

Classic Versus Clinical Symptoms of Borderline Personality Disorder

(This paper draws on the character Susanna Kaysen in the movie *Girl Interrupted*.)

Intake Summary

Patient's Name: Susanna Kaysen

Identifying data: Susanna Kaysen is an 18-year-old, single, female, Caucasian, high school graduate who wants to be a writer. She lives with her parents in Medford, Massachusetts.

Chief complaint: "I don't know why I'm here. My parents sent me here. Explain what? Explain to a doctor that the laws of physics can be suspended, that what goes up may not come down? Explain that time can move backwards and forwards and now to then and back again and you can't control it?"

History of present illness: Two days ago the patient consumed a bottle of aspirin followed by a bottle of vodka. Her stomach was pumped at Community Hospital.

Past history: The patient is an unemployed, only child of a stay-at-home mother and a college professor. She has an uneasy relationship with her parents and has few friends. She has had several sexual partners but few, if any, long-term relationships. She keeps a journal and wants to be a writer.

Medical and psychiatric history: The patient has no current physical health issues. As a baby, she broke her leg and was in a body cast, but there is no continuing condition. She smokes cigarettes. The patient checked herself into Claymoore Hospital following an overdose of aspirin accompanied by a bottle of vodka. She says the overdose was accidental and not a suicide attempt.

Mental status: Patient is neat, clean, well dressed in casual clothing, and has a well-kept, stylish haircut. She is quiet and watchful but responds to direct questioning and can hold a conversation. Speech is calm and mostly mono-tonal. Sentences come out slowly with long pauses in between. She is controlled in movement. At times she appears preoccupied. She will sit with a cigarette, not smoking it, and then realize it has burnt down. Her mood seems to convey she is perplexed. There is nothing particularly out of the ordinary in her general appearance.

Cognitive functioning: Patient's affect switches from interest to boredom and back to disinterest. She has mentioned she has no bones in her wrists at times. It is not clear whether this is a delusion or a way of trying to express her perception of reality. She is alert to a normal level.

Orientation: Patient knows her name, where she is, and what day it is.

Concentration: Not beyond patient's skill level, but she could not be bothered to participate in a concentration test.

Memory: She has reasonable short-term memory, but does not seem to be fully attentive to present activities and is easily distracted. Long-term memory is fine.

Intelligence: Good verbal intelligence and general fund of knowledge.

Abstract thinking: While she is able to discuss and reason on abstract topics, some of her perspectives display non-standard points of view.

Concentration and Attention: Patient is at times distracted or preoccupied, she is not always engaged in the conversation of which she is a part.

Insight and judgment: Patient does not recognize she may have a specific psychiatric problem, nor does she recognize taking a bottle of aspirin and vodka may have been, in her case, a suicide attempt: "I just had a headache."

Patient expectation: "I'm just here to get a rest."

Medications: Patient is not taking any medications.

Diagnosis: Borderline Personality Disorder, Axis II Cluster B

Axis I (primary psychiatric diagnosis):	None diagnosed. Potential dissociative and mood disorders
Axis II (personality disorders):	Classic diagnosis for Borderline Personality Disorder
Axis III (physical disorders, may or may not cause I or II):	None apparent at this time
Axis IV (stressors):	Family and socialization issues impact and compound BPD
Axis V (global functioning):	GAF score 31 to 40. Client has major impairments in family relations, judgment, thinking, and mood

Summary of Classic Diagnosis of Borderline Personality Disorder

Borderline personality disorder (BPD) is a condition in which a person is impulsive in action, unstable in mood and affect, and tends to have chaotic relationships. The disorder affects approximately 1% to 2% of the U.S. population, and women are twice as likely as men to suffer from the disorder. BPD is an illness identified as being between neurosis and psychosis. Onset is often in adolescence or early-adulthood. BPD is in Cluster B and coded on Axis II of DSM-IV-TR (Sadock & Sadock, 2007).

Risk factors for BPD include genetics and, as with all personality disorders, a significant role is played by an individual's own, subjective, experiences. Specific BPD risk factors include an unsupportive and invalidating environment that can hinder development; abandonment in childhood or adolescence; disrupted family life; poor communication in the family; abuse, and sexual abuse (Swift, 2009).

Symptoms.

Mood swings, unpredictable behavior, and impulsiveness are three symptoms of BPD deriving from a similar and deeper cause – namely a lack of clearly defined sense of self. Sadock and Sadock (2007) refer to BPD patients' uncertainty about identity or self-image as *identity diffusion*.

Those with BPD view things in terms of extremes, either all good or all bad. They may be argumentative one moment and depressed the next. They swing wildly from love to hate and back again. Being alone is something they do not tolerate well. They act impulsively, and this impulsiveness may manifest itself in regard to money, substance use and abuse, sexual

relationships, and binge eating. Some with BPD take part in repeated acts of wrist cutting, overdosing, or other self-injury.

