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Intervention with comorbidities encompassing Attention Deficit Hyperactivity Disorder (ADHD), Bipolar Disorder and Borderline Personality Disorder (BPD): A Case Study

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The co-morbidity between ADHD, bipolar disorders and Borderline personality disorder (BPD) has been well established in research. A 21 year old, non- binary person belonging to upper socioeconomic status nuclear family, with professionally qualified working parents, temperamentally anxious and emotionally sensitive, with significant family issues, history of abuse in the childhood and diagnosed with medical condition of fibromyalgia was diagnosed with ADHD, bipolar disorder and BPD, CBT, DBT, and psycho-education were combined for therapeutic purposes, involving education on neurological and psychological aspects of disorders, emphasizing the importance of pharmacological treatment. Techniques included mood monitoring, identifying triggers, emotion regulation, relaxation, distress tolerance, and mindfulness meditation training. The treatment spanned over a year with ongoing follow-up. The client now recognizes mood shifts, minimizes risky behaviors during hypomanic episodes, maintains functionality, and has ceased self-harm. While managing interpersonal relationships and emotion regulation remains challenging, distress tolerance has improved.

Keywords: CBT, DBT, co-morbidity, Attention Deficit Hyperactivity Disorder, Bipolar Disorder, and Borderline Personality Disorder

Bipolar disorder is characterised by mood episodes which include depression, mania and hypomanic states. In bipolar II disorder the client experiences at least one hypomanic episode and at least one episode of major depression (DSM-V). Many of the symptoms of bipolar disorder and issues seen in ADHD overlap with one another like emotion dysregulation, talkativeness and disinhibited behaviours (Milberger et al., 1995, Carlson, 1998, Galanter et al., 2005). There is high rate of co-morbidity between bipolar disorders with ADHD, anxiety disorders and even medical conditions (DSM-V). Study on the family history and possibility of development of psychopathology among family members having bipolar disorders and /or ADHD suggests that both these disorders are transferred together in the first degree relatives (Faraone et al., 1997b; Wozniak et al.1995). There is also co-morbidity between Bipolar disorders and borderline personality disorder (Zimmerman and Morgan 2013).

Pharmacotherapy has been proven to be effective to manage the symptoms of Bipolar disorders. However in the case of co-morbid disorders with the bipolar; combination of CBT, DBT techniques as well as psycho-education and family work seems to be helpful (Provencher, M. D., Hawke, L. D., & Thienot, E. 2011)

Client:

Client is a 21 years old person, identifies as a non-binary gender identity. Her preferred pronoun is she / her. She is an only child. Both her parents are medical professionals. Reportedly there is a significant marital discord among parents since she was a child. Reportedly her father was abusive and both the parents have always been critical about her which was distressing for her. There is also reported history of childhood sexual abuse by unknown adult when the client was in 2nd standard. When the client was in 5th standard, there were complaints of inattentiveness, frequent dizziness and panic like symptoms noticed at school and hence she

was referred to the school counsellor. However, reportedly due to the resistance from parents, the therapy or counselling didn't continue further. After 12th, the client came to Pune for MBBS course where in the first year she started experiencing continuous suicidal thoughts and panic attacks for which she visited the psychiatrist. The psychiatrist diagnosed her with Bipolar disorder, Attention deficit Hyperactivity disorder and Borderline personality disorder.

Reportedly client has always been an anxious, emotionally sensitive child and had significant difficulty in concentrating. After a few sessions with the school counsellor, with behavioural techniques she started managing studies. Reportedly as both her parents were medical professionals and had busy schedules; she used to be with her maternal or paternal grandparents. Although she had difficult relationship with parents, she was very close with the grandparents. Reportedly since she was 15 years old, she started feeling significantly low, anxious and there were some obsessive-compulsive symptoms as well. There were also fleeting suicidal thoughts, crying episodes and deliberate self harm present. After 12th she shifted to Pune for graduation and within a month her paternal grandfather passed away which was the precipitating factor for depressive episode with suicidal ideation and panic attacks. After the diagnosis of Bipolar disorder, Attention deficit hyperactivity disorder and BPD, the psychiatrist started mood stabilizer and antipsychotic medication and referred her for therapy. The client is also diagnosed with Fibromyalgia, a medical condition which is characterised by muscular pain and tenderness.

