

Anticipating suicide act of patient with borderline personality disorder and history of severe depression

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ABSTRACT

Introduction: Suicide as a complication of depression is often caused by two main feelings, helplessness and hopelessness. Patients with borderline personality disorder (BPD) experience these two emotional conditions for a long time in their lifetime, which makes them self-harm quite often. They need another person as a “holding environment”, including their caregiver or doctor. This case study aims to assess how influential the role of medical personnel and pharmacotherapy is on the management of suicide in patients with BPD with a history of major depression.

Case Description: Depression has multifaceted symptoms, including feeling sad, confused thoughts, hopelessness, reduced concentration, loss of interest in doing things, reduced self-esteem and self-confidence, decreased appetite, difficulty breathing, sleeping, contemplating suicide, and eventually attempting suicide. This patient’s dynamics illustrate that suicide is often the last peak of her depressive state, however impulsive she may be with her BPD. The patient experiences a preoccupation with helplessness, that she no longer deserves to live and is no longer able to face the problems she faces. Her meeting with her doctor made her feel recognized that her feelings were valid, and not try to deny what she was feeling. The patient received treatment with fluoxetine 20mg tab and felt that the medicine she was taking was not a “punishment” for her illness, but a way of healing. The patient felt that from the beginning of treatment until now, she admitted that she had never thought about committing suicide again.

Conclusion: The combination of pharmacotherapy with psychotherapy is more effective in anticipating this risk of suicide, and preventing relapse or recurrence of depression, compared to pharmacotherapy or psychotherapy alone.

Keywords: Suicide, depression, holding environment, borderline personality disorder.

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INTRODUCTION

A mental condition known as depression is characterized by lowered mood and negative emotions such as sadness, hopelessness, and lack of enthusiasm. Dysthymic disorder, major depressive disorder, and common emotions of sadness are all types of depression. In some aspects, it is similar to the mourning and lamentation that accompany loss; frequently, there are feelings of low self-worth, guilt, and self-blame, as well as withdrawal from social interactions and physical problems like eating and sleeping disorders.¹

Unless retardation is a dominant symptom, the patient typically displays noticeable tension or restlessness during a serious depressive episode. Suicide is a genuine risk, especially in certain extreme cases, and loss of self-worth and feelings

of worthlessness can be devastating. The assumption here is that somatic syndromes are almost always present in major depressive episodes.² Unless retardation is a dominant symptom, the patient typically displays noticeable tension or restlessness during a serious depressive episode. Suicide is a genuine risk, especially in certain extreme cases, and loss of self-worth and feelings of worthlessness can be devastating. It is from these negative feelings that harmful thoughts can arise; Suicide is one of the effects. One of the mental illnesses that are prone to afflict anyone is caused by even small things: emotional violence, physical violence, bullying, feeling down, and so on. The most common impact of depression is self-harm and eventually suicide. The use of specific pharmacotherapy roughly doubles the chance for a depressed patient to recover within 1 month. All available

antidepressants may take 3 to 4 weeks to show a significant therapeutic effect, although they may also show their effect earlier. The choice of antidepressant is determined based on the side effect profile and the patient’s physical status, character, and lifestyle. A wide variety of classes of antidepressants are available, with different mechanisms of action. Newer substances have made depression therapy more patient- and clinician-friendly, even if the initial antidepressants, monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants (TCAs), are still in use.³

Borderline Personality Disorder is a personality trait that has a persistent, long-lasting pattern related to the environment and oneself that appears in social and personal life. These characteristics can turn into a personality disorder if they become rigid, and difficult to adjust so that there is impairment in social, and work functions

and causes suffering. Personality disorders can be recognized in adolescence, become more pronounced as adults, and then become less pronounced with age.⁴

Everyone has different symptoms of depressive disorder depending on the severity of the symptoms experienced. A person's thought patterns, feelings, behavior, and physical health are usually affected by the depression they experience. Patients with depressive disorders often have such complaints as in the digestive system and pain in parts or the whole body. Most of the complaints they experience are due to the great anxiety and stress associated with their depressive disorder. Symptoms that appear can be divided into those related to changes in thinking, feeling and behavior.⁵ Suicide is the last effect of major depression, because usually at this point the perpetrator has found that she no longer deserves to live and is no longer able to face the problems she faces.³ This case study aims to assess how influential the role of medical personnel and pharmacotherapy on the management of suicide in patients with BPD with a history of major depression.

