

Too Many Feelings: A Case Series of Individuals with Borderline Personality and Intellectual Disability

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Abstract

The co-occurrence of Borderline Personality Disorder (BPD) and Intellectual Disability (ID) is a sparsely covered area in the literature. This case series looks to describe the common presentations of these two disorders, both commonly presenting with self-harm, impulsivity, and intense anger. Additionally, three treatment courses of individuals with co-occurring ID and BPD will be described, illustrating the commonalities as well as the modifications of BPD treatment for individuals and in adapting ID supports for those with BPD.

Keywords: Borderline personality disorder; Intellectual disability; Co-occurring BPD and ID

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Introduction

There is little information concerning the prevalence of individuals with intellectual disability (ID) and co-occurring Borderline Personality Disorder (BPD). BPD is the “pervasive pattern of instability of interpersonal relationships, self-images, and affects” that can affect 6% of the population in the US [1,2]. While the prevalence of ID is estimated to be about 1% worldwide, the prevalence of co-occurrence of BPD and ID is not well understood [3-6]. The similarities of some of the presenting symptoms of each of these disorders can cause diagnostic confusion. BPD can present with self-injury as deliberate self-harm [1], and individuals with ID have higher rates of self-injury than the general population [7]. Symptoms of BPD may be attributed to the individual’s disability rather than to the separate entity of BPD in what is described as ‘diagnostic overshadowing’ [5]. In addition to the diagnostic difficulty, some authors advise not diagnosing patients with a stigmatized disorder, i.e., BPD, when they have already been diagnosed with ID [6].

The Diagnostic Manual for Intellectual Disabilities-2 (DM-ID-2) describes several limitations in diagnosing individuals with ID and personality disorders including “[taking] into account personal characteristics in the context of a normal cultural framework” [8]. This could mean a boisterous airing of grievances needing to be interpreted in the context of the patient’s culture. A helpful question could be “Does the patient’s family of origin see the

noted behaviors as aberrant or unusual?” DM-ID-2 also suggests that IDD itself may have features in common with personality disorders including impulsivity and difficulty regulating frustration and emotions, and because many people with ID have a protected upbringing, they may have limited experience with social norms and community skills [8]. The DM-ID-2 also suggests the adaptation of moving the age of diagnosis to 22 rather than the DSM-5’s 18 years of age [1,8].

The criteria, otherwise, should be met with a “pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity” and also including five of the nine diagnostic criteria including fears of abandonment, chaotic relationships, unstable self-image, potentially harmful impulsivity, suicidal threats or self-injury, affective instability, persisting feelings of emptiness, anger dysregulation, and stress-induced paranoia [1]. Interpersonal hypersensitivity, while not explicitly one of the diagnostic criteria, is considered an intrinsic component of BPD [9]. Because this disorder can also be considered significantly heritable, with around 50% of variance explained by genetic factors [10], families can benefit from knowing the disorder is not an individual’s “fault.”

As well as diagnostic overlap, ID and BPD both have some common neurological components. Individuals with BPD have been noted to have impaired motor skills, problems with visuomotor integration, and with a susceptibility to interference [11]. There have also been findings of deficits in memory,

executive functioning, and processing speed in individuals with BPD alone [12]. Individuals with BPD have also been noted to have hyperactive amygdalar function [13]; whereas individuals with Fragile X Syndrome (FXS) have been found to have less interactive caudate and amygdala suggesting aberrant local interconnectivity [14]. People with ID by definition have cognitive deficits, and more research into individuals with both ID and BPD is needed.

Case Series

Case 1- Too many feelings

Ms. A is a 25-year-old black woman with a history of Mild ID and asthma presented for evaluation to the outpatient psychiatric clinic for self-injury. She had previously been administered the Wechsler Adult Intelligence Scale (WAIS)-IV with a verbal score of 66 and full scale score of 64. Ms. A reports, "When I get too many feelings, I go crazy. When I get too upset, it's the only thing that makes me feel better is hurting myself. I mean, I know it's not good for me, and I try to stop, but it just happens."

