suggests the presence of a personality disorder. AK was recruited as a participant for a comprehensive assessment, as this will help the clinician make an accurate diagnosis, which is essential for effective treatment planning.

AK is a divorcee with three children (aged ten, nine, and six respectively). She works as a civil servant (i.e. English teacher in a secondary school). She experienced sleeping issues. She sleeps between 30 mins to 3 hours per day on average. She was easily angered both at work and home. She felt lonely as she thinks that no one understands her and no one wants to listen to her. She thinks that she is useless and not beneficial to others. AK had self-harming thoughts but she was able to stop herself from performing it as she does not want to be her old self.

She has described family conflicts after her father molested her, which left her feeling that her family members did not care about her, and that she did not have a good relationship with them. AK also had financial disputes with her younger sister. She also showed poor self-concept when her sons do not reciprocate her love. She felt she was a useless and bad mother.

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Whenever AK's mother complained to her about the misbehaviours of AK's sons, this reinforced AK's feelings that she was not a good mother.

In addition, she continued her previous abusive marriage despite feeling used and had a turmoil marriage. She also allowed her name to be used by her best friend for loans. She was betrayed by her close friend and leaving debts under her name. AK also reported moderate stress and anxiety, as well as headache and shoulder pain.

AK also said that it is not fair that she was being judged and no one cared about how is she doing. She has fears of troubling others, she thought about who will mark the exam papers if she died and it will trouble others as the exam papers will be brought to the police station. She has no close friends and feels lonely.

AK had multiple incidents of overdose and self-harm when she felt emotionally unstable since 2020. She faced financial difficulties due to her previous compulsive decisions in spending. She was currently taking fluvoxamine 150mg once daily and zolpidem 10 mg as prescribed by her doctor

Ethical concern

The client provided consent to publish this case study. Names were changed to protect the client's confidentiality. No ethical approval was required.

List of Psychological Assessments

After the clinical interview~~,~~ and screening at the first session, the information gathered leading towards specific assessment selection prior the diagnosis were conducted. Four tests were administered to further understand AK's psychosocial and daily functions, as well as her personality. The Beck's Depression Inventory (BDI; Beck et al., 1988)~~,~~ was administered to understand AK's general mental health condition. The Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011) was administered to assess AK's risk of harming herself. Borderline Symptom List 23 (BSL-23; Bohus et al., 2009)~~,~~ and Minnesota Multiphasic Personality Inventory-2 (MMPI-II; Butcher, 2001) were administered to further assess AK's personality traits.

Assessment Results

Table 1 summarises the descriptive findings of the psychological assessments for the BDI, C-SSRS, and BSL-23. Table 2 and 3 further explain the findings of the MMPI-2.

BDI

The reliability of the BDI is 0.86 among psychiatric populations and 0.81 among nonpsychiatric populations (Beck et al., 1988). The validity of the BDI is 0.72 among psychiatric populations and 0.60 among nonpsychiatric populations (Beck et al., 1988). In

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assessing AK's mood in the past two weeks, she scored 33 on measures of depression on the BDI, indicating depressive symptoms reported within the severe range. This is consistent with AK's reports of currently expressing a depressive episode. It also further supports AK's complaints of having feelings of worthlessness such as the thought of "I'm useless", being punished, irritability, and insomnia issues.

C-SSRS

The reliability of the C-SSRS was reported to be 0.72 (Posner et al., 2011). The validity of C-SSRS was reported to be 0.52 (Posner et al., 2011). Based on AK's response on the suicidal severity rating scale, it indicates that she needs mental health intervention. This is consistent with AK's complaints of having thoughts of better off dying and self-injurious behaviour of pressing a key on her left wrist. It also supports AK's past overdosed attempts.

BSL-23

The reliability of the BSL-23 is 0.97, with a validity of 0.83 (Bohus et al., 2009). AK's BSL-23 score show a high level of consistency with BPD symptoms. She reported having outbreaks of anger, feeling worthless, self-harming thoughts, distrust towards others, fear of criticism, and difficulty concentrating in everyday life.

