Case Report

BORDERLINE PERSONALITY DISORDER

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ABSTRACT

This case report describes a 24-year-old Malay female patient with a history of prolapsed intervertebral disc (PID) who presented with persistent low mood, self-harm ideation, and other depressive symptoms. These symptoms were triggered by a complicated and unstable relationship with her partner, who exhibited controlling and critical behavior. Following the termination of the relationship, the patient experienced profound emotional distress, leading to symptoms such as insomnia, appetite loss, panic attacks, self-harm, and auditory hallucinations. The patient also had a history of suicidal thoughts and postpartum depression. The mental status examination revealed no perceptual disturbances or cognitive impairments. A diagnosis of Major Depressive Disorder with Psychotic Features associated with an underlying Borderline Personality Disorder was made. Biological investigations showed no abnormalities, and treatment included medication (selective serotonin reuptake inhibitors, benzodiazepine, and antipsychotic) and supportive psychotherapy. The prognosis is variable but can be improved with prompt and thorough medical intervention, regular monitoring, and a strong support system .

INTRODUCTION

A personality disorder entails a maladaptive and inflexible pattern of thinking. BPD is characterizedby heightened sensitivity to rejection, leading to instability in interpersonal relationships, self-image, emotions, and behavior [1]. This disorder significantly impairs functioning, causing distress and is often linked to various medical and psychiatric coexisting conditions. Surveys indicate that approximately 1.6% of the general population and 20% of psychiatric inpatients may experience Borderline Personality Disorder [2].

The objective of this case report is (i) to discuss Borderline Personality Disorder, particularly how the rejection sensitivity linked to her symptoms, from a psychodynamic perspective and (ii) to describe types of intervention used in the management of Borderline Personality Disorder.

CASE PRESENTATION

A 24-year-old Malay female patient, with a pre-existing prolapsed intervertebral disc (PID), presented to the psychiatric clinic reporting a persistent low mood over the course of the past year. The patient's depressive state was accompanied by ideation of self-harm, self-reproach, internalised anger, feelings of guilt, and a profound sense of burden on others. All of these emotions originated during a time when her relationship with her partner was complicated and unstable.

Over the course of the past year, she has been experiencing recurrent emotional distress as a result of her boyfriend's demeanour, which has been characterized as exhibiting traits of control, criticism, and excessive demands. She remains and puts up with his behaviour because she feels sorry for him given his turbulent family and upbringing. After a year, she had expressed her emotional and psychological distress to her partner, but instead of offering an apology, the partner stated that he was unable to tolerate her and subsequently ended the relationship.

She experienced profound emotional distress following the termination of her love life, as it appears that this particular partner was the sole individual with whom she opened up about her innermost thoughts and emotions, surpassing even the level of disclosure she shared with her own parents. She felt as though she was being discarded and was worthless. She felt bad for upsetting her ex-boyfriend and was filled with rage, loneliness, and hopelessness. She also regretted ever opening up to the boyfriend, who ended up causing her a great deal of pain.

Subsequent to that, she developed symptoms including insomnia, appetite loss, recurrent panic attacks, self-harm, and auditory hallucinations in the second person. She is being condescendingly addressed by the voices, which also condemn her as pointless and order her to commit self-harm. She

would frequently inflict lacerations on her forearm with a cutter or strike herself with a wooden ruler. Aside from that, she had no history of illicit substance abuse or manic symptoms.

After successfully completing her Sijil Tinggi Agama Malaysia (STAM), she proceeded to pursue studies in Shariah in Egypt. Unfortunately, the COVID-19 lock-down stopped her studies, preventing her from completing her degree there. During her time in Egypt, she had suicidal thoughts and even attempted to jump over the home roof. Fortunately, her acquaintances intervened and rescued her. These difficulties arose as a result of the stressconnected with managing her PID, which impacted her education and put a strain on her relationships with friends in Egypt.

Currently, she has established herself in a private university in Malaysia permanently. The patient expressed a preference for independent work and limited social interaction with her peers, particularly male individuals. This is a result of her previous relationship with her lover, which caused her to develop a degree of fear and skepticism about boys.

Her father is 57 years old, and her mother is 50 years old. She does not have a good relationship with her father because he is verbally abusive. She was constantly criticized and shouted at for unjustified reasons. She is currently married to a 43-year-old man who used to be her secondary school teacher. She strongly relies on her husband, who continuously gives substantial aid and unwavering support. They have been married for a total of one year and five months. They were blessed with a baby girl, who is now 10 months old. She developed postpartum depression following the birth of her daughter, which required hospitalization due to depressive symptoms and suicidal thoughts.

