Key Words: borderline personality, self-injury

Borderline Personality Disorder and Self-Injurious Behaviours—*Attention-Seeking or Attachment-Seeking?* Psychopharmacological Considerations

By Ahmed Naguy

ABSTRACT *~ High rates of both suicidality and NSSI in individuals with BPD indicate the severity of the distress experienced by many of those diagnosed. It behoves clinicians to delve into the many disparate determinants these behaviours might subserve, in order to inform tailored and effective treatment decisions.* Psychopharmacology Bulletin. *2025;55(2):75–79.*

Borderline personality disorder (BPD) is common both in general population and clinical settings. It affects about 1–2% of the general population—up to 6% in primary care settings, 10% of psychiatric outpatients, and 20% of inpatient. Characterized by *stable instability*, the hallmark of BPD has been analytically described as *object hunger* and *affective amnesia*.[1]

BPD has been always thought of as an *ominous* and *stigmatizing* diagnosis.

Borderline pathology is believed to be rooted in the rapprochement subphase of Mahler's separation-individuation developmental theory. Accordingly, these individuals with vacillating views of both self and others exhibit *insecure* and *disorganized attachment styles* reflecting a childhood marked by *erratic* and *inconsistent caregiving*. In the same vein, BPD individuals with disorganized attachment style have showed *lower* plasma oxytocin compared to those BPD patients with organized attachment style. Moreover, those with disorganized style showed *increased* amygdala activation as measured by fMRI in response to Adult Attachment Projective Picture System.[2]

A complex model of borderline psychopathology best describes BPD.[3] This model comprises *acute* and *temperamental* symptoms. Acute symptoms resolve relatively quickly, are the best marker of disorder, and are often the immediate

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reasons for hospitalization. These include *self-injurious behaviours* (SIBs). Temperamental symptoms, in contrast, tend to resolve more slowly, are non-specific to BPD, but tied to ongoing psychosocial impairment. These include *emotional mendicancy* and *abandonment neurosis*.

Suicidality and parasuicidality (repeated self-injury) in BPD are commonplace.[4] However, parasuicidality has an entirely different pattern and purpose. It is estimated that circa 90% of BPD attempt suicide and 10% have completed suicide. Difficulty arises as suicidality in BPD might stem out of *impulsivity*, is generally *unpredictable*, constitutes part of *chronic maladaptive self-destructive* behaviour in face of negative affectivity, or might be related to *comorbidity*. A pitfall commonly on part of clinicians is to trivialize and dismiss these demeanours as a pantomime of 'suicide' imbued with a sense of manipulation.

Individuals with BPD complete suicide more often than individuals in general population. They might account for circa 9–33% of all *completed* suicides. The rate at which individuals with BPD complete suicide is estimated at 50 times greater than general population. Rates of nonsuicidal self-injury (NSSI) in BPD are also pretty high ~ 90%. Taken together, the high rates of both suicidality and NSSI in individuals with BPD indicate the severity of the distress experienced by many of those diagnosed. It behoves clinicians to delve into the many disparate determinants these behaviours might subserve.[5] These include, inter alia-

Antisuicide-at times, patients resort to SIBs in lieu of drastic suicidality.

Prosuicide-this is more typical, where parasuicidality is a presage of suicidality.

Assertion of Agency-when patients with BPD feel they are more 'real' or 'alive' with self-cutting

Atonement for Shame-might reflect a masochistic tendency or else, aggression turning onto self; expiation when guilt-ridden

Biological Underpinnings-through release of endorphins that reinforce these behaviours and hence possible role of naltrexone (an opiate antagonist) as psychopharmacotherapy

Control of Dissociation-to feel more 'real'

Control of Others-for manipulation and secondary interpersonal gain

Communication-albeit ineffective, these might subserve a 'cry for help'

Regulation of Negative Affectivity-maladaptive coping to ward off anxiety, dysphoria, or abandonment neurosis

Repair of Faulty Boundaries-in case of dysfunctional family dynamics which dictates a referral to family therapy