Her team brings her in for increased self-harming. Her mother reports, "She's always seemed so sensitive—like her feelings get hurt even when people don't mean it". Ms. A reports the last significant episode of self-injury occurred when her boyfriend broke up with her at workshop. She reports, "He did it on purpose just to make me mad to try to get me fired". This demonstrates transient stress-related paranoia and anger dysregulation. When asked if she were more sensitive to interactions with others, she agreed that it felt like it was easy to hurt her feelings. She reports that when her habilitation specialist did not say hi to her first thing in the morning, she "knew" that her habilitation specialist was mad at her. As previously noted, individuals with BPD are sensitive to interpersonal rejection which can precipitate dysphoria and suicidality. When screened for idealization and devaluation, she reported that she tends to love her boyfriends and friends when they first meet until she becomes angry at them for some small or large infraction. She reports that they are then "dead to her." She reports that she feels that her mood is overly reactive to her environment, the criterion for affective instability, and that she worries about people leaving her despite having had a stable upbringing and reliable home providers. She reports sometimes she "acts up" just because she knows they'll leave, which is a common manifestation of the fear of abandonment. When screened for impulsive behaviors, her team reports that while she has not had risky sexual behaviors, she has received reprimands at workshop for "making out under the stairs" with two of her last three boyfriends. The team also notes that she will eat anything that is left out, even to the point of making herself sick. The criterion for identity was not able to be elicited as the concept was likely more abstract than could successfully be explained. She did not report dissociative episodes.

Ms. A was diagnosed with Borderline Personality Disorder in accordance with Good Psychiatric Management of Borderline Personality Disorder, by going through each criterion with

the team and with Ms. A [15]. She and her team were offered psychoeducation about the diagnosis, typical course of the disease including remission in 85% in 10 years, and that the symptoms are significantly heritable [16,17]. They were relieved and voiced appreciation for the diagnosis.

Treatment: She began individual sessions 2-4 times a month with her mental health counselor. She was started on low dose lamotrigine, which was titrated slowly to an effective dose of 100 mg/day. At 6 months, Ms. A reported a significant decrease in self-injury and was better able to implement the copings skills that she and her therapist had devised together. At 3 year follow-up, Ms. A reports affective instability, anger dysregulation, and overeating but reports that she feels much better. Her self-injury was reduced to 2-3 times a year and under unusually stressful circumstances.

Case 2- Swallowed feelings

Mr. B is a 20-year-old white man with a history of Mild ID (WAIS-IV full scale IQ of 55) and a chromosomal disorder. He is brought to mental health after multiple emergency department visits for ingestion of non-food items including first the caps of pens and pieces of plastic eyeglass frames and more recently push-pins, staples, and other pieces of metal.

After rapport building with discussion of hobbies and interests, Mr. B reported that he had recently gotten a new roommate with an indwelling gastric tube for feeds. Mr. B reports that since the roommate moved in, staff at home were not able to interact with Mr. B as much as he wanted. Mr. B reports that his roommate received considerably more medical attention as well including trips to the emergency department. Mr. B also reported that his roommate often missed the workshop they attend together for medical appointments which typically include lunch out. While Mr. B is unable to answer 'why' he swallows things that could hurt him, he reports that he feels sad when he asks staff to do things with him and they ask him to wait. His home manager reports that the last three occurrences have been when staff was distracted by the roommate.

Mr. B's symptoms of BPD include self-harm (ingestion of non-food, potentially dangerous food items requiring medical procedures. He endorses fears of abandonment, i.e., losing his uncle or home manager. He characterizes his relationships as "a lot of drama" and "I'm black or white—I either love someone or hate them." He reports impulsivity in overeating and spending money, affective instability, chronic feelings of emptiness, and anger dysregulation. Mr. B's team wished to convey the severity of his symptoms—that he had also begun cutting himself with the knives in the home when upset necessitating their removal. They were also concerned with the number of times he had been to the emergency department and that the gastroenterologist mentioned in escalating danger of Mr. B's ingestions. Mr. B was screened for other causes of ingestions such as psychosis or obsessive compulsive disorder. He was screened and met criteria for generalized anxiety disorder.

Treatment: Mr. B was enrolled in weekly psychotherapy focusing on the development of verbalizing feelings using flashcards and increasing the use of coping skills including asking for help from staff, deep breathing exercises, and listening to music. He was also started on low-dose escitalopram for anxiety and was titrated to an effective dose. Mr. B was also started on a positive support plan wherein he earns an outing for lunch or ice cream with his favorite staff person by not having any hospitalizations for a week, then to two weeks, then to one month at a time. Education was provided to the team on avoiding power struggles, recognizing incendiary situations before they escalated, and working to support Mr. B. With these interventions, he was able to stop cutting. At three months, he had been able to earn several special outings. At five months, episodes of swallowing had slowed to monthly and after one year had stopped altogether. At two years of treatment, Mr. B still reported affective instability and feeling empty but he had a much richer and more stable social network.