The mental status examination reveals a femalepatient of Malay ethnicity with average height, dressed appropriately, exhibiting a calm attitude, and maintaining good eye contact. The patient is cooperative and communicates in Malay with normal volume, speech, and tone. Her speech is rational, relevant, and coherent. The patient's mood is euthymic and her affect is appropriate. She denied any active suicidal ideation or any perceptual disturbances. There is no thought of idea, thought insertion, withdrawal or broadcast. The patient demonstrates appropriate orientation and shows excellent attention. She does not display any psychotic symptoms. Her cognitive functions remain unimpaired. She exhibits excellent cognitive abilities and demonstrates a keen understanding of her circumstances. The results of the physical examinations are within normal limits.

A definitive diagnosis has been established, which is Major Depressive Disorder with Psychotic Features associated with an underlying Borderline Personality Disorder, both of which were precipitated by the distressing breakup experienced emotionally. A previous history of traumatic life events, specifically an adverse relationship with her verbally abusive father, is indicative of predisposing factors. As a result of this stressful psychological condition, she has been driven to predominantly pursue recognition and affection via romantic relationships. A persistent stress response has been induced by the abandonment of her former romantic partner, manifesting as increased anxiety, fear, and extreme sadness. The lack of supportive therapy and the absence of a dependable confidant whom she trusts further intensify this psychological distress.

Biological investigations such as a complete full blood count, renal profile, liver function test, thyroid function test, fasting blood glucose, and lipid profile show no abnormalities. The psychosocial investigation done (BDI Test) shows a result of 43 which is considered as severe.

Treatment includes prescription of selective serotonin reuptake inhibitors, fluoxetine 20 mg ON, benzodiazepine, alprazolam 0.5 mg ON/PRN, anti-psychotics, olanzapine 10 mg ON, and supportive psychotherapy. The prognosis for this is subject to variation, but prompt and thorough medical intervention, encompassing therapy and medication, has the potential to greatly enhance long-term outcomes. The prognosis and long-term health can be improved through regular monitoring, having a solid support system, and working together with mental health experts.

DISCUSSION

Borderline personality disorder is marked by sudden changes in identity, relationships, and mood, as well as acting without thinking, feeling empty, acting suicidal, cutting oneself, having stress-related paranoid thoughts, and severe dissociative symptoms like imagining that oneself or their surroundings are not real. This disorder creates a lot of problems, ranging from controlling feelings and impulses to getting along with others and feeling good about yourself. Emotional instability, impulsive aggression, repeated self-harm, and persistent suicidal thoughts are all signs of the disorder. Some of the exact causes of this disorder are still not fully understood, but genetic predisposi-tions and bad childhood experiences, like physical and sexual abuse, play a big role in how it develops.

Examining the case's complexities reveals that the patient's experience encapsulates the difficult ground of Borderline Personality Disorder (BPD). The distressing breakup she experienced vividly illustrates the profound impact of abandonment, a common trigger for exacerbated symptoms in individuals with BPD. The fear of abandonment, which is a characteristic of BPD, not only intensified her emotional responses but also resulted in the emergence of suicidal thoughts, highlighting the disorder's interconnectedness of emotional dysregulation and self-harm tendencies. The tendency to perceive situations, relationships, and oneself in extremes is a hallmark feature of BPD.

Dichotomous thinking refers to an individual's inclination to engage in cognitive processes characterized by binary oppositions, such as "black or white," "good or bad," and "all or nothing." This cognitive approach may be beneficial for expeditious decision-making. Nevertheless,

dichotomous cognition is associated with an increased risk of suicide attempts [3] and is recognized as a cognitive impairment observed in individuals with borderline personality disorder [4]. This dichotomous perception is exemplified by the patient's post-breakup feelings of being discarded and worthless. The inability to find a happy medium is a factor that contributes to the intense feelingsthat are experienced, which in turn fuels the emotional roller coaster that is characteristic of borderline personality disorder. This cognitive distortion has a significant impact on how people with BPD interpret and respond to their surroundings, contributing to the disorder's emotional volatility.

Psychotherapy offers many therapeutic techniques for addressing non-suicidal self-injurious behaviour. Self-harming behaviours can be categorized as either suicidal or non-suicidal and both forms are commonly observed in individuals with Borderline Personality Disorder (BPD). The selection of psychotherapy modality is crucial for the patient's achievement. Psychodynamic psychotherapy is suitable for patients who possess the cognitive ability to gain self-awareness, the skill to manage emotional regression, and are situated in a stable setting. It may be necessary to modify the therapy approach periodically during treatment if the patient's immediate needs change (Table 1) [5].

There are currently no pharmacological therapies that have been identified as specifically effective for treating self-harm. Psychotherapy continues to be the preferred treatment for BPD, and there is now substantial data supporting the effectiveness of dialectical behavioural therapy (DBT) in particular.

