A 25-Year-Old Affirmed Male with Multiple Comorbid Conditions

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The patient was a 25-year-old affirmed male who presented to the outpatient psychiatric resident clinic to establish outpatient psychiatric care. He had been diagnosed with bipolar disorder type 1, but had been “fired” by his previous psychiatrist for missing too many appointments.

He had most recently been prescribed lithium ER 1,200 mg, clonazepam 2 mg, ramelteon 8 mg, and long-acting formulation of carbamazepine 900 mg every night, as well as narcotic pain medication as needed to manage chronic pain. The patient had also been diagnosed with posttraumatic stress disorder.
disorder (PTSD) related to repeated episodes of sexual violence perpetrated from age 4 to 9 years old by a childhood friend’s father in the neighborhood. He described his psychiatric symptoms as predominantly depressed mood with periods of intense suicidal ideation. He had been visiting several area bridges to evaluate their potential suicide effectiveness. He cut his skin with a buck knife regularly because it helped to manage intense emotional distress. He stated that he had periods of “hypomania” that lasted approximately 3 hours following a compliment or a positive interpersonal experience in which he felt the “world speed up.” The patient recalled an episode at age 17 in which he had decreased need for sleep, racing thoughts, and grandiosity, although he stated that this was during a period of heavy drug use, including cocaine. He reported not having used alcohol or illegal substances for 1 year. During this year, he displayed no symptoms of mania or psychosis.

At initial presentation, he was a college sophomore living in college housing with supportive programming for students recovering from chemical dependency. He had been hospitalized on inpatient mental health units for suicidal ideation three times and had been treated on an inpatient medical unit for hypokalemia related to purging behaviors. The patient reported that he had a history of heavy chemical use, starting with first use of alcohol at age 7, which continued through age 23. He also used diet pills starting at age 14, followed by heavy use of cannabis at age 15, and cocaine and other narcotics, including pills and heroin, at age 18 years.

The patient had several ongoing medical issues, including episodes of lost consciousness, initially believed to be a seizure disorder; however, inpatient EEG monitoring did not indicate epileptiform activity. He experienced chronic abdominal and pelvic pain that was at times excruciating. He underwent multiple evaluations by gastroenterology for these difficulties, including esophagogastroduodenoscopy, colonoscopy, and computed tomography evaluating for the presence of gallstones. He eventually underwent cholecystectomy and exploratory laparotomy, neither of which advanced his treatment course.

About a year before these tests, he was evaluated by a urologist, who noted significant pelvic floor dysfunction likely contributing to pelvic pain. A sacral nerve-stimulating device was implanted to improve functionality of the nerve and pelvic musculature. This was associated with some moderate improvement in pain, voiding, and defecation. The patient also experienced chronic migraines and frequent sinus, urinary tract, and lung infections. He experienced several dissatisfying encounters with medical personnel in which he felt like they were not providing him with respect and were minimizing his symptoms. He perceived his family as generally well-meaning, but unhelpful and lacking in understanding.

The patient was born and raised as a female, but in retrospect realized he did not fully identify with either the male or female gender. In the previous 2 years, he had decided to openly adopt a male gender, name, and manner of dress. He had the intention of pursuing hormone therapy and, eventually, chest reconstruction.

The patient believed he had suffered multiple head injuries related to physical violence and asphyxiation in the context of sexual trauma, but was unclear if he had lost consciousness because of head injury or because of psychological dissociation during these events.

The patient noted difficulty with concentration, learning, reading, and mathematical comprehension, although was noted to be highly intelligent on earlier IQ testing. He received academic accommodations through his college’s disability services department.
A discussion was held with the patient about the inaccuracy of his previous diagnosis of bipolar disorder. He was educated about the diagnosis of borderline personality disorder (BPD) and the dissociative subtype of PTSD. He agreed with the reformulation and was willing to pursue a referral for dialectical behavioral therapy (DBT) in our facility’s borderline personality disorder program. The patient was currently working with a therapist in the community, but agreed to commit to both treatments.

