Psychological and Pharmacological Treatment for Brief Psychotic Disorder with Borderline Personality Disorder

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Abstract

The study aimed to understand human impairment and how psychologists should deal with it psychologically and medically. The treatment should be planned and implemented by psychologists and other professionals. The study is based on a 26-year-old girl. She was reporting complaints of polysubstance abuse, grandiose thoughts, hallucinations, and self-harm. She had an unstable relationship with her family—the conducted assessment tools included behavioral observation, clinical interview, and mental state examination. Through 5 sessions, the client seemed to have Substance/Medication-induced psychotic disorder comorbidity borderline personality disorder. The treatment plan includes psychological therapy and pharmacological medicines. The medication that helped to overcome the severity of her symptoms were as follows: risk, Motilium, lament, olives, rivotril, and onset. The previous studies helped to understand the client's condition and to plan their treatment.

Keywords: Psychotic Disorder, Personality Disorder, Pharmacological Treatment.

Introduction

To further classify individual cases of brief psychotic disorder, it becomes essential to recognize if the triggering of psychotic symptoms was from a stressful event or if it is postpartum. Everyday stressors are death, environmental disasters, military activity, and recent immigration. Acknowledging patient characteristics, such as the presence of a personality disorder that can limit coping skills, will also be crucial to identifying individuals at a greater risk of developing disorders like BPD. It is also essential to keep in mind that the presenting symptoms of BPD may occasionally be highly severe and mimic the presentation of delirium. (Stephen, 2021). How you think and feel about yourself and others causes problems functioning in everyday life. It includes self-image issues, difficulty managing emotions and behavior, and a pattern of unstable relationships (DSM-5).

Brief Psychotic Disorder

According to the DSM-5, brief psychotic disorder has the following diagnostic criteria,

1. Presence of the following symptoms
    - Delusion
    - Hallucination
    - Disorganized speech
    - Grossly disorganized or catatonic behavior
2. Duration of an episode of the disturbance is at least 1 day but less than a month, with eventual full return to pre-morbid level of functioning.

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3. The disturbance is not better explained by major depressive or bipolar disorder with psychotic features or another psychotic disorder such as schizophrenia or catatonia. It is not attributable to the physiological effects of the substance or another medical condition.

Specify if;

- With marked stressor, if symptoms occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual's culture.
- Without stressors, if symptoms do not occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual's culture
- With postpartum onset, whether during the pregnancy or within 4 weeks postpartum.

Specify if;

- With catatonia, refer to the criteria for catatonia associated with another mental disorder.

Specify current severity if;

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each symptom may be rated for severity on a 5-point scale ranging from 0 to 4.

Borderline Personality Disorder

The diagnostic criteria of borderline personality disorder are based on the following symptoms;

1. A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in various contexts, as indicated by five or more of the following.
2. Frantic efforts to avoid real or imagined abandonment.
3. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
4. Identity disturbance: markedly and persistently unstable self-image or sense of self.
5. Impulsivity in at least two self-damaging areas, such as spending, substance abuse, etc.
6. Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior.
7. Affective instability due to a marked reactivity of mood, for example, intense episodes of dysphoria, etc., lasts for a few hours to more than a few days.
8. Chronic feeling of emptiness.
9. Inappropriate, intense anger or difficulty controlling anger, temper, constant anger, recurrent physical fights.
10. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Materials and Methods

History: A 26-year-old girl was reported as unconscious and numb. Eight years ago, in 2010, at the age of 18 years, client N was suffering from migraine, and she went to the doctor. The doctor prescribed her some painkillers and muscle relaxants and allowed her to take those medicines only in the case of severe headaches. She was specified the 'Nelbin' injection. When she started using that injection, prior she used to go to the nearby hospital or any clinic for injections. One day, she went to the hospital with a severe headache; one of the nurses from the hospital staff suggested that she did not have to come to the hospital and give her the personal contact number, and she would provide the injection. After that, whenever she felt pain even less, she gave a call to that nurse, and she came to her house and injected her. She started using that injection daily. Day by day, she was getting addicted to that injection. She started injecting herself on her own. Her family did not know about that. She relayed for peace on those medicines. She started sitting alone and spent most of the time in her room. She started taking those medicines, including Nelbin injection, Gravitate injection, tablet Alp, tablet

