

**CASE REPORT****Borderline Personality Disorder: More than Meets the Eye**

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**Abstract**

Living with borderline personality disorder (BPD) involves a lot of emotional suffering which may be hidden behind the complex and controversial nature of the condition and treatment. The condition is still largely under-diagnosed, undertreated and stigmatized. This paper described the emotional battle faced by a patient living with the disorder and the application of psychosocial treatments in helping her to recover.

**Keywords:** Borderline personality disorder, psychosocial treatments, recovery

**Introduction**

The journey travelled by the patient reported here is similar to those travelled by some 50,000 people in Malaysia. She travelled the journey of living with BPD. The condition is estimated to be occurring in 2% in the general population (1) and up to 20% in the psychiatric inpatient population (2, 3). For reasons such as controversies surrounding the diagnosis and concern that patients may get stigmatized, the condition is reluctantly diagnosed among patients, leading to improper treatment and complications such as iatrogenic drug dependence, suicide attempts, heavy usage of services and distress among treating doctors in addition to disruptions in the patients' lives. This paper aimed to illustrate a long hidden suffering of a patient with the condition and her journey to recovery through evidence-based treatment.

**Case Report**

RS is now a 24 year-old married Malay lady with 2 children. She first presented to a university hospital in 2005 with worsening depressive symptoms since her marriage 3 years earlier following her difficulty in adjusting to her new role as a wife and a mother. At the initial presentation, she had a 1 year-old girl and was pregnant with her second child. She had almost all the features of major depression, in addition to other features described below.

RS's unhappiness had dated back since she was 6 years old. She felt brief periods of happiness while at school, when her intelligence and creativity got recognized by her teacher and given due attention: a privilege she did not received at home. Her unhappiness worsened at 12 years old after she obliged to her parents' decision not to continue secondary school. Being at home most of the time without television,

magazines or friends made her felt bored, empty and alone. The feelings persisted as she grew older, fluctuating in intensity. At the depth of her emptiness, she would feel lost, “not being part of anything” with “no one to help”. This sense of near non-existence was associated with physical sense unreality that made her do things like feeling the water running against her skin or knocking her head against the wall to confirm the reality of her own body parts.

As a result, she was afraid of being alone. She coped by efforts to relive the moments of being with people. She also had imaginary friends with whom she had mental conversations whenever she needed them. This imaginary friend/s appeared very vividly in her mind. She would respond fully to these conversations in her mind that she would appear to others as occupied and inattentive. She, however, could not hear with her ears the person/s talking or see her/him with her eyes.

She also had the tendency to cling onto others. She would rush to get close to people who showed warmth to her. She was so scared of being abandoned as this would confirm her sense of being unlovable that she could engage in behaviors that caused pity and sense of duty to care in others, like being sickly, which was usually followed by uneasiness in others. In relationship, she would expect others to be all good and caring all the time that unintentional deviation of attention from others would be perceived as neglect. She coped unconsciously by projecting her feelings of being unloved into hatred to the person and would consciously feel that he/she was the worst person of all. These idealization and devaluation had become the pattern of her attempted relationships that made her avoid relationship, if she could, for some sense of

control to avoid the emotional pain being abandoned.

RS had difficulties in controlling her anger. She could physically attack her friends whom she thought had wronged her. She stopped this behaviour since her adolescence as she knew it was unacceptable, however, the tendency to feel intense anger remained which was now only limited as thoughts, images & impulses only, even though, it usually got reflected behaviourally in the form of stubbornness and hurtful words. When in this mood, she could have sadistic or murderous thoughts/images/impulses like chopping a person’s body into pieces. Following this, her distress would escalate even further as anger and aggression were perceived as invalid, wrong and sinful, and would eventually be followed by a deep sense of guilt. “Guilt was what differentiated me from those who kill”.

When in distress, typically following a perceived abandonment she could develop psychotic-like symptoms like vividly seeing the hurting person in her mind (not with her eyes) everywhere she goes which made her feel scared. This was accompanied with a sense being watched and a potential danger. This led to marked anxiety symptoms like palpitation, tremor and restlessness.

She also had thoughts of self-harm when in distress. Initially, her religious values had stopped her from executing her thoughts. However, over the recent years when she faced more life challenges with her distress level mounting to a greater height, she started cutting herself mainly on the arms and thighs. This would usually give her some relief as it served to confirm her aliveness and change the “invalid” emotional pain to a “valid” physical one.

She also had transient manic symptoms about 4-6 times a year lasting for 1-2 days each time. These include elated mood, unusual optimistic views of herself, increased energy, a lot of ideas, decreased need for sleep and over-talkativeness. The change in her was noticeable by parents who would typically criticize her for being out of character.

RS had always been struggling with her sense of identity. Her needs for approval would drive her to be pleasant and obliging to others. However, when her own needs to be cared for was not met, she could totally change to be the opposite uncaring self. Her family believed she had a "*kembar harimau*" (tiger twin) in her which could be an explanation for the uncontrollable conflicting nature, which, she later explained as rooting from her inability to accept and integrate her "good self" and "bad self". She also had conflicting views of herself in terms of her sexuality, aspirations, intelligence and capability.

RS's borderline symptoms were only recognized 1 year after she presented at the center after a failure of conventional treatment approach for her Axis I diagnosis of bipolar disorder. Following that, RS was offered a structured dialectical behavior therapy which improved her skills in tolerating distress and self-regulating emotions and followed by transference-focused therapy which improved her skills in managing relationships. Time had witnessed her continuous recovery over the recent years.

## Discussion

Life has become more meaningful for this patient after being helped with the right treatment approach. Dialectical behavior therapy and transference-focused therapy are

two among others which have been shown to be useful in treating BPD (3,4). It is believed that there are many others with the condition who are still undiagnosed, undertreated and stigmatized for their difficult behaviours (5). Clinicians' proactive approach in dealing with this issue would help shorten and alleviate the hidden suffering in people like RS.

## References

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