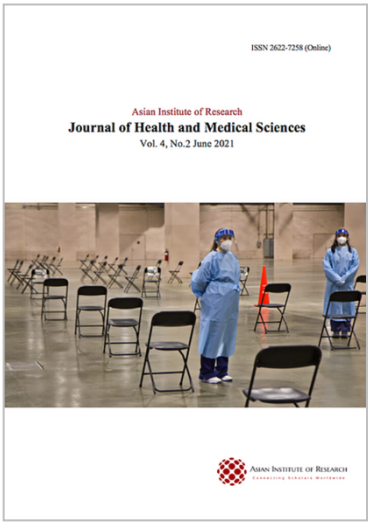

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Borderline Personality Disorder with Paranoid Features

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Abstract
This paper aims to evaluate the current and dynamic profile of a 19-year-old with Borderline Personality Disorder (BPD) with paranoid features. The case allows us to detect how the symptoms associated with BPD evolve on a background of poor management of potentially stressful events. There is a Borderline personality structure with obvious paranoid features, which pushes the patient into dysfunctional behaviors, aggressive acts and suicidal tendencies, the patient's instability, chaotic sexuality, addictive and self-harming behavior being observed. There are elements specific to an antisocial personality with narcissistic notes, which highlight impulsive and manipulative tendencies, accompanied by recurrent conflicts and delinquency. The clinical picture of axis II pathology is highlighted, an accentuated aspect being represented by the deficient defense mechanisms, which prevent the integration of the events in an adequate way. Considering the patient's self-destructive behaviors, impulsiveness, and multiple addictions, in the absence of appropriate treatment, psychotherapy, and/or pharmacological treatment, several future complications may occur, including risks of future problems with the law, self-destructive behaviors, and suicide attempts.

Keywords: Borderline, Impulsivity, Self-Destructive Behavior, Addictions

1. Introduction

Although it was initially considered a variant spectrum of disorders such as schizophrenia, Major depressive disorder, and Post-traumatic stress disorder [Gunderson, Weinberg & Choi-Kain, 2013], borderline personality is currently presented as one of the most troubling problems in psychiatry and is characterized by emotional turmoil and chronic suicidality [Sayrs & Whiteside, 2006].

Regarding the prevalence of borderline personality disorder, it is approximately 4% in the community but up to 20% in many psychiatric clinical populations and is characterized by significant morbidity [Kernberg & Michels, 2009]. Both the recognition of the benign course of the disorder and the emergence of relatively effective psychosocial interventions that accelerate the rate of improvement have led to progress in understanding borderline personality disorder [Fonagy & Bateman, 2006].

The patients with PBD are usually hospitalized after suicide attempts or based on the risk of suicide or danger to others, the severity of symptoms, difficulty with self-care, and non-compliance with treatment [Pascual, Córcoles, Castaño et al, 2007].
Borderline personality disorder is a diagnosis that must be treated with caution especially regarding the severity of the symptoms. The BPD patients have higher lifetime rates of sexually transmitted infections and medical problems and a greater risk for future health problems through the earlier onset of smoking, higher rates of nicotine dependence, and other forms of substance abuse or dependence than other patients with personality disorders [Chanen, Jovev & Jackson, 2007].

Patients with BPD are characterized by hypersensitivity to rejection and preset a fearful preoccupation with expected abandonment, this type of patients feel that their lives are not worth living unless they have a connection with someone who cares for them, but often the idealization can dramatically shift to devaluation when the patients feel rejected [Gunderson, 2011].

The child with borderline tendencies has a genetically based hypersensitivity to interpersonal interactions and this can interact with adverse early caretaking experiences and later stressors and can lead to disorganized and controlling interpersonal strategies, seeming that an important factor in the development of BPD is the disorganized parent-child relationships or the distress caused by separations, which are likely to represent early components that increase the likelihood of BPD [Gunerson & Lyons-Ruth, 2008].