CASE REPORT

This case study was appointed based on the examination of outpatients who had previously been treated at Hospital B Surabaya since 2004 and had been treated for 2 years at Hospital A and performed anamnesis and examination with the patient's consent, Informed consent in this case is based on expressed consent, which is based discuss directly before carrying out the examination and the patient immediately agrees. In this case, only autoanamnesis was performed because the patient was not accompanied by her family.

The third edition of the pocketbook on the diagnosis of mental diseases (Pedoman Penggolongan dan Diagnosis Gangguan Jiwa, or PPDGJ-III), as well as books and journals that were referenced in the literature review, are used in the procedure of establishing the diagnosis and discussion.

Course of Illness

A female patient, 38 years old, medium stature, age-appropriate face, patient in

a neat dress with a brown top and jeans carrying a bag, admitted that she came herself to the hospital for routine health check-ups. She was calm and cooperative. When asked for the name, the place of the patient's date of birth, she could answer, the patient knew it was noon and also knew she was at Hospital A. The patient remembers coming to the hospital alone by using a green microbus. The patient admitted that in the last two years she had regular monthly check-ups with doctors at Hospital A.

This patient suffered from severe episodes of depression and has a borderline personality disorder. She has been receiving regular treatment since 2002 but it is not explained specifically in a month. Her current condition was not restless, came to the clinic without any complaints. The first time she was treated in the Hospital B because she was stressed out and had attempted suicide by scratching and slicing her own body with a knife. The thing that triggered the patients was that she admits that her boyfriend broke up with her who has been dating for a long time since the beginning of high school and broke up when she graduated in 2002.

The patient admitted that after the incident she felt hopeless, sluggish, lacked enthusiasm for life, reduced self-esteem and self-confidence, had time to sleep, had a high sense of worry, was difficult to focus, emotionally unstable, anxious, felt useless, and sad, to the point of not being able to eat, the only thing in her mind is her boyfriend, there is a feeling the patient wants to end her life alone.

So, since 2002 ago the patient has been undergoing treatment in the psychiatric outpatient unit of the Hospital B. The patient admitted that if she ran out of medicine, the patient would be moody, difficult to sleep, and restless, especially if she added that the patient liked to remember the past, although she admitted that this rarely happened.

The patient likes to find her own business and is happy with her work life which still persists until now. The patient prefers to vent her sadness by working and doing worship, she admits, just doing positive things rather than having to sink.

When asked when the last time she felt sad because of the past was, the patient

admitted that she had relapsed 2-3 years ago. At that time, the doctor in charge at the Hospital B advised the patient to move to Hospital A, the patient finally moved to Hospital A at the psychiatric outpatient clinic with Dr. A in 2019.

History of Treatment

Current patient treatment was using fluoxetine 20mg once daily since the last 2 years. She felt secure and comfortable with the drugs given by Dr. A. She routinely checks every month and don't want to run out of drugs. She claimed to be happy when examined by Dr. A as she can vent and talk more. The patient claimed that she was happy and felt calm when she did prayer, as Dr. A and all staffs in Hospital A were God's answer for her prayer. The patient's current condition is very good, not restless; there is no movement full of worries or feelings of sadness. The patient claimed to come only for control without any complaints.

A 50% likelihood of recovery within the first year exists for patients who are admitted to the hospital right away for the initial episode of major depressive disorder, like this patient.

Within the first six months following hospital discharge, 25 percent of patients experience a relapse of major depressive disorder; within two years, 30 to 50 percent; and within five years, 50 to 75%.³ This patient has a 50% - 70% percentage of recovering because in the first episode the patient was taken to the hospital and did not experience a relapse like the first episode when 5 years after being discharged.