Panadol, and capsule Risek in excess amounts, and then they noticed that change in her behavior. But they did not take her to hospital, they just stopped giving her money, for that she could not buy medicines. Her family thought she would be fine by the extinction of those medicines. As a result, she started showing verbal and aggressive behavior and restlessness when the drug was not administrated. The client had a dominating and independent personality. Her family stated that she was moody and stubborn since childhood. She felt superior and had a sense of pride in herself. She did not bother anyone. Her personality was creating problems for her family.

During that period, one of her cousins started liking her. He told her that he liked her and wanted to marry her. She was hesitant because that boy was 2 years younger than her, and her family did not agree to their marriage. But she attempted suicide, and after that, her family settled. After 1 year of her engagement, she was still using the drugs. Her fiancé was talking to her on call. His father heard him talking to her, and when he came to know that her future daughter-in-law was a drug abuser, plus his son was also aware of that, he asked him to leave that girl. His mother called the client's mother and told her about the incident. Then, she asked her to concentrate on their daughter, or they would cancel their marriage. That news from her in-laws made the client frustrated and hurt. Under the influence of those drugs, she called her fiancé's mother and started saying harsh words to her. That event offended her fiancé's family, and ultimately, they canceled their marriage. That event gave her a shock, and her family started blaming and taunting her. Then she attempted suicide for the second time, and this time she took poison. She went on a ventilator for 2 days but luckily survived. Her niece (sister's daughter) loved that guy, and that event forced her to end her life, and she did so. She started hating herself. She came back to life with low self-esteem. She was frustrated, devastated, and wanted to leave the drugs. For that sake, in 2014, her family took her to rehabilitation. When she returned from the complex, she behaved normally. But her ex-fiancé again contacted her and told her he wanted her in his life again, and she again believed him. But his family rejected her.

After that, client N started to retake the same medicines, but this time, she took drugs secretly. However, her maid informed her family about the relapse of her behavior and drug intake. Her family verbally rebuked her for not taking the pills, but they did not take any serious steps. Due to continuous intake of drugs, she started hallucination. She said that someone was calling her name. Her servant said she repeatedly claimed she was married and could see her husband, but that's not true. She used to talk to her imaginary husband. She did not trust her brother and sister that they wanted to kill her, and they envied her.

According to her medical reports, she was physically abused. She also shouted that someone was physically abusing her, and according to her, that person belonged to her brother, and her brother sent him to harass her. However, according to her family, due to her drugs and her extrovert personality, she was abused by someone from her friend circle, and now she was blaming her brother. There was the third point; her niece stated that she might have a physical relationship with her fiancé but was unsure. She suffered through all these events, and she had self-harm and deprived life.

Mental State Examination: A mental state examination assesses a patient's level of cognitive (knowledge-related) ability, appearance, emotional mood, speech, and thought pattern at the time of evaluation (Martin, 1990).

The client was lying on the bed with her eyes closed. The client was anxious and restless because of no administration of drugs. She was thin, pale, and dull. She was not able to walk because of the marks and scars of injections on her body. Her hands were shaking, and she felt shortness of breath as well. She did not establish or maintain eye contact. Otherwise, she avoided eye contact with the trainee psychologist. She was talking in a low-pitched voice. She had slurred speech and irrelevant talk. She was talking to herself while looking at the ceiling.

The client had grandiose and blaming thoughts. Her emotional mood was low as her current condition was depicted, and she claimed that most of the time, she had a low mood. Her mood was congruent. She preferred to stay in her room and did not allow anyone to enter her room. She harmed herself because she did not find drugs, and she showed aggressive behavior, either verbally or physically. Her perception was blurred as the trainee psychologist asked her some questions, but she did not answer those questions. Due to excessive use of drugs, she had hallucinations. Her attention and concentration were disturbed. She was not well-oriented with time, place, and person. She was not aware of her problems and health condition. She did not have insight.