1.1 Family data

The father is an alcoholic, addicted to gambling, aggressive, and an instigator of quarrels. He resigned from his job as a locksmith because the boy's mother was earning enough money for them to have a good life. He is a negative influence on V, drawing him into the area of gambling and alcohol consumption.

The mother is a secretary. In V's childhood, she used to be severe and put a lot of emphasis on school and education. Now she is very permissive and V has a very open relationship with her.

His grandfather is the one who raised him until he was 7 years old. He started a conflict with V's parents because of the boy's desire to stay with his grandfather and not move with his parents to Bucharest.

V is 19 years old and is a high school student in the 12th grade. He is a single child and lives with his parents. He was raised by his grandfather until the age of 7, until the family decided to come to Bucharest, despite his desire to stay with his grandfather.

In 2006, in the first grade, for the first time, he started to be very aggressive. He destroyed objects in the classroom, but without hurting other people, out of the desire to return to his grandfather. "Until then I was never violent." This incident led to his hospitalization for 2-3 weeks, receiving the diagnosis of Attention deficit hyperactivity disorder (ADHD) and Oppositional defiant disorder (ODD) at 7 years old. It has been observed that higher levels of ADHD and ODD at age 8 predict higher levels of BPD symptoms at age 14 [Stepp, Burke, Hipwell & Locher, 2012]. Considering this aspect, the diagnosis of oppositional disorder may be a precursor to the specific manifestations of borderline disorder that appeared in V's adolescence.

Because he wanted to stay with his grandfather despite his parent's decision, V became very aggressive and agitated in class. Because of that he's father was forced to supervise him in school, at the request of the school management, but this was not helpful for V, especially since as soon as he got home he was surrounded by conflicts, quarrels, swearing, aggressive behaviors, or, when the father was at gambling or at the bar, he had to stay home with his mother, who was "obsessed with homework." Early separation has been linked to BPD in children and adolescents with associations found, also, between BPD in adults and early separations based on retrospectively reported data. The BPD symptoms are higher on average among children with early separations, also, the BPD symptoms decline at significantly slower rates for these children compared to the young people without early separations [Crawfors, Cohen, Chen et al, 2009].

In 5th grade, he had to move to another school because of his disciplinary misconduct and negative influence on other children. "I always had something to object." "I had the power to influence others, I was told that I was ruining the class." V claims that he was never interested in school and considered it useless "The educational system is flawed, the school does not focus on people, personal development, spirituality, does not focus on what matters," and this determined him to behave inappropriately in class.

In his first year of high school, he was turned down and mocked in front of the class by two girls he liked, which "hurt him deeply" and this led him to change and document about personal development, to read books, and to attend various courses. "I started looking for personal development sites on the internet, at 15 I learned how to talk to girls." After that, he got into a relationship with M, "I went to the most beautiful girl in the class, I said that she would be mine and things happened as I said." Due to the frequent quarrels and the mismatch between the two, the relationship ended shortly after, leading to V's first suicide attempt.

At the age of 17, because his father introduced him to gambling, he started developing an addiction to such games. "I had a passion and a psychological dependence on the game, the inability to control my impulse to play." The patient claims that gambling was a way to escape the quarrels and conflicts around him, being a way of disconnection and intense experience. "It's about the disconnection that gambling offers, it stops your mind and you feel that you are alive, you live the moment intensely."

At the age of 16, he began a very intense relationship with G, which lasted 2 years. Due to disagreements between V and the girl's father, the relationship ended with a restraining order for V. This separation led to a new suicide attempt, so the restraining order was followed by an involuntary psychiatric hospitalization order requested by the girl's father.

At the age of 19, he decided to continue his studies, wanting to take the baccalaureate and finally to go to Law school. He was also claiming that he no longer kept in touch with G since the issuance of the restraining order, and accepted the breakup "I don't even miss her anymore, I already have experiences with other girls."

1.2 Psychiatric history

His first symptoms appeared at the age of 7, in 2006, following the violent episode at school in which he was very aggressive, an event that led to his hospitalization for 2-3 weeks, receiving the diagnosis of ADHD and ODD, a diagnosis that now, V accepts to be true. "I think I had ADHD, I did not accept the things that were imposed on me from the external environment."