Table 1
Descriptive Findings of the Psychological Assessments

Test	Score	Classification
BDI	33/63	Severe depression
C-SSRS - Suicidal Ideation	1/5	Low risk - need for mental health intervention
BSL-23	2.52/4	High severity due to BPD symptoms
MMPI-II		Refer to Table 2 and 3

MMPI-II

The reliability of the MMPI scales ranges from 0.71 to 0.84 (Hunsley et al., 1988). The validity scale of MMPI-2 included nine subtests which are VRIN (Variable Response Inconsistency) to detect random responses, TRIN (True Response Inconsistency) to detect fixed responses, F scale to identify over-reporting, FB to identify changes in responding between the first and second half of the test, FP to detect intentional over-reporting in individuals with psychopathology, L scale to detect intentional under-reporting, K scale to detect unintentional under-reporting and S scale to identify under-reporting with the entire MMPI-2 item pool. Table 2 summarises AK's T-score on the nine validity scales.

Based on AK's responses, AK did not omit any items. Hence, her profile is valid and can be further interpreted. AK's validity scales of VRIN and TRIN scales were valid based on

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scores in clinical settings. However, AK's Infrequency scale (F) and Infrequency-Psychopathology (FP) T-scores were high. This indicates that AK is faking bad and she is crying for help by exaggerating the psychopathological symptoms that she is experiencing now.

Table 2
Validity Scales T-scores

Scale	T-score
VRIN	50
TRIN	65
F	109*
F_B	81*
F_P	89*
FBS	92*
L	63
K	37
S	32

*T-score above 65
VRIN = Variable Response Inconsistency, TRIN = True Response Inconsistency, F = Infrequency, FB = Back F, FP = Infrequency-Psychopathology, FBS = Fake Bad Scale, L = Lie, K = Correction, S = Superlative Self-Presentation

The 10 clinical scales are Hypochondriasis (Hs), Depression (D), Hysteria (Hy), Psychopathic Deviate (Pd), Masculinity-Femininity (Mf), Paranoia (Pa), Psychasthenia (Pt), Schizophrenia (Sc), Hypomania (Ma), and Social Introversion (Si). Table 3 summarises AK's T-score on the clinical scales.

Table 3
Clinical Scales T-scores

Code	Scale	T-score
1	Hs	77*
2	D	83*
3	Hy	89*
4	Pd	81*
5	Mf	43
6	Pa	89*
7	Pt	65*
8	Sc	76*
9	Ma	59
0	Si	54

*T-score above 64

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Hs = Hypochondriasis, D = Depression, Hy = Hysteria, Pd = Psychopathic Deviate, Mf = Masculinity-Femininity, Pa = Paranoia, Pt = Psychasthenia, Sc = Schizophrenia, Ma = Hypomania, Si = Social Introversion

The Welsh code of the basic scale profile for AK is 3624"18'7-90/5:F*K#L-. Table 3 outlined six (6) clinical scales with T-scores greater than 64, indicating significant psychopathology. AK scored the highest on the Hysteria (Hy) and Paranoia (Pa) with a Code Type of 36/63.

Assessment Interpretation

Overall, AK's assessment findings supported the presenting complaints reported. The MMPI-II results were consistent with the somatic complaints, insomnia, anxiety, sadness, and stress level reported by AK in the clinical interview. Furthermore, AK's elevation on the subscales of Depression (2), Hysteria (3), Psychopathic Deviate (4) and Schizophrenia (8) are consistent in the MMPI-2 profile are consistent with the MMPI-II profiles of BPD (Emil Öğünç et al., 2018). This is also consistent with the BSL-23 findings. AK reported unstable interpersonal issues since young. She is currently socially isolated from her friends and family. She also reported family conflicts. Also, AK's current condition of low mood and insomnia ~~also~~ fulfils the MDD diagnostic criteria.

