

Chapter 16

Jennifer: A Young Homeless Woman Who Has Borderline Personality Disorder



Jennifer is a 23-year-old white cisgender, questioning female. She was referred for mental health services by a staff member at a community homeless shelter. They arrived together, with the staffer doing most of the talking initially. Jennifer had been involved in several verbal and physical altercations with other residents at the shelter and was finally asked not to return. Jennifer has no job or income and no family or friends to ask for help. A recent boyfriend “kicked her out” a few weeks ago and then left the area. He did not return texts or calls friends made on Jennifer’s behalf. She has resided at the local shelter since his departure and has now lost her chance to stay at the shelter.

Jennifer is tall, large framed, and muscular. She can be physically intimidating. Her clothes could use some washing, but she is clean and her hair neat. She says she “never got along well with anybody” and has been on her own for several years. She says her only living relative is her father, who is in jail on a 15-year sentence for sexually assaulting her as a young teenager. She has been in touch with him on and off, wanting to have “somebody” but always becoming upset as “he makes more promises he can’t keep.” “It’s just filling the time for him.” She doesn’t mention his sentence has only 2 years left.

Jennifer was asked not to return to the shelter after pulling an old pay telephone from the wall and throwing it at another resident. She says it reminded her of the last call she got from her boyfriend, where everything “was sweet and wonderful” the day before he kicked her out and disappeared. The other person had a disagreement with Jennifer about a book that “got all out of proportion.” This man had “tried to hit on me before” and got angry and insulting when she didn’t give him “what he wanted.” Staff said she flew into a rage and a number of people had to break them up and separate them. Jennifer also threw punches at the man who, they said, “mainly covered up and tried to get away.” Several less intense episodes had preceded this one, with different people involved.

Jennifer was born in the Midwest to parents who both worked in retail. “They were always busy and out.” She is an only child and very quickly learned to take

care of herself. She says that at age 4, she was making breakfast for everybody. Her parents had loud arguments and some fights followed by “making up and making love.” Jennifer saw this as a pattern. She says she was pretty much ignored until she reached puberty and then her father began to sexually abuse her. She says she enjoyed feeling important to him and the physical contact they had. When her mother literally walked in on them together, she turned around, walked to the phone, called the police about the abuse, and left. “I guess she was so mad she dropped a dime on him. He deserved it. But I think she forced him out...the one good thing in my life.” Still, her mother seems quite idealized at times despite her role in breaking up the family and abandoning Jennifer. Jennifer saw her father only a few more times as she went to foster care and her father went to jail. It is unclear what led him to move so quickly through the legal system, especially since the mother’s whereabouts were unknown almost immediately after the “call.” She also recalls her mother saying, “You even had him taken away.” Sometimes she thinks what happened is her fault. There seemed to be no extended family involvement, and only a neighbor babysitter was recalled as a source of pleasure. “Mrs. Jones would play with me and do my hair.”

Jennifer next lived in four different foster homes, each of which was “pretty good,” but none of them “wanted me.” A good home meant food, shelter, and clothing. Jennifer could not describe the characteristics of her foster parents beyond that they “took good care of me.” She was moved several times and no plans for adoption proved viable. Still she said once, in a whisper, “each new place was like a wound.” She dropped out of high school at 16, left foster care, and “ran away.” Jennifer thought about going to the area where her father was in jail but learned that it was small and isolated. Instead, she went to a moderate-sized urban area where she lived on the streets prostituting and “living on others people’s generosity.” It was not clear if this generosity was a gloss over for the coercion she actually experienced. She was able to do food service work but ended up quitting or being fired for disputes with other workers or her bosses. She seems both intelligent and quite verbal. She knows she is “moody” and has a “quick temper, like my father.” She enjoys other people’s humor but almost never jokes.

Jennifer said she had “tried about every drug you can imagine” but found most of them made her feel “worse.” She said pot and most pills made her “feel crazy” and that she avoided them. She said she liked “downers” and that drinking “made her forget.” She acknowledged some binges but said she didn’t drink much. However, she was not very specific about when and how much she drank. A long-time shelter staffer had said “it was a point in her favor that she wasn’t ‘big’ into alcohol or drugs.”

Jennifer has been briefly hospitalized on several occasions for suicidal threats and gestures. Most of these involve cutting her legs and wrists but did not appear to emergency workers as life-threatening. She denied during assessment that she had been using drugs or alcohol. She denied any current suicidal ideation or plans. She says her cutting was always brought on “by being left” despite her very independent presentation. Even hints of sadness and loss are rare and took several sessions to emerge. Her nonverbal presentation makes one feel like there is a veritable pool of

sadness inside her. She has been connected with therapists several times by hospital staff and says, “I mainly blew them off.” She truly seemed to doubt that other people are trustworthy.