Case 3- Boiled over

Ms. C is a 30-year-old white woman presents to the clinic for “depression” and suicide attempts. She was previously assessed with WAIS-IV full scale IQ of 69. She reported wanting to walk into traffic and attempting to access the medication closet to overdose on her medications. She is accompanied by her home manager, Ms. HM, who reports that these events “come out of nowhere.” Ms. HM reports that Ms. C “just does this to get attention.” Ms. C replies, “Ugh, you are the worst. I only overreact when people are trying to make me mad.” Ms. HM says, “Nobody is trying to make you mad. You just don’t get your way and start saying you’re suicidal.” They then argue in the office until the psychiatrist intervenes. Her medication list includes two antipsychotics, a benzodiazepine, valproic acid, and clonidine. Other symptoms meeting criteria for BPD in addition to the patient’s demonstrating interpersonal relationships characterized by splitting, Ms. C also endorses fears of abandonment, recurrent suicidality, affective instability, anger dysregulation, and transient stress-related paranoia. She requests a medication to help her with her “mood swings” and her anger. Ms. C’s team determined triggering events included rejection hypersensitivity with Ms. HM.

Treatment: As psychotherapy was not available in Ms. C’s area, Ms. C and her home manager received psychoeducation from the psychiatrist to foster improved coping skills and to work on relationships. After tapering off valproic acid, Ms. C was started on lamotrigine for affective instability and for anger symptoms. Although lamotrigine is not approved by the Food and Drug Administration, it has shown improvement in some patients for symptoms of BPD [18]. She was titrated per manufacturer instructions until she responded to a dose of 150 mg/day. Education was provided to her team to better support Ms. C and to process her feelings which resulted in an improved ability of the direct care staff to avoid arguments with Ms. C. At two months, she no longer exhibited threats of suicide. At six months, she was doing much better at workshop, and her team reported significantly fewer arguments. At one year, polypharmacy was

significantly reduced with improvements in coping skills and alertness. Ms. C and her team were pleased with her progress.

Management and Outcome

Each of these cases demonstrates commonalities in individuals with ID and co-occurring BPD. Interpersonal hypersensitivity and rejection sensitivity are important factors when interpreting symptoms and behaviors. Not uncommonly, individuals with ID are not considered to have the full range of human emotions. Gentle, corrective education on these matters often give immediate results in reducing “overreactions” as a result of interpersonal hypersensitivity.

Psychotherapy is the treatment of choice for individuals with BPD as well as those with co-occurring BPD and ID. Two of these cases showed improvement with psychotherapy; however, resources in some areas are not available. Mental health counselors at community mental health agencies do not always feel prepared to work with individuals with ID. More training and additional guidance from the psychiatrist can benefit these teams.

Each of these cases demonstrate individual methods of achieving alleviation or remittance of BPD symptoms in individuals with ID. For these cases, medications were prescribed to target specific symptoms of BPD. Care was taken to reduce side effects that reduce cognitive reserve and to reduce polypharmacy that is common in BPD and in ID.

Discussion and Conclusion

More research is needed for the treatment of co-occurring ID and BPD. This gap in the literature can leave physicians and prescribers uncertain about how to proceed with care plans. In order to address these gaps in the literature, these cases demonstrate that co-occurrence of borderline personality disorder and intellectual disability are represented in the clinical setting. The tenets of Good Psychiatric Management of Borderline Personality Disorder [15] can be of benefit to individuals with both these conditions. Psychoeducation for the patient and team can be helpful in instilling hope and aiding in team cohesion which ultimately result in a more supportive, nurturing environment as opposed to a more adversarial one. The interdisciplinary treatments teams that individuals with ID have allow for increased resources and care strategies that can be mobilized to encourage progress. Despite the potential detriments of having two potentially stigmatizing illnesses, ethical treatment in medicine and especially that in psychiatry encourages the open and frank discussion of diagnosis so individuals may have full and fair disclosure of all important factors in their treatment. While there does remain reasonable hesitation in diagnosing personality disorders in individuals with ID, these cases describe that clear symptomology despite intellectual disabilities can be easily observed, and furthermore that the diagnosis of BPD in individuals with ID are quite similar in presentation, treatment, and outcome for those individuals without ID. The diagnosis of other personality disorders such as schizoid and dependent personality disorder are not being recommended in this paper as too many qualities of the culture

of intellectual disability coincide with the diagnostic criterion reflecting artificial pathology. However, when a patient with ID meets adapted criteria for diagnosis of BPD, diagnosis should be

considered. This paper describes three such cases and additionally outlines the successful treatment of the co-occurrence of BPD and ID.