Table 1: Summary of Different Areas of Mental State Examination

Areas	Status
Appearance	Dull and restless. The client was well dressed and clean
Eye contact	The client did not establish and maintained an eye contact
Speech	Low pitch
	Slurred and irrelevant
Mood	Subjective = Low
	Objective = Low
Thoughts	Congruent mood
	Blaming and grandiose
Perception	Blurred and inappropriate
Hallucination	Auditory and visual
Orientation	Not well orientated
Attention and concentration	Disturbed
Cognitive process	In appropriate and slow
Insight	Poor

Case Formulation

A 26 years old girl referred by her family with the complaints of poly substance abuse, grandiosity, self-harm and hallucination. This case was formulated by biopsychosocial modal in which predisposing, precipitation, perpetuation and protective factor were highlighted.

The predisposing factor of parenting as the client's parents had no so attentive and caring for her. They let her did what she want to do. Research explained that uninvolved parents give their child a lot of freedom and generally stay out of their way. Diane Baumrind explained the parenting styles, and explained that uninvolved parents might be parenting and their communication with their children would be limited (Diane Baumrind, 1960).

The precipitated factor of somatic illness as the client had severe migraine and she was taking the prescribed medicine but, in the end, she addicted to those medicines. It had been found in study, Hans Eysenck proposed a modal '*psychological resource model',* according to the modal drug used to fulfill the certain purpose that is related to the individual's personality. For them the drug holds benefit even there are negative consequences that are occur after some time. The client N the personality from the Eysenck's modal, which had the characteristics of moodiness and irritability. The people with these characteristics have a high risk of addiction or drug dependency (Eysenck, 1997).

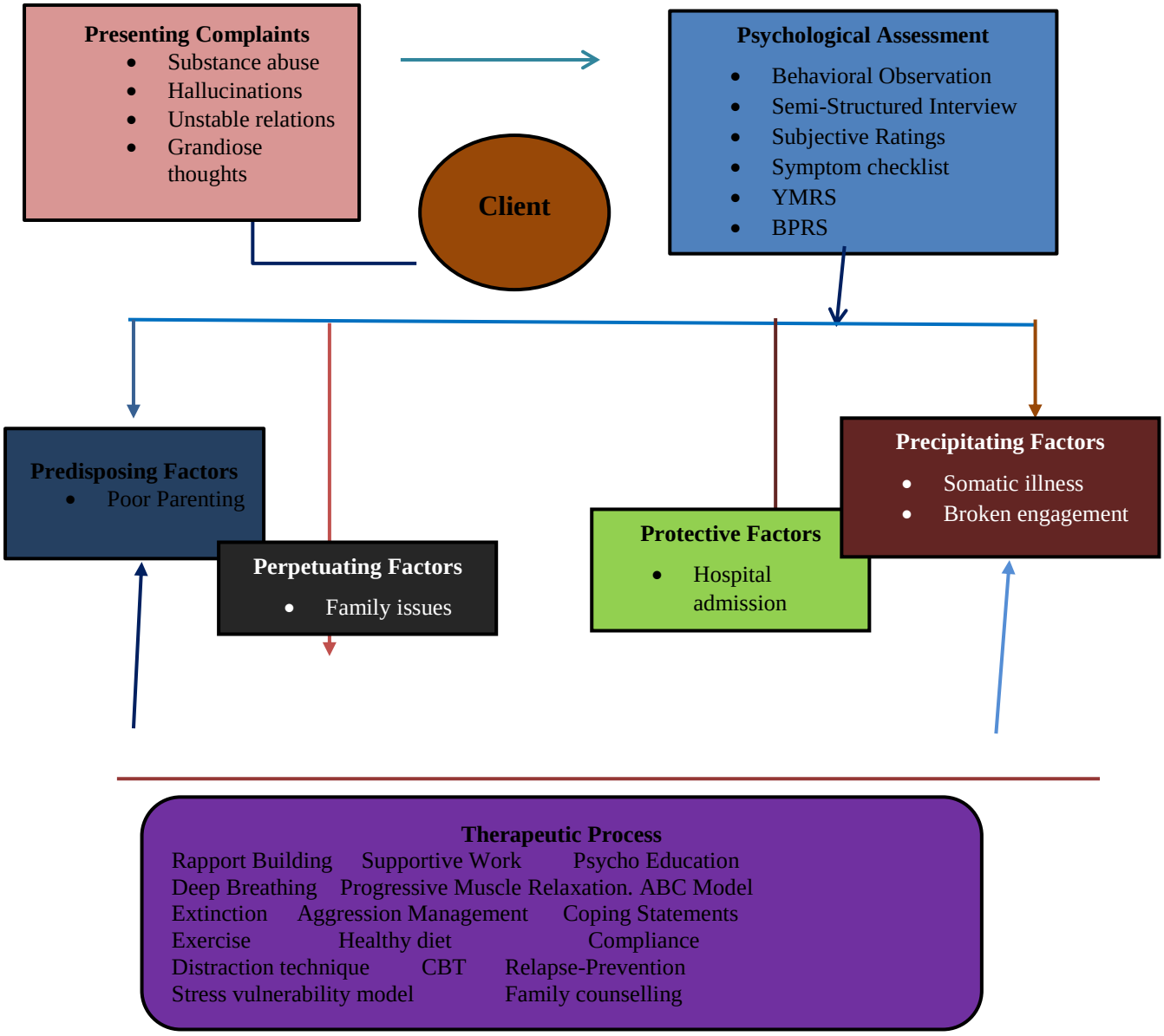
Her problems were further precipitated by her broken engagement as the client's drug addiction was the reason and for that she started hating herself. It had been found in the study the Kubler-Ross model had described the 5 stages of grief. According to that modal the client had the 2