When she was reminded she had “been left” just a short while before (the apparent precipitant of the phone incident), she became angry and loud but insisted she did not want to hurt herself. “Him... well, that might be different. But he’s gone.” This little emotional storm passed quickly. When asked if the time in the hospital helped, Jennifer said it was good to be cared for but mentioned nothing specific. “Those doctors and social workers kept asking me who I am. I don’t really know... It gets worse when I am alone.” Her wish: “to have a home where I am loved and taken care of.” Her range of affect was very constricted and heavily weighted to the negative. People who were against her were “bad”; only two shelter staffers were rated as “good.” “It’s hard enough bein’ on the streets... it takes so much effort.”

When asked where she might stay, she mentioned “the streets” or a shelter in a nearby town. “It’s just starting to get really cold now; but it ain’t so bad,” she said. Both Jennifer and the shelter worker said she was on a subsidized housing waiting list—with a 5-year wait. When asked if she’d consider being part of a residential program, she said “Sure... you think they’d even take me?”. The worker told her she would search for “what works” for people with her kind of needs, including worries about loss and a quick temper who were homeless. The worker was not sure that there were programs locally, and they would probably take some work to make sure they could be funded.

Applying the Six Steps of EBP to the Case

Step 1: Drawing on Client Needs and Circumstances Learned in a Thorough Assessment, Identify Answerable Practice Questions and Related Research Information Needs

Jennifer meets criteria for a borderline personality disorder (BPD) diagnosis. Her history of sexual abuse, loss, and multiple foster placements also suggest a significant trauma history. She does not, however, meet criteria for post-traumatic stress disorder, though she has lived through significant trauma. Her lack of attachment, impulsivity, self-harm, and coercive interpersonal relationships appear to replicate her family of origin’s style of interaction at great social cost. She has very limited social support and few marketable skills for employment. It is unclear she could make, and sustain, a commitment to enter a treatment program. Her homelessness and lack of current insurance make finding services still more difficult. In her state, she would qualify to reapply for public insurance. Another dimension to her situation is that she has “aged out” of services for teens under age 21 and yet has many of the issues they confront. In the service world, she is just another adult.

In the PICO model, the **P**opulation is people who have borderline personality disorder along with people who are homeless. Given Jennifer's circumstances, it was not immediately clear where she would stay, and no additional resources to serve her needs were immediately apparent. She could be long-term homeless. The **I**nterventions under consideration are psychosocial interventions and possibly medication with the goals of reducing aggressive outbursts and more broadly to help Jennifer regulate her emotions and reduce suicidal ideation, gestures, and self-harm. In addition, the issues of her prior trauma and her relationship with her father are clearly of interest to Jennifer, though they are not immediate treatment priorities. Finding ongoing shelter or an apartment and gainful employment to support it are also clear needs. Comparisons would be across different therapies and perhaps medication alone or in combination with therapy. **O**utcomes would include reducing aggressive outbursts, improved emotional regulation, reduced suicidal ideation and self-harm, and finding ongoing shelter. Interventions to help with her personality disorder may not necessarily coincide with her needs for shelter.

Step 2: Efficiently Locate Relevant Research Knowledge

PubMed revealed only three incidence studies for “borderline personality disorder” + “homelessness,” including one German field study indicating high levels of comorbid disorders and a common motive of flight from violent situations among these women (Torchalla, Albrecht, Buchkremer, & Langué, 2004). Using the same search terms in Google yielded quite a bit of information, mainly from the United Kingdom (i.e., <http://handbooks.homeless.org.uk/hostels/individuals/pd/rjapd>). These sources ranged from efforts to create “low key” structured housing programs, to personal narratives, to a description of a program in Colorado to engage homeless persons who have BPD with mental health services by building an ongoing presence at soup kitchens. The connection between BPD and homelessness is common given how it can interfere with employment and, in turn, obtaining and maintaining housing. A major focus was on gaining housing and government support to get a “starting point” for other kinds of efforts. Though there was no large-scale research cited to support this point of view, the literature repeatedly pointed to having a place to live as the first order of business in helping people who have BPD. Organizations focused on homelessness are also looking for the connection between homelessness and treatment once they are in shelters or in some form of residential care. For example, the United Kingdom's Homeless Link web site (<http://handbooks.homeless.org.uk/hostels/individuals/pd>) specifically cited Bateman and Fonagy's partial hospitalization program as a potentially effective treatment program for persons who have BPD.