The first hospitalization in psychiatry took place in 2015, when V was 16 years old, being diagnosed with Bipolar Affective Disorder. The hospitalization took place after the separation from M and V's suicide attempt, on a background of alcohol consumption of "400 ml of vodka in 3 minutes." He tried to jump off the building where the girl lived, as a result of not accepting their separation and her refusal to resume the relationship. "I told her that I will jump off the building because of my inability to accept the separation." V claims that the separation between the two took place due to frequent quarrels, reproaches and "due to unconsciousness, attachment and the dysfunction that led to a love-hate relationship," as well as V's failure to know when to accept the end of the relationship, which he considers to have originated in the attachment traumas from his childhood. "Because of my inability to know when to end things, I think it's because of the attachment traumas.". V confesses that his climb on the building was a subtle way of blackmail to make M reconcile with him "It was a manipulation in all its splendor, an unconscious manipulation." During the hospitalization, V refused to take the medication prescribed to him, he left the hospital after 2-3 days, without giving any importance to the diagnosis.

The second psychiatric hospitalization took place in 2017, at the age of 18, following the separation from the last partner, after a relationship of approximately 2 years. He was hospitalized by court order for temporary involuntary hospitalization until recovery or until the elimination of any state of danger, and he was diagnosed with BPD.

At the age of 16, V began a relationship with G. Their sexual intercourse used to take place anytime and anywhere. "I was just sleeping, talking to her and having sex all day." Also, sex and sexual activities such as messages and pornographic language were the main activity of the couple. Due to the restrictions imposed by the girl's father, the meetings between them were limited to short encounters and sexual intercourses, which displeased V, who wanted to spend even more time with G. “I noticed that I had sex at my discretion, affection, things couldn't be better than that. The big problem was that we couldn't go out too much, we just had sex." "I put a lot of psychological pressure on her to get more freedom." This determined G to stop listening to her father, which led him to start a civil lawsuit to obtain a restraining order so that V can no longer approach his daughter. Despite the restraining order, V tried to meet with G, thus violating this order on the first day of the issue, because he could not accept the separation between them, “I violated the restraining order because I love her and want to go to prison.” V filed an appeal to have the restraining order annulled, but lost the civil lawsuit. "I appealed the restraining order just to fight with her father, at least to take his money because I knew he was paying a lawyer."

As a result of the separation, in December 2017, a series of suicidal tendencies and self-destructive behaviors were triggered. He cut his wrists very badly, stopped eating, self-mutilated, and took 84 paracetamol pills, behaviors performed because of "pure suffering and despair."

A second case was opened in V's name for involuntary hospitalization in psychiatry but the patient decided to appeal not to be hospitalized, knowing, however, that this appeal did not suspend the execution, making this gesture out of a conscious desire to aggravate the situation of the father. "My macabre satisfaction was to make those people walk more.”

Before arriving at the hospital, a violent incident took place with the girl's father, on a background of alcohol consumption. "I drank almost a liter of vodka," thus he got close to the girl's house and started an argument with her father. I thought I'd make another joke and be evil and slick. I stalked her father, I cursed him a little to make me feel better, he got out of the car, put his hand in my throat and we started a fight. He didn't hit me, but I punched him." Because of this event, there is a risk of opening a new case for acts of violence, but the patient does not attach importance to this aspect. He asked to represent himself in the appeal and managed to win the appeal for involuntary hospitalization, being allowed to leave the hospital "I know I'm selfish and tough, but I'm glad I kind of beat him. Based on the hospital ticket I can no longer be hospitalized.”

2. Method

An examination of the current mental state was made.

Activity: he has a fluctuating functioning, both with moments of alteration of the activity caused by the alcohol consumption “I couldn't stand up anymore,” and with moments of depressive states that prevent him from carrying out his activities in an optimal way.

Disease awareness: the patient has minimal confidence in the diagnosis received and presents non-compliance with the prescribed treatment "Diagnosis that turned out not to be true." "My problem is the only problem of humanity, namely unconsciousness."