stage, stage of depression. Rejection and guilt leaded her towards the depression state and under that state she committed suicide (Kubler-Ross, 1990).

The problems were maintained by her conflicts with family as she had blaming and negative thoughts for her family members. According to the research, the nature of family relationship leaded towards the problematic drug abuse. The risk of substance misuse is higher if the family member had discord, poor and inconsistent behavior and low level of bonding within the family (Hawkins et al.,1992).

The protective factor for the client was the administration in the hospital. As her family was not interested in her recovery so, there was no any family and emotional support for the client.

Figure 2: Summary of Case Formulation



The following figure shows the summary of client's problems, the various modes of assessment used, different factors contributing to the problem and the proposed management strategies.

Psychological Treatment

Short Term Goals

- *Rapport Building:* Rapport building is referred as the empathetic and shared understanding of the issues between a therapist and client. It implies a team approach to management of the problems and issues of the client (Fritscher, 2021).
- *Psycho Education:* The client was explained about the root causes and the reasons of her issues. ABC model was shown to the client to make her understand her thought and negative behavioral pattern
- *Deep Breathing:* Deep breathing is a form of relaxation that may help you to let go of physical stress and mental strain that often leads towards panic or anxiety (Star, 2021).
- *Progressive Muscle Relaxation:* PMR involves participant actively contract muscle to create the tension and progressively releasing the tension. The routine is repeated until client acquire complete relaxation state (Toussaint et al., 2021).
- *Supportive Work:* Supportive techniques contribute in client and therapist relationship and provide positive and healthy environment for the intervention process. Supportive work helps to reduce anxiety and promote the improvement in client's betterment process (Barber & Stratt, 2001).
- *Extinction guidelines:* Interfering behaviors are those that are disruptive or restrictive behaviors that can interfere with optimal development, learning and/or achievement. Extinction is a formal term, but it basically means to get to the bottom of the function or cause of a certain behavior and then terminate access to that function in order to extinguish the behavior. We have to examine what is happening before and after the behavior in question to figure out how it's being reinforced so we can understand why it's still occurring. Then we cut off that reinforcement (McClymont, 2022)
- *Coping Statements:* Coping statement are used to put a full stop to the negative or those thoughts that lead towards anxiety and replace those thoughts with realistic, practical and rational thoughts. Rational thoughts would take time and automatically occur until than keep practicing (Richards, 2020)
- *Distraction Techniques:* Engage in a wide variety of distraction techniques to alter the focus of attention away from the bodily symptoms you are experiencing
- *Anger Management:* Anger management includes the tips and ways through which we can manage and control the anger outburst. The goal of anger management is to reduce both emotional and physical arousal that cause anger (American Psychological Association, 2022).

