Patient Management Exercise

PERSONALITY DISORDERS

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This exercise is designed to test your comprehension of material presented in this issue of *FOCUS* as well as your ability to evaluate, diagnose, and manage clinical problems. Answer the questions below, to the best of your ability, on the information provided, making your decisions as you would with a real-life patient.

Questions are presented at "decision points" that follow a section that gives information about the case. One or more choices may be correct for each question; make your choices on the basis of your clinical knowledge and the history provided. Read all of the options for each question before making any selections. You are given points on a graded scale for the best possible answer(s), and points are deducted for answers that would result in a poor outcome or delay your arriving at the right answer. Answers that have little or no impact receive zero points. At the end of the exercise, you will add up your points to obtain a total score.

CASE VIGNETTE PART 1: PRESENTATION TO PSYCHIATRIC EMERGENCY SERVICES

Michelle is 20 and a junior in college. She was brought to the psychiatric emergency room by her roommates after threatening to kill herself. Alhough she had verbally threatened such behaviors in the recent past, her roommates became more concerned because Michelle had been increasingly upset over the prior week after a phone argument with her parents concerning her drinking and deterioration in her academic school performance. While Michelle had throughout her college career been a drinker, having 4–5 mixed drinks twice a week on weekends, over the past month that drinking behavior had increased to 7–8 drinks, 3–4 times a week accompanied at times by blackouts during which she had no recollection of what she had done.

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There was no history of abuse of other substances save for an occasional episode of a few puffs of marijuana approximately once every 2 weeks. On presentation in the ER her speech was not pressured, there was no tangential or circumstantial thinking, she did not have pressured speech, and she could easily stay on topic and was not distractible. She made good eye contact with the social worker and was overall mostly cooperative during the interview, although she could suddenly show flashes of irritability and could, for brief moments, get very angry if she thought that the social worker was not understanding her. These would subside quickly, some thought because she did not want to be kept in the hospital. She considered herself healthy and had no medical complaints or problems and was taking no medications.

The recent situation had escalated over the preceding 10 days with decreased sleep, increased irritability, and, over the last 2–3 days, more pressured speech and suicide threats. There was no increased spending, sexual promiscuity (as far as can be recollected through the blackouts), grandiose thinking, or psychosis. She was always thought of as somewhat narcissistic (information gleaned from one of her roommates), but her current behavior appeared to ignore even more the needs or space of others. While this situation appears to have been much more acute over the past 10 days,

it appeared to have become more troublesome for about a month since Michelle found out that her boyfriend from another college had been sleeping with someone. While in the past she had frequently used the phrase "I would like to kill myself," she had never, as far as her roommates knew, made any attempt to actually harm herself. However, on this particular evening, after drinking at least a half dozen shots, she had taken a kitchen knife and placed it on her forearm and had threatened to cut her arm. The intake social worker looked at the patient's left forearm (she was right handed) and noticed that there were a number of old scars on that forearm. She had a history of binge eating, but that is not something that many people knew about.

She denied any prior psychiatric hospitalizations but did say she had been in psychotherapy for a short time during high school because her parents didn't like how she was reacting to them; there were lots of arguments between her and her parents. She said the treatment lasted for less than 6 months because the therapist was not really interested in her and simply wanted her to behave in the manner that her parents wished her to behave. She denied ever having been treated with psychiatric medication and said she was not suicidal, that her roommates were simply overreacting, and she simply wanted to return to her apartment with her friends.

Consideration point A

This is the material that the intake social worker had obtained on a brief screen of Michelle. When considering what is known so far, your thoughts with respect to diagnosis would include (any or all of the following):

A.1—— Manic episode
A.2—— Bipolar II disorder—most frequent episode hypomanic
A.3—— Alcohol abuse
A.4—— Borderline personality disorder
A.5—— Primary insomnia
A.6—— Adjustment disorder with mixed emotional features

Case vignette part 2: gathering further history

As you interview this young woman, the following facts were uncovered. She grew up in an upper middle class family where both her parents worked at high pressure jobs. She had always been an excellent student and had done well in college up until the past semester. In fact her GPA was 3.7 (on a 4.0 scale) and she was hoping to go to law school. Although she had begun to drink on weekends in high school, usually having up to 4 drinks on one night of the weekend, those drinks were ordinarily beer and she had never blacked out. She recalled that when she was "high" in high school she was pretty happy. Recently she said that she could not currently count on always being happy when she drank. In fact, she now more often than not gets angry when she drinks too much, and on remembering the anger the next morning she would be unhappy with herself, although she said there was always a good reason for her being angry at those times. She said she had never blacked out before coming to college, and while she had rarely blacked out during her first 2 years in college, it was happening more frequently but she did not seem to be able to limit her alcohol intake.