Resolving Conflict over Sexuality-with ambivalence over orientation for instance

Redirected Social Aggression
Sensation Seeking–for those with 'hypo'-arousal
Werther Effect–'copycat' effect

Neurobiologically,[6] SIBs can be categorized into *Major* (most dramatic, life-threatening and mediated by opiates), *Psychotic* (mediated by dopamine), *Stereotypic*, *Compulsive* (mostly serotonergic) and *Impulsive* (noradrenergic). Although there is no general consensus on this typology but it might inform tailored pharmacotherapy based on clinical phenomenology (e.g. naltrexone for major type, antipsychotics for psychotic type, SSRIs for compulsive type and so forth)

Role of psychopharmacotherapy[7] can span *different BPD symptom domains* of *impulsivity/anger dyscontrol*, *affective dysregulation*, *interpersonal psychopathology*, and, *cognitive-perceptual* domains. There was a shift in clinical practice from reliance on selective serotonin reuptake inhibitors (SSRIs) to *mood-stabilizers* and low-dose *atypical antipsychotics*—which is currently the state-of-art. Most beneficial effects were found for the mood stabilisers *topiramate, lamotrigine* and *valproate semisodium*, and the second-generation antipsychotics *aripiprazole* and *olanzapine.* Psychopharmacotherapy is also typically indicated for bona fide *comorbidities*[8] which are the rule rather than the exception including mood (88%), anxiety (71–83%), substance use disorder (50–65%), attention-deficit/hyperactivity disorder, PTSD, eating disorders (17–26%), and, other personality disorders. Psychopharmacotherapy might also *facilitate the engagement* of clients into therapy, *bolster ego-strength*, and *hasten recovery process*. *Polypharmacy* is ubiquitous with nearly 36% on 3 drugs, 19% on 4 drugs, and 7% on 5 or more drugs! Although no single drug can bring about a remission, it still can 'take the edge off' symptoms. Interestingly, a recent systematic review from Australia suggested a potential for *clozapine* in treating *severe refractory* cases of BPD especially those at high risk for suicide and repeated hospitalizations.[9] Also of note, Omega-3 fatty acids have demonstrated improvements in depressive symptoms, aggressive behaviours, impulsivity, anger, and self-injury.[10] Through a psychodynamic lens, medications might function for some patients with BPD as *transitional objects* creating a feeling of security and a strong emotional attachment. (Naguy, personal communication). Some caveats regarded psychopharmacotherapy in BPD are depicted in Table 1.

Dialectical behavioural therapy (DBT) is an empirically derived treatment for parasuicide, including self-mutilation, and other characteristic behaviours associated with BPD. It is humane and incorporates a biosocial perspective, acknowledging the powerful role of the environment in the aetiology and maintenance of these often

TABLE 1

Caveats for Psychopharmacotherapy in BPD

Tease apart comorbidities and differentials (TR depression, bipolar II, PTSD, SUD)

Response to meds is at best modest and patients with BPD are quite sensitive to side effects

Given limitations of effectiveness of meds, patients should remain in therapy

Adherence and adequate duration of trial

Prescription is probably a trial-and-error process

Use of meds as firstline or solo is not supported by current evidence

Use of antidepressants in BPD (barring comorbid MDD) has fallen out of favour. Anti-epileptic moodstabilizers may reduce irritability/aggressivity. Atypical antipsychotic may have a role in reducing impulsivity/cognitive distortions.

Polypharmacy is a common prescription trap. Resist urge to make medication change/adjustment with every (catathymic) crisis. Avoid PRN use of meds (esp. BDZs). Make one change at a time. Have a time-bound symptom-targeted plan and reassess the need for ongoing psychpharma that should be always adjunctive to therapy

longstanding behavioural patterns.[11] Other therapeutic modalities,[12] such as *mentalization-based* (MBT), *transference-, schema-focused*, and *cognitive-analytic* therapies have supported evidence of utility in BPD as well. ✤

Disclosures

Author declares no competing interests or financial affiliations.

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