Willpower: he has plans for the future in the professional field and he has achievable goals "I do not go to college this year, I want to study law, to enter the first places, especially since I already have experience."

Affectivity: the predominantly observed feelings are those of anger, shame, and sadness, the emotional tone of the discussion is consistent with his stories.

Thinking: the patient has organized thinking, showing logical, coherent reasoning, noting the tendency to philosophize. Concerns for fairness and law enforcement are noted.

The language: he is coherent, the discussion is fluid, the answers provided contain details and the spontaneous discourse is rich. It is observed that he chooses carefully his way of expression and he uses an intellectual language “I want the inalienability of freedom.” "Identification with an external source of psychological gratification."

Attention: he can concentrate and sustain the speech throughout the discussion, managing to stay attentively connected to the situation.

Social functioning: social functioning is disrupted by behaviors specific to an antisocial personality, characterized by breaking the law, violence, irresponsibility. Paranoid traits are manifested socially through the fixation for injustice, being in a constant fight with the system.

Appearance and behavior: it has a neat, clean appearance, being noticed the concern for the external appearance and the presented image. The behavior is consistent with the appearance, he has controlled gestures, which denotes care for the appearance of a pleasant image.

Attitude: he shows an attitude of superiority, nuanced by charisma and good self-control.

Instincts: an exacerbation of sexual instincts can be observed. The patient manifests impulsiveness in his sexual desire and sexual intercourse. Also, an accentuated self-defense instinct can be observed, manifested on a physical level through repeated conflicts with the father of the former partner, as well as on a moral level, the patient refusing to be represented by a lawyer and chooses to defend himself in court. In his depressive episodes, a disturbed eating pattern is observed, the patient refusing the consumption of food.

3. Results

In V currently has a cluster B, dramatic-emotional disorder, and was diagnosed at his second hospitalization with Borderline personality disorder. Borderline personality disorder is characterized by instability, impulsivity, chaotic sexuality, suicidal acts, self-mutilation, identity problems, and feelings of emptiness and boredom [Kaplan & Sadock, 2001].

V presented a series of self-destructive gestures and acts and suicidal tendencies which has been present in multiple situations: he climbed the building after excessive alcohol consumption after breaking up with M, he took 84 pills and tried to commit suicide by cutting his wrist after the end of the relationship with the second partner.

As time passed, his tendencies of hyper dependence and excessive demands were more predominant [Predescu, 1989]. "I wanted to spend time with her, I put psychological pressure on her to spend time together, my mind wanted even more than that."

He showed excessive impulsiveness that was observed in several areas of his life: he spent excessive amounts of money on gambling, alcohol, and food; he abused alcohol. "I had a problem with alcohol, I drank 400 ml daily, I drank everything I had," and presented impulsivity in relationships and sexual intercourses. "I had sex in an apartment building." "I was sleeping, talking to G and having sex all day."

He presented emotional instability due to the marked reactivity of the mood. He had depressive episodes for several days in which he refused to get out of bed, eat, and had suicidal tendencies and self-mutilating behaviors. Also, he showed ruminant tendencies. "What brings me to extreme situations is the identification with an external source of psychological gratification, and when there is a risk of loss or change, the thoughts generate a great resistance, which creates emotions, which create thoughts that never end.”

V's efforts to avoid real or imaginary abandonment could be observed, which he considered having originated in the attachment traumas. "I could not accept this separation" ; ”We broke up because of my inability to know when to end things, I think it's because of the attachment trauma"

V's relationships were characterized by instability. He had very intense and unstable interpersonal relationships, characterized by countless quarrels, conflicts, reproaches. Also, he presented manipulative tendencies in interpersonal relationships, highlighted by his climbing on the building to force M to reconcile with him, and by the pressure put on G to spend more time together and to not listen to her father.
Given the classification made by Grinker, V falls into group IV -neurotic border- characterized by narcissism, this aspect being accentuated by his tendency to establish hyper-dependent and difficult relationships [Predescu, 1989]. He could not tolerate being alone, and showed identity disturbances, which were the most present when he was not involved in a relationship. "I seek gratification through a relationship with someone else and when this identification is broken, my identity no longer exists. Who am I without her?"