The patient has been on outpatient treatment for 19 years, since 2002 until 2019 at Hospital B plus the last 2 years at Hospital A, the patient admitted that the last 2 years felt that the medicine was more suitable because of the minimal side effects and the therapist who could make him relieved when she vented. There is no data regarding the patient's subsequent treatment history regarding the therapist and also the type of drug used; only the patient admitted that she did not routinely control and was not diligent in taking medication at that time, so that in 2009 and 2019 the patient admitted that she had relapsed.

DISCUSSION

According to Rice PL, 1992, patients with depression will cause prolonged emotional conditions that harmful thoughts can arise; suicide is one of the effects. As mentioned by Kaplan, 2010, psychosocial factors that influence depression include: life events, repeated failure, and social support. Kane, 1999 also mentions that depression also occurs due to the inability to have intimate relationships, loneliness, and separation. In accordance with what this patient admitted, she had experienced hopelessness and loneliness due to repeated failures in dating. It triggered her to think that she had no way to continue living, and committed suicide.³

Suicide is the last effect of major depression because at this point the patient has found no reason to live; for who and what for.³ In the other side, associated with major depression, repeated behaviors of self-harm, such as suicide attempts, self-mutilation, and physical fights are the main characteristics of BPD. The inability to maintain social relationships is also one of the causes of BPD patients' failure in dating. This may result that the patient feeling rejected or abandoned.⁴ This loneliness-threat-rejection cycle is also what makes the partner of BPD patients feel trapped in an unhealthy relationship.⁶

Suicide desire in this patient first occurred because the patient felt she could not live without her ex-boyfriend anymore, felt hopeless and couldn't do anything else, after she felt sad, powerless, and cried, during the initial months she admitted she often attempted suicide, even claimed to feel happy when her hand was injured and bleeding. The patient often wanted to commit suicide even though she was under treatment for about the last 17 years, especially when she felt lonely after remembering her ex-boyfriend.

Diagnostic challenges on this case are follow-up access beside routine control, when the patient is asked to be followed up by phone, the patient says that he does not need to give a phone number because as long as he doesn't run out of medicine he will feel safe.

A chronic feeling of emptiness is described as a deep feeling in the stomach or chest. This is not boredom and is often associated with loneliness.

Psychodynamically the patient tries to eliminate the feeling of emptiness by filling her room with a love object (boyfriend), so that she feels warm and comfortable. This explains the reason the patient enjoyed when she was with Dr. A. She transferred the dependence of the object of love to Dr. A, and by the attitude of Dr. A she felt welcome. Therapists/doctors should act as a holding environment as mentioned by Winnicott, then slow but sure weaning the patient after she reached the therapeutic goals.⁷

Although the FDA notes that fluoxetine can increase the risk of suicidal ideation, some studies show fluoxetine controls suicide risk by up to 50-60%.⁸⁻¹⁰ This is the reason why fluoxetine is still used as a first-line antidepressant, combined with psychotherapy. Apparently, this antidepressant effect becomes more suggestive for patients when Dr. A is able to be a "holding environment" for the patient.

The limitations of this study are that it does not explain the follow-up of patients and the outcomes obtained and does not explain the patient's condition every time after administering therapy or management.

CONCLUSION

Depressed episodes in BPD patients require long-term therapy in order to reduce relapse or recurrence. To anticipate suicide attempts, several therapeutic modalities can be used. The combination of pharmacotherapy with psychotherapy is more effective in anticipating this risk of suicide and preventing relapse or recurrence of depression, compared to pharmacotherapy or psychotherapy alone. Further research with different study designs and sample sizes is needed to find out more about other factors that influence the anticipating suicide act of patients with borderline personality disorder and a history of severe depression.

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AUTHOR CONTRIBUTION

All authors contributed to this study's conception, data collection and interpretation, article drafting, critical revision, final approval of the article.

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CONFLICT OF INTEREST

There is no conflict of interest for this manuscript.

ETHICAL CONSIDERATION

Not applicable.

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