Dialectical Behaviour Therapy (DBT) emerges as a structured outpatient treatment that was methodically created by Dr. Marsha Linehan in the early 1990s to particularly target Borderline Personality Disorder (BPD) [6]. Based on cognitive- behavioral principles, Dialectical Behaviour Therapy (DBT) emerges as the only treatment with empirical support for Borderline Personality Disorder (BPD), indicating its effectiveness within the therapeutic field. "Dialectical" refers to the way that different ideas connect with each other. Using both acceptance and change as necessary for improvement is what "dialectical" means in DBT. The goal of dialectical behaviour therapy is to treat the symptoms of BPD by replacing negative behaviours with better ways to deal with stress, such as mindfulness, interpersonal effectiveness, mood control, and distress tolerance.

Dialectical Behaviour Therapy (DBT) is a flexible approach that may be adapted to the patient's initial level of problem. When a patient comes to Dialectical Behaviour Therapy (DBT) with issues that involve severe behavioural dyscontrol, such as suicidal behaviours, the patient is considered to bein the initial stage of treatment. At the beginning of the therapeutic process, the objective is to eradicate harmful behaviours that either pose an immediate risk to the patient or result in a significant degree of handicap. Additionally, it is the goal of the first stage of work to improve abilities such as mindfulness, interpersonal effectiveness, emotion control, and the ability to tolerate distress. The second stage of treatment, which focuses on transitioning from quiet desperation to emotional experience, is for patients who have behavioural

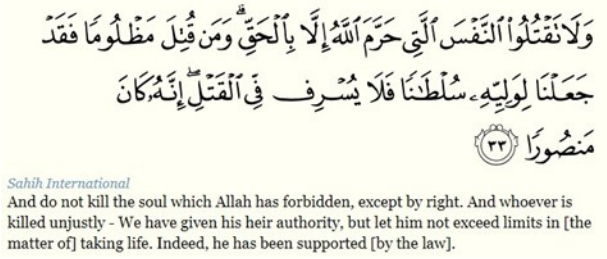
Table 1: Patient selection for four therapies

TYPE OF THERAPY	SELECTIVE PATIENT VARIABLES
Psychodynamic	• Chronic sense of emptiness and underestimation of self-worth • Loss or long separation in childhood • Conflicts in past relationships • Capacity for insight • Ability to modulate regression • Access to dreams and fantasy • Little need for direction and guidance • Stable environment
Cognitive	• Obvious distorted thoughts about self, world, and future • Pragmatic (logical) thinking • Real inadequacies (including poor responses to other psychotherapies) • Moderate to high need for direction and guidance • Responsiveness to behavioral training and self-help (high degree of self control)
Interpersonal	• Recent, focused dispute with spouse or significant other • Social or communication problems • Recent role transition or life change • Abnormal grief reaction • Modest to moderate need for direction and guidance • Responsiveness to environmental manipulation
Supportive	• Failure to progress in other types of therapy • Suicidal • Cognitively impaired and illogical • Acute or chronic medical illness • Presence of somatization or denial of illness • Requiring high levels of guidance or responsive to behavioral methods

dysfunction under control andhave moved on to the second stage. For example, uncomplicated Axis I illnesses, work issues, and marital issues are all addressed in Stage 3, which focuses on living concerns. As a final step, the fourth stage entails assisting the patient in diminishing feelings of incompleteness and cultivating the ability to experience freedom and joy. Emptiness and loneliness may be addressed as treatment targets during the fourth stage [7].

In Islam, self-harm is generally discouraged, as it goes against the principles of preserving one's physical and mental well-being. The body is considered a trust from Allah, and Muslims are encouraged to take care of their bodies and avoid causing harm to themselves. The Quran emphasizes the sanctity of life, stating:

Self-harm, including cutting or any form of intentional injury to oneself, is not aligned with the teachings of Islam. Islam encourages seeking help and support from others, including mental health professionals, when facing challenges or distress. Muslims are urged to turn to prayer, patience, and reliance on Allah during difficult times (Figure 1).


وَلَا تَقْتُلُوا النَّفْسَ الَّتِي حَرَّمَ اللَّهُ إِلَّا بِالْحَقِّ ۗ وَمَن قُتِلَ مَظْلُومًا فَقَدْ
جَعَلْنَا لِوَلِيِّهِ سُلْطَانًا فَلَا يُسْرِف فِّي الْقَتْلِ ۖ إِنَّهُ كَانَ
مَنصُورًا ﴿٣٣﴾

Sahih International
And do not kill the soul which Allah has forbidden, except by right. And whoever is killed unjustly - We have given his heir authority, but let him not exceed limits in [the matter of] taking life. Indeed, he has been supported [by the law].

Figure 1: Demographic of study participants and attitude score

Islamic teachings also emphasize compassion, empathy, and support for those going through hardships. Individuals struggling with self-harm or mental health issues are encouraged to seek understanding, empathy, and professional help, andthe community is encouraged to offer support and compassion without judgment.

CONCLUSION

The case report concludes that Borderline Personality Disorder is complex and difficult. The patient's experience shows how emotional dysregulation, self-harm, and dichotomy are linked. BPD is best treated with psychotherapy, especially Dialectical Behaviour Therapy (DBT), which addresses non-suicidal self-harm.

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