She denied any episodes or symptoms that could be considered in the psychotic range. She said that until recently she had never had difficulty sleeping. She said that her not sleeping was not related to having increased positive energy or because she had so many things she wanted to do that sleep would merely be a bother. She said she wanted to sleep but was so anxious and worried (about what she could not say) that it was very difficult to be able to sleep. Lying in bed trying to sleep was terribly uncomfortable to her, and so she would get up and busy herself with things in order to try to diffuse her anxiety. She said she was much more fatigued because she was not sleeping and often hoped that the alcohol would help her to sleep. But drinking did not always lead to her being able to sleep, and even when she was able, she did not wake up feeling refreshed. She said her appetite was not always good but also said that since she had been drinking so much she was often not hungry and her stomach often felt upset. But she did have times when she was hungry and food still had a lot of flavor to her.

She did admit to being increasingly unhappy with herself and with college over the last few months and she was unclear as to why. She said that she had always presented herself as a happy person, but in truth she felt that she had always been unhappy but could not show her unhappiness to anyone, including the people in her family. In fact, the arguments that she had with her family during her junior year of high school were around her parents refusing to believe she was unhappy, particularly since her parents insisted that Michelle had everything a person would want: attractiveness, intelligence, money, good friends, a good home, etc. She had her whole life ahead of her. It was then in high school, particularly after arguments with her parents, that she began to cut herself. When living at home, she would cut herself on her thighs so no one would notice. In college she would cut either her

forearms in the winter time when she wore long sleeves or her thighs or ankles in the summer. She said that these episodes of cutting occurred about every 2 or 3 months and lasted for 2–3 days when she could cut herself up to four times a day. She said the cutting seemed to relieve the emotional pain of being depressed, especially when she thought that showing anyone the level of her unhappiness was simply going to get her rejected. "In fact," she said, "isn't that true?" seeing as her roommates had rejected her by bringing her to the emergency room that very evening.

She denied having specific episodes of depression but felt that she was always on the edge of falling into a depression. Then she could suddenly fall into a deeper depression and then a few hours or a few days later, feel better. But she said she never really felt good. She denied having any sexual abuse happen to her as a child or teenager, but it was clear that she felt that she could easily and suddenly encounter her mother's rage if she (Michelle) even hinted at being unhappy.

She did not want to talk about the fact that her now ex-boyfriend had slept with someone else. She just dismissed it by saying that he "was a total [expletive]" and was that way from the beginning, and the only reason he had ever been nice to her was because he wanted sex from her. Their relationship had had many ups and downs in it and she said that most relationships with men were that way because all that men wanted was sex. But that didn't stop her from getting into new relationships with men. She said she was really looking for someone she could count on and at times lean upon, especially when she felt these terrible feelings of emptiness and loneliness that she has had since early high school. She said that she didn't understand that because she had always had friends, but she was unsure whether she ever had friends she could really depend upon. While she said that her friendships with women were mostly "ok," she did say that she had lost a number of her friends whom she thought herself closest to because she felt like they did not consider her feelings sufficiently. Rather than argue with them, she would slowly drift away from them but had no difficulty finding another set of good friends. The current roommates were the most recent set of good friends, and she did express some concern that now after they had brought her to the emergency room, she could no longer count on them to be her good friends.

Michelle describes her mother as anxious. Her father's brother and father had problems with alcohol, and her grandfather was seen as not a very nice man. Her father rarely drank because of what alcohol had done to his father. The father's mother had been in psychiatric hospitals on a number of occasions, but Michelle did not know why. She said that the family said that as her paternal grandmother grew older, she seemed more kind and mellow. Michelle's contacts with her paternal grandmother were always positive. Michelle had an older sibling, a brother, who was a resident in radiology at a West Coast medical school.

She did say that she always had had trouble controlling her emotions and worked hard at keeping them from other people. She seemed to be less able to do that recently, even before her drinking had escalated. The increased drinking seemed to make it easier for her to dismiss (to herself) her mood changes.

CONSIDERATION POINT B

What diagnoses do you think should be considered in the differential at this point?