Diagnosis: Bipolar disorder, Attention deficit Hyperactivity disorder and Borderline personality disorder

Treatment: considering the co-morbidities, combination of Cognitive Behavioural Therapy (CBT) and Dialectical behavioural Therapy (DBT) model of treatment was chosen. The following techniques were used for the symptoms in therapy-

Psycho-education and supportive work- The client was ready for treatment that there was no resistance from the beginning of treatment. However as the depressive episode was going on, there was significant hopelessness and victimized feelings. The client had difficulty in making eye to eye contact due to overwhelming emotions. She was psycho-educated about bipolar disorder, its etiology, treatment and prognosis. The nature of suicidal ideation was intrusive and obsessive in nature hence thought stopping technique was used for the same. After 6 sessions of vent out, supportive work with empathy and client centred approach, the suicidal ideations were gone.

Behavioural techniques for mood regulation-

1. Mood log- To understand and monitor the shifts in the mood, mood log worksheet was used.
2. Identifying and acknowledging the difference between impulse and normal thought was discussed and worksheet was used for the same. Postponing was used for the impulses associated with the mood disregulation.
3. Structuring was done and monitoring was provided for the same.

Emotion Regulation and distress tolerance-

1. The client was explained about the concept of emotion regulation.
2. Freezing frame technique- freezing frame techniques was used to understand and analyse overwhelming emotional experiences.
3. JPMR, mindfulness meditation training and sensory calming activities were used for self soothing. As the client is very artistic, drawing and painting as well as writing down emotional experiences in the form of narratives and poems helped significantly.
4. The panic attacks tapered down after 4 months with the help of identifying the triggers, regular JPMR and 5 countdown techniques.
5. Negative self talk was identified and was worked on with self compassion sentences practice.

CBT-thought challenging/restructuring- The client had a negative self concept regarding her capabilities which was causing significant social anxiety and distress. Core belief worksheet and Socratic questioning was used to gain insight into the thoughts. Cognitive distortions were introduced and monitored. It was understood that emotional reasoning, arbitrary inferences and all or none thinking errors were most frequent. Challenging and restructuring the error cognitions has been practiced by the client.

Interpersonal

The client came out to her peers and parents, identifying as non binary. Reportedly due to this revelation, interpersonal difficulties became more prominent and frequent. Hence assertiveness training is going on with the client. Through Socratic questioning worksheet the client is able to understand the negative self talk and assumptions while dealing with people, which is helping the client to be effective with interpersonal relationships.

Results

The client is in the psychotherapy for 13 months and behaviourally there is significant progress. The client is able to identify the initial stage of her going in hypomanic state, which is making her possible to seek help immediately and thus the indulgence in risky behaviours during the episodes is null. She is able to maintain the functionality.

Challenges

1. The impulsivity in ADHD, emotion dysregulation due to cluster B traits and the mood swings, it is difficult to identify the cause and manage the symptoms.
2. Due to the fibromyalgia, it is difficult to follow through the therapy exercises.
3. There are significant pathological family dynamics have been identified, however due to traumatic experiences during childhood with the parents; there is strong resistance from the client for family therapy.
4. The fibromyalgia is also causing the client significant sensory overload making it difficult to maintain the attention despite using behavioural techniques.
5. As the client identifies as non-binary and exploring her sexuality, considering the lack of awareness and misconceptions about LGBTQ community in the society makes it more difficult for her to socialise despite the motivation and efforts from her side.

Conclusion and Discussion

The client is a 21 year old identifies as non-binary person with Bipolar disorder, ADHD and BPD. The client is also diagnosed with Fibromyalia. CBT, DBT, psycho education and supportive work is used to treat her issues. The client is an intelligent person with partial insight into the issues and is cooperative in therapy. The consistent medication and psychotherapy seems to be helping with maintaining functionality and minimise anxiety and emotion dysregulation related issues in the euthymic state and reach out early during mood episodes. However due to the co-morbid conditions and family pathology, it is difficult to maintain the progress.

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