A search of the Cochrane Library for the term “borderline personality organization” revealed five systematic reviews (SRs), one of which was not relevant. Regarding psychotropic medication for BPD, Stoffers et al. (2010) found 28 trials involving 1742 participants examining 4 classes of antipsychotic, mood stabilizing and antidepressant drugs. They report that:

The available evidence indicates some beneficial effects with second-generation antipsychotics, mood stabilisers, and dietary supplementation by omega-3 fatty acids. However, these are mostly based on single study effect estimates. Antidepressants are not widely supported for BPD treatment, but may be helpful in the presence of comorbid conditions. Total BPD severity was not significantly influenced by any drug. No promising results are available for the core BPD symptoms of chronic feelings of emptiness, identity disturbance and abandonment. Conclusions have to be drawn carefully in the light of several limitations of the RCT evidence that constrain applicability to everyday clinical settings (among others, patients' characteristics and duration of interventions and observation periods). (Authors' conclusions)

Another SR by Huband, Ferriter, Nathan, and Jones (2010) examine the use of antiepileptic medications for treating aggression and associated impulsivity. They summarized 14 studies of 5 medications including 672 participants. Huband et al. conclude that:

the body of evidence summarized in this review is insufficient to allow any firm conclusion to be drawn about the use of antiepileptic medication in the treatment of aggression and associated impulsivity. Four antiepileptics (valproate/divalproex, carbamazepine, oxcarbazepine and phenytoin) were effective, compared to placebo, in reducing aggression in at least one study, although for three drugs (valproate, carbamazepine and phenytoin) at least one other study showed no statistically significant difference between treatment and control conditions. Side effects were more commonly noted for the intervention group although adverse effects were not well reported. Absence of information does not necessarily mean that the treatment is safe, nor that the potential gains from the medication necessarily balance the risk of an adverse event occurring. Further research is needed. (Authors' conclusions)

Medication might be one treatment for Jennifer to consider but is unlikely to impact core BPD feelings of identity disturbance and abandonment.

Borschmann, Henderson, Hogg, Phillips, and Moran (2012) did an SR on crisis interventions for persons who have BPD. They found only two RCTs and conclude that "currently there is no RCT-based evidence for the management of acute crises in people with BPD and therefore we could not reach any conclusions about the effectiveness of any single crisis intervention" (Authors' conclusions).

Stoffers-Winterling et al. (2012) found 28 RCT studies of psychological treatments for BPD involving 1804 participants. They found RCTs on 15 types of therapy for BPD, including both models that involved individual psychotherapy and other models that centered on interventions without individual therapy. Overall, they report that:

Data were sparse for individual interventions and allowed for meta-analytic pooling only for Dialectical Behavior Therapy (DBT) compared with treatment as usual (TAU) for four outcomes. There were moderate to large statistically significant effects indicating a beneficial effect of DBT over TAU for anger ($n = 46$, two RCTs; standardized mean difference (SMD) -0.83 , 95% confidence interval (CI) -1.43 to -0.22 ; $I^2 = 0\%$), parasuicidality ($n = 110$, three RCTs; SMD -0.54 , 95% CI -0.92 to -0.16 ; $I^2 = 0\%$), and mental health ($n = 74$, two RCTs; SMD 0.65 , 95% CI 0.07 to 1.24 $I^2 = 30\%$). There was no indication of statistical superiority of DBT over TAU in terms of keeping participants in treatment ($n = 252$, five RCTs; risk ratio 1.25 , 95% CI 0.54 to 2.92).

All remaining findings were based on single study estimates of effect. Statistically significant between-group differences for comparisons of psychotherapies against controls were observed for BPD core pathology and associated psychopathology for the following interventions: DBT, DBT-PTSD, Mentalization-based treatment [MBT] in partial hospitalization and outpatient, MBT-[Partial hospital], MBT-out[patient], transference-focused psychotherapy (TFP), and interpersonal therapy (IPT). IPT was only indicated as being effective in the treatment of associated depression... Statistically significant superiority was demonstrated for DBT over Client-centered therapy [CCT] (core and associated pathology) and for Schema-focused therapy over TFP... No data were available for adverse effects... (Main results)

In several studies, treatment with DBT showed reduction in anger and parasuicidality and improvement in overall mental health. In single studies, DBT and several other treatments empirically demonstrated better outcomes than did controls for core BPD pathology and associated challenges (e.g., Giesen-Bloo et al., 2006). There are several treatment options for Jennifer to consider, with DBT having the largest number of studies. The best research evidence suggests either entry into a DBT program fully using Linehan's model or a psychodynamically oriented mentalization-focused or transference-based program. However, no mention is made of the effectiveness of any of these programs for the treatment of homeless people. McNeill (2005) refers to "adaptations" of DBT to better serve the needs of homeless people, but just what these adaptations are is not specified. (No follow-up article was located.) A partial hospital program *might* provide temporary shelter as part of the program.