He repeatedly demonstrated the feeling of emptiness and chronic boredom that he could only remove it by engaging in high-intensity, high-risk situations: gambling. "It's about disconnection gambling offers, it stops your mind and you really live, you live the moment intensely," intense relationships. "I seek gratification through a relationship with someone else," going to the courts, because of the legal issues about which he stated that, "they are a pleasure, these experiences seem to be something out of the ordinary," seeming that all these events gave him a feeling of pleasure and intense experience.

In many situations could be observed both inadequate anger and inability to control this nervousness that appeared at an early age, marked by the episode of aggression from 7 years old that required his hospitalization. V frequently engaged in inappropriate behaviors at school, interrupted classes, was dissatisfied with the "defective" educational system that did not allow him to assert himself and restricted his freedom. "I want the inalienability of freedom," and he actively sought conflicts with G's father, eventually resulting in physical violence.

V manifested aspects of paranoid personality disorder (bizarre-eccentric cluster A). In psychiatric nosology, DSM-IV and V describe PPD as a disorder with suspicious and ruminative traits, ICD-10 PPD including traits of excessive importance and hostility [Lee, 2017]. V was distrustful of the last partner's family, their motivations being interpreted as malicious, and he was looking for signs that confirmed the idea of threat. "I am not the universe, but I admit that their desire to hurt me seemed too exaggerated, I wanted to hurt them."

V had notes of suspicion, he perceived attacks on his reputation, which were not visible to others, and tried to counterattack. "I know I'm selfish and tough, I'm glad I kind of defeated him. Based on the hospital ticket, I can no longer be hospitalized." V showed irritability and hostility towards the former partner's family and the court proceedings, and manifested hypervigilance throughout them. "I appealed the restraining order just to fight with her father, at least to take his money because I knew he was paying a lawyer." He showed permanent tension, pursued his personal goals, and manifested the ability to logically present his arguments even in situations with increased importance. "At the moment I can't stop, because there are still some appearances at the court, but I don't mind."

In V's case, the paranoid side stood out very well and was highlighted by his fixation on fairness and injustice. He was interested in law, was in a continuous battle with the system, found pleasure in the courts, and expressed his desire for others to set the limit. "I would have stopped at any time if only the girl dared to tell me to stop."

There was also a series of actions specific to a personality with antisocial tendencies (cluster B), who was in constant conflict with society, was selfish, irresponsible, and lacked compassion. He was repeatedly impulsive and unable to feel guilt or learn from his experiences, coupled with a low level of tolerance for frustration and a tendency to blame others [Kaplan & Sadock, 2001].

V expressed non-compliance with social norms regarding his behaviors within the law, indicated by both the violation of the restraining order submitted by the family of his former partner. "I violated the restraining order, I do not see anything serious." "I told her I love her and I want to go to prison," as well as the possibility to open a third case in court for acts of violence. He showed signs of irritability and aggression, indicated by physical attacks during the misunderstanding with G's father, thus impulsively ignored his own safety and that of those involved: "He did not hit me, but I punched him."

V showed persistent irresponsibility, which was indicated by the repeated inability to maintain a regular work behavior, an aspect manifested at the end of the 11th grade when he had to transfer to another high school to avoid the negative consequences of this behavior “I had 82 absences,” “I was laughing at people, I'm not at school because I want to, but because I have to, that's why I am objecting, that's why I am doing it.”

There was a lack of remorse and sensitivity towards other people, which could be seen in the way he referred to the beginning of his former relationship and in the repeated appeals brought in court. “I wanted to see if I could get to bed with this young lady as well. It was something selfish on my part, she was attracted to me and I wasn't interested.”

The evidence of conduct disorder began before the age of 15 and was present in the incident that led to the first hospitalization, at the age of 7, in which he had an impulsive outburst with aggressive indices, without being violent towards people. “I threw chairs, benches. I didn't hit anyone."