- B.1—— Bipolar II disorder—most frequent episode hypomanic
- B.2—— Major depressive episode—single episode
- B.3—— Dysthymia
- B.4—— Alcohol abuse
- B.5—— Borderline personality disorder

VIGNETTE CONCLUDES

It was clear that Michelle was not in imminent danger of harming herself. When the suggestion was made that she get into treatment that would both help her better control her emotions and help her reduce her alcohol abuse, she told the staff to "go to hell" and said she wanted to leave. She was then allowed to calm down, and when faced with the issue of how unhappy she currently is and how she has struggled for a long time against this unhappiness that seems to overwhelm her with the slightest disappointment, she was willing to consider treatment. She seemed relieved that she might be able to meet with someone who would accept her feelings as legitimate ones.

CONSIDERATION POINT C

At this point given the information you have received, the APA Guidelines for the treatment of borderline personality disorder (BPD), and the article by Gunderson, Weinberg, and Choi-Kain in this issue, you make which of the following recommendation(s):

- C.1—— Dialectical behavior therapy
- C.2—— Mentalization-based therapy
- C.3—— A referral to a psychopharmacologist for medication

C.4—— A referral to the office in the Student Health Services that deals with substance abuse

C.5—— A referral to a partial hospital program

ANSWERS: SCORING, RELATIVE WEIGHTS, AND COMMENTS

CONSIDERATION POINT A

A.1—— **(0)** *Manic episode.* Though there is some suggestion for a manic episode, there are a number of elements opposing this diagnosis. There was no increased spending, sexual promiscuity, grandiose thinking, or psychosis. While Michelle reported being irritable, she was not euphoric, did not have decreased need for sleep, racing thoughts, flight of ideas, grandiosity, or excessive involvement in pleasurable activities. And the clinical picture was confounded by excessive use of alcohol. Thus manic episode cannot be ruled out completely, but the suspicion of one would not be very high (1, 2).

A.2—— **(+1)** *Bipolar II disorder—most frequent episode hypomanic*. While this cannot be ruled out, the diagnosis of bipolar II is often confounded with borderline personality disorder. Michelle does not appear to have autonomous shifting of her mood. Rather, moods are triggered by events or her perception of events, primarily interpersonal, occurring around her. She was more moody and emotionally labile than hypomanic. She was able to stay on topic, her speech was not overly pressured, and she related well to the social worker (1).

A.3—— **(+2)** *Alcohol abuse.* She clearly has a recent history of alcohol as manifested by her deteriorating academic performance and her continuing to use alcohol despite her awareness that it was leading to blackouts and to increased irritability and unhappiness (1).

A.4—— **(+3)** *Borderline personality disorder.* She clearly at this moment in time appears to meet criteria for borderline personality disorder given her emotional lability, her repeated statements about wanting to kill herself, her substance abuse which is both chronic and impulsive, her escalation of her substance abuse in response to the fact that her (ex) boyfriend had cheated on her, and her binge eating. The idea that she wanted to cut herself also strongly suggested BPD, and her flashes of quite intense anger that quickly subsided also supported the diagnosis (1, 3, 4).

A.5—— **(−1)** *Primary insomnia.* The insomnia is most probably related to another psychiatric disorder. It would not be wise at this juncture to consider pharmacologic treatment of a primary insomnia until a more thorough understanding of other potential comorbid psychiatric conditions was arrived at (1).

A.6—— **(0)** *Adjustment disorder with mixed emotional features*. While adjustment disorder can be included in the differential as there is at least a substantial change in Michelle's behavior (at least as far as alcohol intake is concerned), there are too many other diagnoses that deserve consideration. Further, in obtaining more history, we find that many of these symptoms have been going on for many years even if they had only been revealed to others most recently. Adjustment disorder provides us with no information and should in this instance be used only after a more thorough understanding and explanation of the current situation can be arrived at (1).

CONSIDERATION POINT B

B.1—— **(0)** *Bipolar II disorder—most frequent episode hypomanic.* It becomes clearer with additional history that this woman's emotional ups and downs are more in relation to and in reaction to interpersonal events rather than to autonomous internal rhythmic changes in mood. While this does not completely rule out bipolar II disorder, it is clear that Michelle at this point is not hypomanic but more anxious, angry, and disappointed (2).

B.2—— **(−1)** *Major depressive episode—single episode.* While Michelle describes herself as depressed, this depression appears to be related to loneliness,

emptiness, a neediness of others, and a feeling that she cannot maintain (because of her emotional lability) the relationships that she longs for. The scoring here is given a negative because there is a danger of jumping to the conclusion that she is in a major depressive episode. Such thinking can then lead to using antidepressants that have not been shown to reverse the depression found in BPD unless the depression is part of a *bona fide* major depressive episode. This does not mean that at some point in the future Michelle might not have an episode of major depression because the possibility of people with BPD experiencing a major depressive episode some times in their lives is quite high (3, 5).