The symptoms related to AK's Code Type of 36/63 are moderate tension and anxiety, deep-chronic feelings of hostility toward family members, pollyannaish - tend to perceive their relationships in positive terms and have difficulty understanding why others react to them the way they do and contributes to significant marital turmoil. They tend to be naïve and deny any suspicious attitudes and comfort themselves with a naive and rosy acceptance of things as they are. They are hypersensitive to criticism, experience considerable anxiety and tension, and frequently have somatic complaints. AK expressed personality and interpersonal characteristics of this Code Type.

AK's elevation in the scale Depression (2), Hysteria (3), Psychopathic Deviate (4) and Schizophrenia (8) are consistent with the MMPI-2 profile characteristics of BPD. Patients with BPD has a profile trait of elevation in the scale Psychopathic Deviate (4), Schizophrenia (8), Hysteria (3), and Depression (2) (Emil Öğünç et al., 2018). The Depression scale showed AK had low self-worth and experiencing sleep issues as reported in the Insomnia Severity Scale. She also had thoughts of "I'm not a good mother". In the Hysteria (3) scale, AK was submissive towards her ex-husband, she also had to pay the car instalment before her ex-husband gives her the alimony. AK also reported anxiety-related somatic complaints and demands for her children's love to feel worthy. AK's elevation on the Psychopathic Deviate (4) scale is also consistent with BPD's diagnostic criteria of unstable interpersonal relationship as she had no close friends since young and had difficulty controlling her anger towards her children and used physical punishments on them. The elevation on the Schizophrenia (8) scale showed AK has an unstable self-image. In conclusion, it appears that AK's MMPI-2 profile is valid and consistent with her self-reported symptoms.

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AK met most of the criteria for BPD and MDD based on AK's history of presenting problem, AK presented with low mood and anxiety. AK also reported unstable relationships with her children, family, friends, and romantic partners. AK tries to please her ex-husband and parents despite having financial issues as she is afraid that others might leave them. She has thoughts of not being a good mother when her children do not follow her instructions. She has difficulty controlling her anger and hit her children. She also reported impulsive behaviours of spending excessively on supplements while having financial difficulties and driving long distance at late night while expecting a baby. She also reported recurrent self-harm behaviours. These instances are consistent with the criteria of BPD. This diagnosis is further supported by AK's results obtained from the BDI, BSL-23, C-SSRS, and MMPI-2.

For MDD, AK reported feeling sad and loss of interest in doing what interests her in the past. She also reported insomnia and easily irritable when managing her children. She reported recurrent thoughts of suicide and felt worthless as a mother. This diagnosis is further supported by AK's results obtained from BDI, and C-SSRS.

Provisional diagnosis

Based on the assessment findings, AK met the diagnostic criteria for both BPD and MDD. AK is diagnosed with 301.83 (F60.3) Borderline Personality Disorder (BPD) and 296.32 (F33.1) Major Depressive Disorder (MDD), moderate and recurrent episode.

DISCUSSION

AK presented with a wide range of symptoms related to her BPD and MDD diagnosis. Based on AK's report, she is currently experiencing a depressive episode and has had unstable interpersonal relationship since young, impulsive behaviours, and unstable self-image. Upon further investigation, AK's symptoms overlap with symptoms of PTSD.

AK's case presentation was unique as comorbidity rates of PTSD and MDD is between 30% to 50% (Angelakis & Nixon, 2015). In addition, 25 to 30% of adults meeting criteria for either PTSD or BPD also met criteria for the other disorder (Ford & Courtois, 2021). Furthermore, 30% to 70% of adults diagnosed with BPD had an episode of PTSD at some point in their lifetime (Ford & Courtois, 2021). AK experienced a few traumatic events in her life (e.g., being in an abusive relationship and sexually molested by father). AK does not have any close friends and is currently experiencing conflicts with her family members. In addition, she is experiencing severe insomnia and persistent sadness.

PTSD was ruled out as AK did not report any intrusion symptoms. One of the limitations was no objective assessment to rule out PTSD was conducted. Overall, the assessments results showed that AK's presentation fits into the BPD and MDD diagnostic criteria.

