

Non-Suicidal Self Injury and Suicidal Behaviour in Borderline Personality Disorders

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Introduction

Non-suicidal self injury (NSSI) and suicidal behavior are not an uncommon presentation in the patients with borderline personality disorder (BPD). Presence of self harm causes poor treatment outcome and often required emergency admissions and clinical observation in BPD. NSSI is most commonly described as the direct and deliberate destruction or alteration of body tissue without conscious suicidal intent, such as deliberately cutting or burning of the skin. Approximately 13.0 to 23.2% of individuals in the general population are estimated to have a history of NSSI.

NSSI was previously considered as a symptom of BPD and a continuum of self-harm in a place of lesser severity than suicide attempts. Very few studies have looked into the relationship between NSSI and suicide attempts among patients with BPD. It was reported that nearly half of female patients with history of NSSI also had met criteria for a diagnosis of BPD^[1]. In fact, BPD symptom severity has also been associated with higher frequency of NSSI^[2].

At the same time, NSSI is a significant predictor of subsequent NSSI and risk of subsequent suicide attempts^[3]. Research suggests that as compared to individuals without a history of NSSI, individuals with a history of NSSI were over nine times more likely to report suicide attempts; seven times more likely to report a suicide gesture; and, nearly six times more likely to report a suicide plan^[4].

There have been various proposed theories regarding the addicted nature of NSSI. The interpersonal-psychological theory of attempted and completed suicide theorizes that NSSI may habituate an individual to physical and emotional pain and to the very act of self-injury^[5-7]. Joiner and colleagues^[6] suggest that the frequency of NSSI episodes might be more important for predicting suicide than the mere presence of NSSI because, the more the number of NSSI episodes an individual engages in, the more is the opportunity for habituation to physical and emotional pain, and to acquire the ability to self-injure, and thereby this behavior puts the individual to a greater risk of suicide in future.

Role of endogenous opioids system has also been proposed as underlining biological mechanism for addictive nature of NSSI. People with NSSI may have chronic low level of endogenous opioids. Low level of opioids may result from a history of abuse, trauma or neglect or may be biologically endowed through other processes^[8]. These people via NSSI restore their endorphins at normal level which results in a feeling of pleasure and relief from negative emotions. Repeated activation of opioids system may lead to a tolerance effect, which makes them less sensitive to pain while self-injuring over time^[9,10].

There is also evidence of a distinction between NSSI and suicidal behavior as well as NSSI and BPD. There has been a misconception about relevance of NSSI as an independent distinct diagnostic category in the absence of BPD. Many studies have found that NSSI is characterized with high level of depressive symptoms, anxiety, suicidality, emotion dysregulation, loneliness and low functioning^[11,12]. In fact, NSSI is its own a distinct diagnostic category which has been included in the Diagnostic and Statistical Manual of Mental Disorders - 5 (5th ed.; DSM-5; American Psychiatric Association)^[13].

Existing literature suggests that NSSI is often found to co-exist with BPD and frequency of NSSI is also associated with risk of future suicide attempts. It is important for clinicians to use NSSI as a distinct diagnostic category in their clinical practice to delineate various functions of NSSI. It is also clinically vital for early detection and appropriate psychological interventions for presence of NSSI in BPD to prevent future suicidal risk and improving the outcome of BPD.



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