The impulsiveness and related behaviors put pressure on the relationships people with BDP have with others, resulting in relationships that are both intense and unstable.

People with BPD complain both of having no feelings and of not feeling anything. They describe themselves as empty or bored.

Persons with BPD typically view themselves as victims of circumstance and take little responsibility for themselves or their problems. They show ordinary reasoning on *structured* tests, but deviant reasoning on *unstructured* tests. While persons with schizophrenia may have prolonged psychotic episodes, those with BPD may have short psychotic periods, described by Sadock and Sadock (2007) as *micropsychotic episodes*.

Just like those with other personality disorders, those with BPD do not feel anxiety about their maladaptive behaviors. Thus, many with BPD do not accept the need for treatment. As such, they are usually disinterested in the treatment, and so prognosis for treatment is not very good. However, most people with BDP are able to live relatively normal functioning lives. They can often get by without acknowledging their disorder or seeking treatment. It is when the disorder stops normal functioning that it becomes a problem.

Comparison of Susanna's Case to the Classic Diagnosis of BPD

In the case of psychopathology there is always a sense in which “there, but for the grace of God, go I.” This is particularly true for BPD because the symptoms are not so distinctly different from normal psychology in the face of unpleasant experiences. The path of an individual is strongly constrained by their physiology, their experiences, and their choices. In the case of BPD, the classical diagnosis seems like an observation that, in part due to lack of love or

lack of inclusion in society, someone's life has taken on a pattern of reaction in a desperate search for meaning and belonging. Search for meaning and belonging is entirely normal and applies to all of us. The only question is how to gain a balance that is both sustainable and conducive to some sense of fulfillment for the individual and therefore within the range of socially acceptable.

In this movie, Susanna was a stereotypical example of a person with a classic diagnosis of BDP. Susanna displayed all the following symptoms outlined by Sadock and Sadock (2007):

- Onset in adolescence or early adulthood
- Mood swings
- Argumentative one moment, depressed the next
- Complained of not feeling anything
- Short-lived psychotic episode
- Doubtful
- Achievement rarely at level of ability
- Felt both dependent and hostile
- Complained about feeling of emptiness or boredom

Susanna also displayed symptoms of potential dissociative and mood disorders. The first involved disassociation or denial in what Sadock and Sadock (2007) referred to as a Pollyanna-like replacement of unpleasant affects with pleasant ones. A mood was described as a pervasive and sustained feeling tone that is experienced internally and that influences a person's behavior and perception (Sadock & Sadock, 2007, p. 527). Those with mood disorders have conditions characterized by a loss of that sense of control and a subjective experience of great distress. Susanna appeared to have mood disorders as well as BPD.

While there would be a desire to use either a Psychosocial or Cognitive-Behavioral frame of reference to address the issues Susanna faces, there would be drawbacks to both.

Psychotherapy would probably not work, initially, because Susanna would likely not participate. The Cognitive-Behavioral frame would also require acknowledgement of the issues, and illness, and a willingness to do homework or assignments. Thus, the Behavioral frame of reference would work best because it is reality oriented, sets limits, and creates clear values and goals. It works well with addressing the problems Susanna faced with work, leisure, sociability, and relaxation.

The Impact of BPD on Susanna's Life

Susanna's life had been significantly affected by the set of symptoms that together are called BPD. It should not be regarded as normal for an 18-year-old to feel so unloved and disconnected as to consider suicide – whether as a cry for help or as a serious intent – as being a preferable option to their everyday existence. There was a strong indication that Susanna's parents were more self-involved and concerned about the effects of their daughter's illness on them than on understanding what their daughter was suffering. This may well have been a sign of some of the deeper causes for her condition. The movie made reference to a specific set of events where Susanna broke her leg, was put in a body cast, and then strapped to a board and immobilized for the duration of a coast-to-coast car journey. When combined with parental distance, this could easily have been a significant childhood trauma that served to emphasize Susanna's isolation.

Those with personality disorders, of which BDP is one, do not adjust or move through the normal stages of lifestyle progression. Susanna has become an adult with an idea of what she would like to do in life (she said she wants to write), but we do not see her having any real plan

or structure. Susanna was a drifter, a person with intelligence who was apathetic toward the world, and who had no meaningful engagement with or commitment to adult communities.

Patient Strengths and Weaknesses

Susanna had a couple of distinct strengths including an awareness of emotions in others. She was intelligent and perceptive. On the other hand she had several weaknesses. These include a world-view resulting in a lack of meaning in her life and a lack of emotional connection to her family and almost any other person. Partly as cause and partly as effect she had no stable focus for love in her life. Susanna's lack of self-confidence resulted in a lack of self-assertiveness.