B.3—— **(+1)** *Dysthymia.* There may be some rationale for considering dysthymia here. The chronic depression found in patients with BPD could fit dysthymia, albeit at times loosely. While Michelle may have binge eating, she does not have appetite changes directly related to her mood changes. She denied low energy or fatigue (except when she has poor sleep). We have little evidence of low self-esteem and poor concentration. Moreover, Michelle has a variability of mood that one would not find in a dysthymic individual. She most probably experiences mood improvement when she feels she has made a real emotional connection to others, even if that connection does not last very long (1).

B.4—— **(+3)** *Alcohol abuse*. This is a major problem for Michelle and must clearly be kept in the differential given the family history of alcohol and Michelle's strong inclination to self-medicate with the alcohol. And it is very common that patients with BPD have comorbid axis I or axis II diagnoses (6).

B.5—— **(+3)** *Borderline personality disorder.* As we gather more information, it is clear that Michelle does suffer from BPD, and BPD along with alcohol abuse appears to be her primary diagnoses.

CONSIDERATION POINT C

C.1—— **(+3)** *Dialectical behavior therapy.* While dialectical behavior therapy (DBT) is only one of a number of evidence-based therapies for BPD, it is the one that currently has the most empirical evidence supporting its use in this population. However, one might wish to consider other evidenced-based treatments for BPD as well. DBT employs a behavioral model (akin to CBT) and skills training as its major interventions. Its goals are better control over one's emotions while reducing self-destructive behaviors (2, 3).

C.2—— **(+3)** *Mentalization-based therapy*. This is another evidenced-based treatment for BPD. The body of empirical supporting data is growing. Mentalization-based therapy is based on a psychodynamic model that emphasizes issues of attachment. Mentalization involves focusing on learning to better understand not only what one is feeling oneself but also on developing a better understanding of what others might be feeling rather than assuming we know and react to what we think the other person is feeling and thinking (7, 8).

C.3—— **(0)** *A referral to a psychopharmacologist for medication.* It is premature to make a recommendation for medication. We are not yet certain of all the elements contributing to this clinical presentation, and given that medications in BPD are viewed as adjunctive to psychotherapy and that medications in BPD have as best as we can tell very limited effectiveness, it is wise to wait until a better understanding of the patient and her moods, affects, and behaviors is gathered (2).

C.4—— **(+3)** *A referral to the office in the Student Health Services that deals with substance abuse*. It is important that Michelle appreciates the role substance abuse has played in her current difficulties. It is also important that Michelle understands more fully her vulnerability to substance misuse given her family history. A referral at least to some sort of educational program on substance abuse emphasizes the seriousness with which this problem needs to be considered (6).

C.5—— **(−1)** *A referral to a partial hospital program.* At this point Michelle is

not showing the severity of symptoms or the safety issues (if she can decrease substantially her substance use) that would warrant this level of care. Further, if this recommendation were made she would probably refuse it and not wish to engage in treatment. The main thrust at this point in her care is to engage her in treatment and get her to appreciate that understanding her moods and not trying to hide them or cover them up from herself and others will lead to better understanding of who she is and why she struggles with her behaviors in the ways that she does.

YOUR TOTAL

Decision Point	Score	Ideal Score
A		6
B		7
C		9
Total		22

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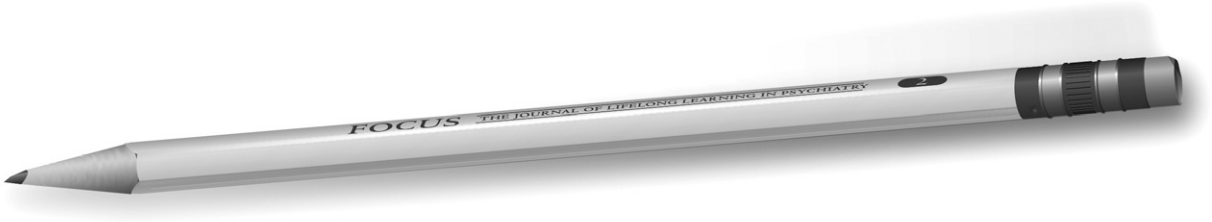

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