References

- 1 American Psychiatric Association (2013) Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub.
- 2 Grant BF, Chou SP, Goldstein RB, Huang B, Stinson FS, et al. (2008) Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *J Clin Psychiatry* 69: 533-545.
- 3 Maulik PK, Mascarenhas MN, Mathers CD, Dua T, Saxena S (2011) Prevalence of intellectual disability: a meta-analysis of population-based studies. *Res Dev Disabil* 32: 419-436.
- 4 Westerinen H, Kaski M, Virta LJ, Kautiainen H, Pitkälä KH, et al. (2017) The nationwide register-based prevalence of intellectual disability during childhood and adolescence. *J Intellect Disabil Res* 61: 802-809.
- 5 Moreland J, Hendy S, Brown F (2008) The validity of a personality disorder diagnosis for people with an intellectual disability. *J Appl Res Intellect Disabil* 21: 219-226.
- 6 Lindsay WR, Steptoe L, Hogue TE, Taylor JL, Mooney P, et al. (2007) Internal consistency and factor structure of personality disorders in a forensic intellectual disability sample. *J Intellect Dev Disabil* 32: 134-142.
- 7 Huisman S, Mulder P, Kuijk J, Kerstholt M, van Eeghen A, et al. (2017) Self-injurious behavior. *Neurosci Biobehav Rev* 84: 483-491.
- 8 Fletcher RJ, Barnhill J, Cooper SA (2016) DM-ID-2: diagnostic manual-intellectual disability: a textbook of diagnosis of mental disorders in persons with intellectual disability. National Association for the Dually Diagnosed Press p: 720.
- 9 Gunderson JG, Lyons-Ruth K (2008) BPD's interpersonal hypersensitivity phenotype: a gene-environment-developmental model. *J Pers Disord* 22: 22-41.
- 10 Distel MA, Willemsen G, Ligthart L, Derom CA, Martin NG, et al. (2010) Genetic covariance structure of the four main features of borderline personality disorder. *J Pers Disord* 24: 427-444.
- 11 Swirsky-Sacchetti T, Gorton G, Samuel S, Sobel R, Genetta-Wadley A, et al. (1993) Neuropsychological function in borderline personality disorder. *J Clin Psychol* 49: 385-396.
- 12 Richman MJ, Unoka Z (2015) Mental state decoding impairment in major depression and borderline personality disorder: meta-analysis. *Br J Psychiatry* 207: 483-489.
- 13 Lieb K, Zanarini MC, Schmahl C, Linehan MM, Bohus M (2004) Borderline personality disorder. *Lancet* 364: 453-461.
- 14 Bruno JL, Hosseini SMH, Saggat M, Quintin EM, Raman MM, et al. (2017) Altered brain network segregation in fragile x syndrome revealed by structural connectomics. *Cereb Cortex* 27: 2249-2259.
- 15 Gunderson JG (2014) Handbook of good psychiatric management for borderline personality disorder. American Psychiatric Pub p:180.
- 16 Zanarini MC, Frankenburg FR, Reich DB, Fitzmaurice G (2010) Time to attainment of recovery from borderline personality disorder and stability of recovery: a 10-year prospective follow-up study. *Am J Psychiatry* 167: 663-667.
- 17 Gunderson JG, Stout RL, McGlashan TH, Shea MT, Morey LC, et al. (2011) Ten-year course of borderline personality disorder: psychopathology and function from the Collaborative Longitudinal Personality Disorders study. *Arch Gen Psychiatry* 68: 827-837.
- 18 Reich DB, Zanarini MC, Bieri KA (2009) A preliminary study of lamotrigine in the treatment of affective instability in borderline personality disorder. *Int Clin Psychopharmacol* 24: 270-275.