Based on the positive therapeutic alliance established during the initial evaluation, the psychiatric resident agreed to serve as the individual DBT therapist under supervision of one of the trained DBT psychologists in the department. Because of the presence of suicidal behaviors, the supervisor provided the patient with telephone coaching. The patient participated in a DBT skills group facilitated by the program’s supervisor and another DBT-trained psychologist. The psychiatry resident also managed the patient’s medications.

The patient continued outpatient DBT with only one hospitalization after he attempted to discontinue his clonazepam without tapering and experienced intolerable withdrawal symptoms and emotional crisis with suicidality.

Suicidal thoughts and behaviors were identified as the highest-priority target; after 6 months, these thoughts and behaviors had resolved. The patient was engaged in therapy and did not require significant emphasis on therapy interfering behaviors; therefore, quality-of-life interfering behaviors could be targeted, including purging behaviors, urges to use substances, self-injury, self-care, and interpersonally effective behaviors with friends, family, and other medical professionals. He graduated phase 1 of DBT therapy and proceeded to phase 2 to continue working on healthy emotional experiencing and management of trauma sequelae.

The patient graduated college with a high grade point average and went on to pursue master’s level education. He underwent sex hormone treatment and chest reconstruction.

He developed additional medical comorbidities, including insulin resistance and adrenal insufficiency. These medical conditions necessitated moving back in with his parents, resulting in significant familial conflict. The patient’s therapist made a referral for family therapy through our department, which was coordinated among treatment providers. The patient is enthusiastic about the progress made in treatment and states he often wonders if he would be still be alive without the intervention he received. Over the course of 3 years, his medications were all tapered to discontinuation, with the exception of prazocin 10 mg at bedtime for nightmares, ramelteon 8 mg for sleep, and clonazepam 1 mg three times a day, which was continued to assist with pelvic musculature functioning.

**DISCUSSION**

Psychiatrically and medically complicated patients tend to overwhelm not only the medical system, but also family and loved ones. Intense, chronic emotional distress and interpersonal reactivity, rooted in early trauma, can seem insurmountable and place patients at a high risk for suicide. Chronic psychological and physiologic stress significantly affect physical health, increasing the likelihood of medical comorbidity and complications of treatment, including well-documented immunologic dysfunction in both cellular and humoral immunity, pain processing dysfunction, and metabolic disturbances related to the HPA axis. However, the underlying foundation of these multiple diagnoses is the presence of early developmental trauma to the emotion regulation system —

**DIAGNOSIS**

PTSD and Borderline Personality Disorder

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which manifests as physical and emotional pain with impulsive and maladaptive attempts to engage in behaviors to meet personal needs, including safety. Zanarini and colleagues performed a study examining Axis I comorbidity in patients with BPD and identified high rates of comorbid PTSD. They also observed that meeting criteria for multiple Axis I disorders predicted meeting criteria for BPD. 

This may partially account for the practice of overdiagnosis of bipolar disorder in this population. Ruggero and colleagues studied 610 outpatients and found 82 patients previously misdiagnosed as having bipolar disorder. For these patients, meeting criteria for BPD increased the odds of a previous bipolar misdiagnosis (24% vs 6%). This study highlights the need for careful differentiation between these two disorders, as treatment and prognostic considerations differ. In this patient, we were able to taper his mood-stabilizing medications over time, a practice that would pose a different set of risks if the patient met criteria for bipolar disorder type 1.

CONCLUSION

Complicated patients require a thoughtful hierarchy of treatment targets and symptom domains. DBT was initially recommended in this patient to address directly the ongoing issues related to suicidality, but also helped target other important psychiatric symptoms and behaviors.

Using a unified team approach that included the psychiatry resident, at least three members of the program’s psychology staff, and the coordination of care between the patient’s primary care provider, endocrinologist, community-based therapist, neurologist, and pain specialist, helped to protect against clinician burnout and provided the needed redundancy for skill reinforcement and generalization.

Complicated patients tend to induce hopelessness in clinicians, especially at times of crisis and intense need. Re-orienting to the data that suggest a hopeful prognosis for many of the core symptoms of pervasive, chronic, emotional dysregulation can help fuel a sense of optimism, empathy, humanism, and alliance with “difficult patients.”

REFERENCES