IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 23, Issue 12 Ser. 6 (December. 2024), PP 37-39
www.iosrjournals.org

Self-Harm And Borderline Personality Disorder: About A Clinical Case

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Abstract:
The most common type of personality disorder is known as borderline personality disorder (BDL), which is also linked to an elevated risk of committing suicide. Patients who suffer from this personality disorder typically engage in self-aggressive behaviors, such as attempting suicide (SU) and purposely inflicting injury on themselves. Despite this, there is a great deal of controversy on the links between self-inflicted harm and suicidal behaviors in BDL. Some authors believe that self-mutilation is a preventative technique against suicide, and they advocate for its use. The presence of others constitutes a substantial risk factor for suicide behavior and ought to be treated with serious consequences. Through the use of a clinical case study and a review of the relevant literature, we will make an effort to shine light on this relationship in order to draw attention to the issue of self-mutilation, what it looks like, and how critical it is to get assistance as soon as possible.

Keywords: *borderline personality, anxiety-depressive disorders, self-harm, impulsivity, opioidergic system, fronto-limbic circuits, suicide attempts*

Date of Submission: 15-12-2024 Date of Acceptance: 25-12-2024

I. Introduction:

Borderline personality disorder (BDL) is the most common personality disorder and is also correlated with a high risk of suicide. Self-aggressive acts (suicide attempts (SU) and self-mutilation) are very common among patients with this personality disorder. However, the links between self-harm and suicide in BDL are controversial. For some authors, self-mutilation is a protective factor against suicide. For others, they constitute an important suicidal risk factor to be taken seriously.

Through a clinical case and a review of the literature we will try to shed light on this relationship to highlight this self-mutilation, its characteristics and the need for early treatment.

II. Clinical Case:

This is a 24-year-old patient, without function, in a relationship, who came for consultation accompanied by his girlfriend for disorders that had been present for several months: agoraphobia and social phobia. The patient was very distressed. He reported that for several months, he had started to isolate himself from the world, to have strong anxious ruminations about his future with a fear of being abandoned by his girlfriend, whom he had known for around ten years before. the beginning of the troubles and becoming homeless. Given the worsening of symptoms with the appearance of insomnia while falling asleep and the ineffectiveness of therapeutic trials (self-medication), the patient, encouraged by his girlfriend, finally decided to consult a psychiatrist.

The presentation is marked by multiple self-mutilation scars, a large one on his right cheek, others on the left forearm and at the right cervical level. Tattoos on his hands bearing the initials of his mother and his former girlfriends. Multiple, recent scars from cigarette burns. The patient reported that this self-mutilation began at the age of 14, and which was exacerbated during situations of frustration (most often conflicts with his girlfriend), qualifying it as a means of "escaping the worse ".

The psychiatric history is marked by multiple suicide attempts, outpatient follow-up with several psychiatrists and a 1-month hospitalization in 2014 for a psychotic episode (persecutory delirium with an interpretive mechanism, with strong anxiety and sad mood), placed on quetiapine. 300mg/day, levomepromazine

100mg/day and escitalopram 20mg/day. The evolution was marked by relative stabilization without any further follow-up until the current consultation.

The biography describes an only son whose parents divorced before his birth. His mother, described as an unstable and immature anxious woman, was unable to take care of him, especially at his young age, entrusting him to his aunt who took care of him until the age of 5. The patient describes this separation as very distressing.

His father is described as an unknown person. He tried to reconnect with him when he was 6 years old but his mother refused. This unstable family context led to a lack of communication with his parents and an average education until the first year of high school. During adolescence, he began to have negative ideas, to feel existential unease, low self-esteem and a conflictual relationship with his mother. In 2013 he was imprisoned for a year, following agitation and verbal aggression and breaking objects at home. This period of prison was marked by the emergence of remorse, as well as active and passive suicidal ideation.

His romantic relationships are described as turbulent, his current girlfriend whose relationship dates back 10 years, and whom the patient describes as being his first love, was marked by phases of idealization and phases of conflict marked by verbal aggressiveness and rarely physical which the patient explained by a feeling of jealousy and a strong anxiety of abandonment, something which also contrasts with a breakup which lasted three years before reconnecting with her.

In terms of toxic habits, active smoking with heavy cannabis consumption was noted, especially during conflicts, which the patient weaned 4 months ago.