A search of the Campbell Collaboration Library located several resources for the search term "homelessness." Most related to reviews registered but still not completed or reported. A PowerPoint style report of a presentation by Antilla (2009) indicates that across several studies, a number of programs reduced mean days of homelessness. The target population was persons with mental illness (not further specified) and substance abuse. Assertive community treatment (ACT) proved very effective by visual inspection over a year to a year and a half after start of services. Case management services also appear appropriate. The search also revealed an abstract on a pilot study by Cavanaugh, Gelles, and Solomon (2009), provided descriptive information about a pilot program adapting DBT to a psychoeducational workshop to prevent interpersonal violence. Results of the study were not reported in the abstract.

Step 3: Critically Appraise the Quality and Applicability of This Knowledge to the Client's Needs and Situation

The best available research for Jennifer's concerns was limited, but the full-model DBT or transference-based or mentalization-focused programs appear to fit her concerns well in general. However, neither program's research data included any information about people who were homeless. Both programs appeared to presume

clients had relatively stable and ongoing living situations. The lack of such living situations might be viewed as making Jennifer quite different from the people included in these study results.

No partial hospitalization program similar to Bateman and Fonagy's (1999) was available regionally. One DBT program was found but had an 8-month or longer waiting list. This left no available therapeutic resources based on the best evidence possibilities for further discussion with Jennifer. Similarly, it was clear that she had "burned her bridges" with the available local shelters. She would likely be accepted at another shelter in a nearby town, but this left unresolved how she would be helped to avoid future aggressive incidents, as well as to find more permanent housing. It would also require yet another move and change, excluding her from the few local supports she trusted in.

Jennifer did not qualify for case management or assertive community treatment. Both programs are available in her community for persons with severe and persistent mental illness. Despite her earlier hospitalizations, Jennifer does not meet criteria for such services in her local area. Severe and persistent mental illness does not lead to any priority in publicly subsidized housing. It might lead to access to housing programs for persons who have mental illness, but again, Jennifer does not qualify for such services.

Step 4: Actively and Collaboratively Discuss the Research Results with the Client to Determine How Likely Effective Options Fit with the Client's Values, Preferences, and Culture

It was challenging to simply present these complicated research results. The full DBT model has been demonstrated to reduce anger and parasuicidality. Jennifer did not view either as a primary concern of her own. Mentalization-based and transference-based programs reduced core BPD symptomatology, but could not assure no future feelings of isolation, abandonment, or emptiness.

When these research supported treatment options, and their practical limitations were discussed with Jennifer, she was very interested in a partial hospitalization program. Her interest had little to do with the program philosophy or its preliminary support as an effective program. Instead, she viewed the structure and support of a partial hospital program as useful to help "organize" her. Her response is consistent with a research summary on effective relationships for persons with personality disorders (Castonguay & Beutler, 2006). A working group of clinicians and researchers, including Marsha Linehan, found considerable empirical support for intensive initial intervention for persons with personality disorders. They noted that regular mental health care, with weekly sessions and low intensity support for people who have personality disorders, was often ineffective. Nonetheless, access to such a program was not immediately available through a partial hospital or an intensively structured program. Neither access to empirically supported treatments nor access to long-term of immediate shelter was available.

Step 5: Synthesizing the Client's Clinical Needs and Circumstances with the Relevant Research, Finalize a Shared Plan of Intervention Collaboratively with the Client

With no access to interventions supported by the best available evidence, Jennifer agreed to a plan of weekly sessions and some telephone contact if a crisis occurred. She endorsed a focus on planning to locate shelter and to, over time, look at how her “touchiness” (her word) kept her from housing, employment, and more fulfilling relationships. The clinical social worker noted in her record that she had a substantial and unexamined sexual trauma history and that her father was nearing likely release from prison. Having a regular place to live would be a vital foundation for doing the psychological and interpersonal work facing Jennifer.

Step 6: Implement the Intervention

Jennifer left the office and headed for the streets. The lack of resources and her “burnt bridges” with several shelters left few immediate shelter or housing options. She did not seem overwhelmed by this result. She agreed to keep in touch and to drop in after 3 days. At the 3-day check-in, Jennifer had decided to move to a larger nearby city and stay at their shelter. She was unwilling to sign releases to allow staff to speak with staff at the new shelter about her needs. A week later she returned, unexpectedly, and said things were going well, “so far.” She had changed her mind and agreed to sign releases, allowing sharing of information with the new shelter and its mental health consultant. Many of her needs remain unmet.

References

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