Prior studies have shown that MMPI-II is a comprehensive personality assessment tool to measure personality disorders (Emil Öğünç et al., 2018). Overall, AK's elevation in the scale

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Depression (2), Hysteria (3), Psychopathic Deviate (4) and Schizophrenia (8) are consistent with the MMPI-2 profile characteristics of BPD. Patients with BPD has a profile traits of elevation in the scale Psychopathic Deviate (4), Schizophrenia (8), Hysteria (3), and Depression (2) (Emil Öğünç et al., 2018). In addition, AK's current condition also fulfilled the MDD. This is supported by the BDI and Insomnia Severity Index.

Based on the diagnosis, an individualized treatment plan for AK was prepared. When BPD and MDD comorbid, it is important to treat BPD with dialectical behavioural therapy (DBT; Konvalin et al., 2021). DBT is the primary therapy for BPD (Konvalin et al., 2021). In addition, AK has a comorbid of major depressive disorder. Individuals with BPD and comorbid of depressive disorder are recommended to received treatment for BPD as the treatment for MDD is less effective when there is an absence of BPD appropriate treatment (Rao & Broadbear, 2019). Past study found that MDD symptoms tend to reduce when individuals with comorbid of BPD and MDD received treatment for their BPD symptoms first (Konvalin et al., 2021).

DBT was reported a promising treatment option in managing individuals diagnosed with BPD (Campbell et al., 2020; Kleindienst et al., 2021). DBT addresses BPD's core problem of emotional dysregulation with strategies of acceptance and change (Bohus et al., 2021). DBT helps individuals with BPD to develop skills through mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness (Bohus et al., 2021).

There is a long-standing debate in diagnosing personality disorder from a dimensional versus categorical nature (Campbell et al., 2020). The categorical model in diagnosing personality disorder has its limitation of heterogeneity within the disorder and comorbidity issues (Campbell et al., 2020). When more than one category of personality disorder is diagnosed, treatment planning of specific evidence-based treatment is more challenging and the prediction on the efficacy of the treatment is limited (Campbell et al., 2020).

Campbell et al. (2020) argued that diagnosis is a necessity to prevent iatrogenic harm caused by incorrect or absence of diagnosis. Due to the nature of personality disorder as an enduring and psychiatrically untreatable disorder, there is a high rate of stigma (i.e. therapeutic nihilism) from health care professionals (Campbell et al., 2020). As a result, individuals with BPD did not receive adequate treatment options as diagnosis is needed for funding and treatment development (Campbell et al., 2020). An accurate diagnosis helps with treatment access and referral (Campbell et al., 2020). Individuals with BPD can be help with reducing self-harm, suicidal behaviour, and emergency hospital visits, ending the therapeutic nihilism (Campbell et al., 2020). Clinicians are often divided when it comes to diagnosing BPD (Campbell et al., 2020). This case study supports Campbell et al.'s (2020) argument that a diagnosis accompanied by a formulation can help individuals receive treatment and achieve personal and clinical recovery. Delays or failures to diagnose BPD can impede the treatment process.

A notable strength of this case study is its emphasis on the importance of assessment and diagnosis for treatment planning. AK was initially referred for cognitive behavioural therapy due to her MDD. However, patients with BPD and MDD have a poorer response to MDD treatment alone (Ceresa et al., 2021). Psychotherapy is the main treatment for BPD and

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it should be started as early as possible after diagnosis (Bohus et al., 2021). A limitation of the case study is lacked a standardised assessment to rule out PTSD given the high comorbidity between BPD and PTSD. It is important to consider appropriate and evidence-based treatment such as DBT for PTSD when patient is diagnosed with a dual diagnosis of BPD and PTSD (Kleindienst et al., 2021).

CONCLUSION

This case report illustrates the diagnostic decision-making process for BPD, emphasizing the integration of psychological assessment findings with relevant literature. BPD often co-occurs with other psychological disorders and has a high comorbidity rate with PTSD. Therefore, it is crucial to make a diagnosis after thorough information gathering and assessment.

ACKNOWLEDGEMENT

No funding was received for this case report.

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