Susanna is independent in her Activities of Daily Living (ADLs) and her Instrumental Activities of Daily Living (IADLs). It is the extent to which she did not participate in other occupational areas that is her greatest weakness. She is weak with regard to: sleep, education, work, play, leisure, and social participation. She also appears unclear with regard to her values, beliefs, and spirituality. One could say Susanna holds great potential, but her development has been disrupted so severely she does not even recognize what might give her meaning or purpose.

Three Problems to Address in Occupational Therapy

Using the behavioral frame of reference, the underlying goal would be to address the development and greater integration between the patient, Susanna, and her society. The three problems selected are:

1. Perspectives: Getting a different perspective on your problems
2. Goal setting: Understanding it is possible to work with people to achieve collective goals
3. Relaxation: Understanding it is all right to do nothing from time to time and that rest is the basis of activity

Perspective treatment group.

Based on a behavior modification approach, the treatment group would take turns in discussing problem situations in their lives and the action they took as a result. Each of the rest of the group would then describe how they perceive the situation and what they would have done in the circumstances. After everyone has contributed, the therapist would ask the person who started whether they might look at the situation differently now that they see other people's perspectives. Generic situations or scenarios could be used if people in the group were not ready to discuss personal issues or where the group could benefit from learning certain lessons. This group follows a philosophy not far from that of Aaron Beck who aimed to have clients identify and understand their own thoughts and imagine other ways that they could be interpreted (Bruce & Borg, 2002).

Goal setting and working together treatment group.

This group would train patients in time management and cooperation techniques. For instance, a certain ADL or IADL could be selected to be performed as a group, for instance, meal preparation. The group would be under some time pressure to encourage the team members to prioritize the steps so the more important activities were completed before time runs out. Another possible activity for this group would be to actually teach time management, from keeping calendars to setting appointments to scheduling their day. Through these activities, members of the group would learn about structure, goals, and meeting social expectations and obligations. Meeting the expectations of other would help build social and community skills. This activity provides a structure that in some ways could be argued to follow Donald Meichenbaum's Cognitive-Behavioral Modification methods, particularly task analysis and self-

instruction, or in this case group instruction (Bruce & Borg, 2002). Oftentimes, cognitive-behavioral activities also work well in a behavioral frame.

Relaxation treatment group: Practicing resting in a group.

This activity can be implemented in two main forms. One is simply lying on the floor with eyes closed (optionally listening to classical music if silence is too difficult). This would demonstrate that not all social experiences have to be collaborative. The second would be doing some collaborative activity together such as assembling a jigsaw puzzle, but doing so in silence. This is a demonstration of collaboration in a social group without competition.

Individual Session

Susanna said, “Talk isn’t worth shit. It never really helps anyone.” This issue is worth exploring with the patient directly because while there are some truthful aspects to it, it also reveals a mechanism for keeping social distance. The thought also undermines one of the essential elements of binding a society together, communication through the spoken and written word.

The three activities to be performed during individual sessions would be:

1. Going to get an ice cream. Starting with the question, such as “Would you like to get an ice-cream?” would ensure that the patient is exposed to a full range of actions starting from introspection to discover some aspect of their desire, to asking for their desired item, to receiving it, on to enjoying it. In going through the cycle of feelings and actions and discussing it afterwards the patient would be exposed to the lesson that speaking, while insufficient, is a necessary part of social life. Outings of all sorts should be encouraged.

2. Watch a movie or You Tube video together or simply by sit on a park bench and watching passers-by. Work with the patient to observe other people and comment on any emotions they may be visibly expressing. Then encourage the patient to find something nice, loving, or uplifting to say about the observed person. The intent here is to begin to engage the patient in practicing a positive emotional response to people they encounter.
3. Introduce the patient to a pet. Get the patient to undertake some of the duties involved in the care of another dependent being. The intent here is to engage the patient in a loving and caring relationship that makes only the gentlest of demands and does so in a non-threatening manner.

References

- Bruce, M. A. G., & Borg, B. A. (2002). *Psychosocial frames of reference core for occupation-based practice*. (3rd ed.). Thorofare, NJ: Slack Incorporated.
- Sadock, B. J., & Sadock, V. A. (2007) *Kaplan & Sadock's synopsis of psychiatry behavioral sciences/clinical psychiatry* (10th ed.). Philadelphia, PA: Lippincott Williams & Wilkin.
- Swift, E. (2009). Borderline personality disorder: Aetiology, presentation and therapeutic relationship. *Mental Health Practice*, 13(3), 22-25.
- Wick, D., Ryder, W. (Producers), & Mangold, J. (Director). (1999). *Girl Interrupted* [Motion picture]. USA: Columbia Pictures.