Long Term Goals

- Reduce the frequency of affected behavior and increase the level of independent functioning.
- Acceptance of oneself.
- Improving the mental health and the coping mechanism.

Psychotherapy

Long-term, it's important to treat any underlying mental health conditions to reduce the chances of experiencing substance/medication-induced psychosis again. Treatment options may include:

- Cognitive behavioral therapy (CBT)
- Inpatient rehabilitation for drug and/or alcohol use
- Outpatient rehabilitation for drug and/or alcohol use
- Eye movement desensitization and reprocessing (EMDR)
- Dialectical behavior therapy (DBT)
- Group therapy

Session Report

Session 1

Goal

The goal of the session was to build rapport with client, to know about her interests and gather some background information from client.

Procedure

Clinical psychologist introduced herself to client. She was asked about her hobbies or interests. Clinical psychologist had started the conversation with the client and her family to get to know them.

Outcome

The client was nervous and anxious but after sometime she became relax and started responding to asked questions. She also shared some background information with counselor. Supportive work was done.

Session 2

Goal

The goal of the session was to build rapport and gather detailed information about client's familial, educational and personal factors and to get in depth understanding of her current issues.

Procedure

Client was generally asked questions about her family, school environment, daily routine, and friends and about her own personality. Client's mother was also addressed to have the information about the client. Clinical psychologist assured her and her family about her mental condition. Extinction guidelines were also addressed to the parents and asked them to strictly follow them.

Outcome

The goal of the session was achieved as detailed information about her issues and background history was taken from client. Deep breathing was also introduced in this session. Supportive work was done.

Session 3

Goal

Goal of the session was to informally assess client's problems. For this purpose, open ended questions were asked out during the session. Unconditional positive regard was given to client to answer the asked questions well.

Procedure

The client was allowed to freely associated with the clinical psychologist. In order to gather detail and in-depth information, open ended questions were asked to her. The client had answered the questions. Her family was also included in the session.

Outcome

The detail information was collected and assembled through this session. This session helped clinical psychologist to understand the ground of the client's issues

Session 4

Goal

The goal of session was to conclude history taking and provide support, unconditional positive regard and diagnose the client.

Procedure

In the fourth session the client was asked to explain her thoughts and her family was also included in history taking process. The symptoms of the client evaluated and manage to propose a diagnosis.

Outcome

It was observed that client was having visual hallucinations explained by clinical psychologist to client. At the same time, she developed the understanding of her problem. Session helped clinical psychologist to understand the ground of the client's issues.

Session 5

Goal

The goal of session was to provide psychoeducation about his problem through ABC model for her symptoms.

Procedure

In the fifth session the client was elaborated by clinical psychologist that how antecedent (reason) would lead towards a negative behavior and have consequences. One thought led to another one and then turned into a behavior leads to consequence. she had a negative thought pattern and how her thinking affected her mental health. The trigging point or starting point which initiate an attack in her found and descried than explained to client by the clinical psychologist.

Outcome

It was observed that client had developed an insight about her problem and she understand her problem by the ABC model. She also got to know about triggers and signs of her anger and irritability.

Session 6

Goal

The goal of session was to make a management plan collaboratively with the client and provide support, unconditional positive regard to the client. Client was also asked to provide subjective evaluation of her presenting complaints.

Procedure

In the sixth session the client was asked to evaluate and ranked her presenting complaints and also included her in making a management plan for her problems. Client had provided a table of ranked complaints to the clinical psychologist. Anger management tips were also instructed.

