

## CASE REPORT

# DIALECTICAL BEHAVIOUR THERAPY FOR A WOMAN WITH BORDERLINE PERSONALITY DISORDER: A CASE REPORT

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### Abstract

**Objective:** Borderline personality disorder (BPD) is often manifested by maladaptive behaviours such as self-injury. The interpersonal style characteristic of BPD makes it difficult to maintain stable therapeutic relationships, with the patient often discontinuing treatment. Although dialectical behavior therapy (DBT) has been reported to benefit patients with BPD, reports in Asian countries have been few. We herein describe a 22-year-old female with BPD and a history of attempted suicide and self-injury who underwent DBT at our hospital. **Methods:** Our 6-month DBT consists of 4 parts: weekly psychotherapy by a psychiatrist, weekly skills training by a clinical psychologist and nurse, emergency consultations, and supervision/consultation meetings. Individual psychotherapy and skills training sessions, respectively, were conducted for this patient 24 times. **Results:** After completing DBT, the number of self-injuries and frequency of suicidal ideation in our patient decreased. **Conclusion:** Although more costly than standard treatment for BPD, a trial of DBT might be worthwhile in Japanese patients. *ASEAN Journal of Psychiatry, Vol. 14 (1): January – June 2013: XX XX.*

**Keywords:** Psychotherapy, Behaviour Therapy, Borderline Personality Disorder, Mindfulness, Skills Training

### Introduction

Borderline personality disorder (BPD), which is characterized by impulsiveness, unstable interpersonal relationships, disturbance in sense of identification, and emotional instability, is often manifested by maladaptive behaviours such as suicidal and/or non-suicidal self-injury. Since a review by Cochrane Collaboration reported lack of efficacy of pharmacotherapy for treatment of the core symptoms of BPD, psychotherapy for BPD has received increased attention in the fields of psychiatry and psychology [1]. Regarding psychotherapy, dialectical behaviour therapy (DBT) is the most

often reported and has been shown to decrease the severity of symptoms, including self-injury [2, 3]. However, case reports of patients with BPD treated with DBT among Japanese are few. Thus, we herein report a case of BPD who was treated with DBT at our university hospital.

### Case Report

Ms. A, a 22-year-old female, began to slash her wrists at age 15 in her third year of junior high school. Around that time, her absence from school gradually increased. After depressive moods, emotional dysregulation, and feelings of worthlessness and self-blame were pointed out

by a physician about 5 years ago, she began to see a psychiatrist irregularly as an outpatient. Although she performed well academically and completed high school and was accepted into a university, she dropped out of the university in her first year because she felt alienated in class. She then took on a part time job, but could not keep it. Since then, she frequently changed jobs and for the 4 months prior to presentation at our hospital, she was unemployed.

After repeated overdoses of medication and suicidal/non-suicidal self-injury, her parents requested that she visited our hospital where she was subsequently hospitalized. The day following admission, she bitterly complained about the administration of medication by nurses and restriction on the possession/use of scissors, and unsuccessfully attempted to return home. She made no attempt to recognize that her emotional instability was within herself, and instead blamed those around her. Then, after bitter quarrels with roommates, she left the ward without permission and attempted suicide at home. As she had deeply slit her wrist down to the fatty tissue, she was taken to hospital by ambulance. She had obvious intense abandonment fears, unstable interpersonal relationships, emotional instability, feelings of emptiness, recurrent attempts at self-injury, and difficulty controlling anger; her condition met the Diagnostic and Statistical Manual of Mental Disorders, 4th edition text revision (DSM-IV-TR) criteria for BPD. The hospital personnel felt that her expression of rage was a means of expressing anxiety or fear, as if she obtruded her fears onto others by the means of psychological 'projection'. We exploited the opportunity afforded by her disturbing actions to discuss her emotional instability and emphasized the need for DBT. We introduced her to DBT to reduce her tendency for self-injury.

We regarded her behaviour problems as the interaction of a pervasive emotional dysregulation system with an invalidating environment. The strategies of our intervention aimed to validate the patient's emotional response and to help her learn an adaptive behavioural pattern. DBT consists of 4 elements: 1) psychotherapy, 2) skills training, 3) 24-h

emergency consultations, and 4) supervision/consultation meetings. In our program, individual psychotherapy was provided by a psychiatrist weekly (50 minutes). A psychologist and a nurse held weekly skills training sessions consisting of the following: mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance. The ward nursing staff provided emergency consultations. Finally, all staff involved in the treatment attended and participated in supervision/consultation meetings. In these meetings, we discussed the treatment plan and expectations for treatment outcome along with supervision of case management for approximately 90 minutes. Pharmacotherapy, which was continued in tandem with DBT, was switched from quetiapine 25 mg/day for 12 weeks to mirtazapine 15 mg/day. Even though the patient was discharged from the hospital 3 months after beginning DBT, she continued DBT as an outpatient. All elements of the DBT took place over a period of 6 months. Of the 24 sessions, she missed only one. After completing DBT, the number of self-injuries per month decreased, and she no longer meets the criteria for BPD. Manifestations of defense mechanisms such as '*splitting*,' called all-or-nothing thinking, have decreased without our direction through her increased use of skills learned. She is continuing to receive follow-up counseling, with a mild sleeping pill as her only medication.

## **Discussion**

In this case report, we firstly highlight the importance of the technique of mindfulness taught through skills training sessions. Mindfulness essentially originated with Western contemplative and Eastern meditation practices. Mindfulness skills focus on the patient's observing and describing external stimulus and/or internal sensations. Then, the patient is encouraged to focus attention on a particular task or activity without intrusion of thoughts of the past or the future. Further, judgmental expressions and feelings, whether positive or negative, are discouraged. DBT includes mindfulness skills to increase the capability to consciously experience oneself and events. When a serious problem occurred in our course

of treatment, the 'here and now technique' in relation to mindfulness allowed our patient to recognize that the problem of emotional instability existed within herself and motivated her to face her problems, and set goals for therapy. Secondly, we placed special emphasis on the role of supervision/consultation meetings. Treatment could proceed without confusion among staff on therapeutic relationships or staff 'burnout'. These meetings acted to maintain the framework of the therapy. As therapeutic relationships in psychotherapy for BPD usually become wobbly and threaten to break down, supervision/consultation meetings that stabilize the framework of therapy were quite effective. Thirdly, self-injury that is often observed in adolescence will have adverse effects on mental health in young adulthood [4]. Early intervention in adolescence may be crucial for suicide prevention in young adulthood. Fourthly, to our knowledge, there is no validated questionnaire in Japan such as the Zanarini Rating Scale for Borderline Personality Disorder to assess the severity of BPD even though a credible scale is indispensable for studies of interventional effectiveness [5]. It, therefore, is necessary to translate this scale into Japanese and validate it. Although DBT costs more than standard pharmacotherapy in the Japanese medical insurance system, a trial of DBT in Japan might be worthwhile. Also, in Asian countries, a study of its efficacy such as a randomized controlled treatment trial might provide interesting results.

#### **Conflict of Interest**

None.

#### **Acknowledgment**

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