III. Discussion:

BDL personality disorder affects 2 to 4% of the general population [1], and constitutes the most observed personality disorder in psychiatry (11 to 15% of patients followed in outpatient settings and 15 to 50% of hospitalized patients), and the one who is most at risk of suicide (10% of suicides, most often occurring late). [2]

Indeed, our patient meets most of the diagnostic criteria for BDL disorder listed in DSM-5. According to the latter, it is characterized by instability on the emotional level (dysphoria, irritability, anxiety), self-image and interpersonal relationships (alternation between idealization and devaluation), accompanied by notable impulsivity. Individuals experience problems controlling their anger and may exhibit temporary paranoid or dissociative signs associated with stress. Finally, frequent self-aggressive actions (from self-harm to suicide attempts). [2]

BDL patients with self-injurious behavior are distinguished by increased psychiatric comorbidity, greater frequency, duration and diversity of psychotropic treatments, and a higher frequency of current or chronic suicidal ideation.[2] Self-harm or suicidal behavior in patients with borderline personality represents one of the most specific manifestations of impulsivity.[4] Concerning self-mutilation, we observe a higher prevalence in the in-hospital psychiatric population (5.8 to 77%) than in the general population (0.75 to 4%).[2]

In our patient the self-mutilations are repetitive, early and of several types, something well described in the literature. Indeed, in the case of BDL, self-mutilation is common (50 to 80%), recurrent (41% of patients suffer more than 50 self-mutilations), early (5% started between 0 and 5 years) and manifests itself in various forms. : cuts, burns, ulcerations, scarifications, bites, lacerations. [2]

The particular history of our patient as well as several studies support the hypothesis of a particular developmental trajectory in BDL adolescents. It is made up of insecure first attachment relationships associated with traumatic exposure which makes them vulnerable to depressive suffering, experiences of separation and fragility in terms of interpersonal relationships. [4]

However, the links between childhood abuse and self-harm are contradictory. Most authors note that patients with self-mutilation have a greater number of histories of childhood mistreatment such as physical, emotional neglect or sexual abuse. However, others suggest the absence of a direct link between abuse and self-mutilation, but rather an association between abuse in childhood and the occurrence of BDL disorder. [2]

The repetitiveness and intensity of self-mutilation call into question the notion of analgesia, in fact 50 to 60% of patients suffering from a BDL disorder report an absence of physical pain during self-mutilatory behavior, but relief from psychological pain. [1]

These behaviors would therefore be a maladaptive emotional regulation response. Neurobiologically, BDL disorder could be associated with a dysfunction of the opioidergic system and fronto-limbic circuits, largely involved in the pain phenomenon. [1]

The links between self-harm and suicide in BDL personality disorder have been a subject of controversy. For Durkheim, self-mutilation is only a variant of suicide (embryo suicide) where the risk of mortality would be lower, joining the Anglo-Saxon notion of Parasuicide (a term encompassing TS and self-mutilation).[2]

For other authors, these are two distinct concepts, providing elements allowing them to be differentiated, namely: intentionality, lethality, frequency or chronicity of the act in favor of self-mutilation, and the methods used (varied for self-mutilation/identical for TS). [2]

The notion that self-mutilation would be a protective factor has been developed by several authors based on the fact that self-mutilatory behavior constitutes an attenuated form of suicide (compromise) making it possible to avoid suicide (anti-suicide act) or to a greater extent. less, greater self-destruction, or even regression to a psychotic state. The risk of suicide does not increase as long as self-harm produces the expected internal relief.[2]

However, most authors emphasize the significant suicidal risk factor represented by self-mutilation based on the following data:[2]

- BDLs with a history of self-harming behaviors have a suicide rate twice as high as those who do not exhibit these behaviors.
- Self-harm can precede a suicidal act by serving as "practice"
- Repeated self-harm leads to an intensification of dysphoria which will only be relieved by a suicidal act.
- Self-harmers with TS have a higher risk of suicide, because they express more depression, are more aggressive, have more marked emotional instability and above all they underestimate the lethality of their TS.

The management of BDL patients with self-mutilation is based on a psychotherapeutic approach (psychodynamic or dialect-type behavioral) and a pharmacological approach combining to varying degrees: SSRIs, mood stabilizers and atypical antipsychotics. [2]

Authors suggest partial hospitalizations with an analytical orientation, or short and sequential hospitalizations allowing the reduction of suicidal ideas and self-harming behavior, leading to better social and interpersonal functioning. [2]

Finally, benzodiazepine anxiolytics should be used with caution in BDL patients because certain studies show an increase in the rate of suicide attempts and self-mutilation (paradoxical increase in impulsivity). [5]

IV. Conclusion:

The various studies carried out to date have not been able to conclude on the link between self-mutilation and suicide, even if some literature seems to highlight self-mutilation as a risk factor for suicide. The management of BDL patients with a history of extreme and repeated self-harm must remain vigilant, as these patients underestimate the lethal potential of their self-injurious behavior.

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