Outcome

It was observed that client had shown interest and felt positive about having the right to choose or select her own management process. Simultaneously client had given a chance to evaluate her symptoms and its intensity.

Session 7

Goal

The goal of session was to administer 16 PMR Progressive Muscle Relaxation to tackle client's issues related to her muscles and irritability.

Procedure

In the seventh session the client was explained by the clinical psychologist about the technique selected for her muscle and anger related issues which is PMR. This technique was first demonstrated by clinical psychologist and then instructed client to follow the steps.

Outcome

It was observed that client had shown betterment because of this technique. Client had reported that her muscles felt less stiff and he felt more relax than before.

Session 8

Goal

The goal of session was to administer distraction technique, this technique could help the client to prevent the negative thoughts and anxiety.

Procedure

In the eighth session the client was provided the demonstration of the proposed technique in order to develop the understanding of the rationale and benefits of the technique. After the demonstration, the client was asked to repeat the techniques.

Outcome

It was observed that client was learnt about the mechanism of avoiding at the time of having fearful and negative thoughts and then she asked to repeat the given steps of techniques. That helped him to find her triggers and prevent the outburst.

Pharmacological Treatment

Medications may be used to help reduce symptoms of substance/medication-induced psychosis and stabilize the individual's mood. Medications that may be used include

- Benzodiazepines
- Selective serotonin reuptake inhibitors (SSRIs)
- Antipsychotics

Table 2: Drug and its uses

Drug	Salt	Uses
Risek	Omeprazole	For her gastro-esophageal issues
Motilium	Domperidone	For nauseas Vomiting
Lament	Lamotrigine	For epilepsy For low mood
Olifass	Olanzapine	For hallucinations Delusions too
Rivotril	Colanzepam	For seizures For sleep
Onset	Antiemetic	For upset stomach

Conclusion

This study is a pioneer in this field. Significant variations found in the study can aid in case management and diagnosis differentiation. This is especially important for long-term intervention and in the management context. Although substance misuse in the United States is covered in most publications, there is a significant disconnect between the amount of research available and how it is used in real-world settings. The educational interventions must be successful and uniform across all levels of healthcare providers in order to prevent substance abuse. Additionally, resources for substance misuse prevention and treatment must be accessible to patients, families, institutions, universities, and community leaders.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders.* Washington, DC: Jay Pee Brothers, Ltd.
- American Psychological Association. (2022). *Anger Management.*
- Barber & Stratt. (2001). Supportive Techniques. *J Psychother Pract Res.*, 165–172.
- Borderline personality disorder. *In: Diagnostic and Statistical Manual of Mental Disorders DSM-5.* 5th ed. Arlington, Va.: American Psychiatric Association; 2013. https://dsm.psychiatryonline.org. Accessed May 8, 2018.
- Comer, R. J. (2015). *Abnormal psychology.* 9th(ed). A Macmillan Education Imprint.
- Fritscher, l. (2021, july 15). *What to Know About Therapeutic Rapport.*
- Kay, S, R., Opler, L. A., Fiszbein. A. (1987). The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophr Bull, 13*(2), 261–76.
- Leahy, R. L. (2011). *Cognitive Therapy Techniques: A Practitioner's Guide.* New York: The Guilford Press.
- McClymont. (2022). *ABA Therapists Use "Extinction" to Reduce Interfering Behavior.* Retrieved from therapy and wellness connection: https://therapyandwellnessconnection.com/insights/aba-therapists-use-extinction-to-reduce-interfering-behavior/
- Richards, T. A. (2020). *Coping Statements For Anxiety.* Anxiety Network.
- Star, K. (2021, january 23). *Verywellmind* . Retrieved from How to Use 3-Part Breath for Panic and Anxiety.
- Stephen, A. (2021). *Brief Psychotic Disorder.*
- Toussaint, L., & Nguyen, Q. A., Roettger, C. (2021). Effectiveness of Progressive Muscle Relaxation, Deep Breathing, and Guided Imagery in Promoting Psychological and Physiological States of Relaxation. *Evid Based Complement Alternat Medicine.*