Finally, the patient had manifestations specific to a personality with narcissistic tendencies (cluster B). Could be remarkably noted the feelings of grandeur, the feeling of entitlement, the lack of empathy, the manipulation, and the need for attention and admiration, which represents a pervasive pattern of grandiosity and hyper-concern with self-esteem issues [Kaplan & Sadock, 2001].

V manifested a grandiose feeling of self-importance, which was associated with the sensation of being a special person "I was aware of my intelligence." "My parents couldn't beat me, they didn't have the physical strength to beat me, nor did they try to slap me or anything." The patient had also fantasies of success, power, and ideal love, manifested both in his aspirations regarding his academic future “I am not going to college this year, I want to study Law, especially because I already have experience.” and in the way he described the relationship he had with his last partner “I noticed that I had unlimited sex, affection, I had everything I wanted, it couldn't be better than that.”

Based on his relationship with G, there was an interpersonal exploitation behavior. He was taking advantage of her feelings for him and accepted that the girl violated her own morality by stealing the sum of 600 ron from her parents to offer to him, thus he achieved his own goals through her. “She brought me the money. Is not stupid who receives, is stupid who gives." He expressed the feeling of entitlement in his relationship with his last partner. He wanted her to comply with his own expectations from their relationship. He wished that she would miss high school and quarrel with her family to spend more time with him, and resorted to various ways to convince her. "I was putting psychological pressure on her to spend time together."

There were superior behaviors and attitudes about both the educational process. "The education system is defective," and the people he came in contact with and stated that he has strong persuasion skills. "I had the power to influence others, they told me that I was ruining the class.”

4. Discussion

The stress-diathesis model for V, involves, along with the heredocolateral antecedents, the following traumas that loaded the patient's vulnerability:

- Diagnosis of ADHD and ODD at 7 years old and refusal of medication;
- The rigid living environment, in which he was supervised at school by his father, and at home was forced to do homework by his mother;
- Family quarrels and conflicting atmosphere;
- His father facilitated his contact with gambling, thus triggering his addiction to them, although in the past he felt hatred for them "I fought with them for months." Also, the constant exposure to his father's addiction led to problems in managing alcohol consumption "I had a big problem with alcohol;"
- The permissive attitude of his mother that accentuated V's hostility within the lawsuits; -Alcohol consumption from an early age;

- The traumas he experienced during the period of personality development and structuring [12].
- Stress (trigger) is represented by:
- Early loss of the person he was attached to at the age of 7 so that the separation from his grandfather and moving with his parents triggered his violent outburst at school;
- The death of his grandfather;
- Separation from M, which triggered alcohol consumption and suicide attempts, the patient wanting to jump from the building where the girl lived;
- Separation from G, which triggered a second suicide attempt by paracetamol overdose accompanied by self-mutilating behaviors (cutting his wrists).

The factors that maintained V's dysfunctional behaviors are represented by both the lack of adequate treatment and the permissive attitude of his parents, especially his mother, during V's adolescence and the constant receipt of money (300 lei per week), which facilitated and maintained behaviors such as alcohol consumption and gambling. Morison indicates that for borderline adults with childhood hyperactivity syndrome, educational factors also intervene, such as the children's behavior being insufficiently controlled by parents [Predescu, 1989].

In V's case could be observed a constantly reduced capacity to persevere in purposeful activities, especially when it involved long periods of time and delayed satisfaction [Trifu, Dragoi & Vlaicu, 2019]. The patient does not find a reason why the school would be useful for him, thus from the age of 7 he began to be agitated and impulsive at school, and faced absenteeism and unsatisfactory school outcomes. Despite these problems, he did not consider it to be anything serious or wrong, and stated that the educational system is the "defective" one, where nothing useful weas learned. "The school does not focus on people, on personal development, spirituality, it does not focus on what matters." The patient stated that the school does not let him assert himself, it violated his rights and freedom. "I want the inalienability of freedom." and considered that his behavior was the most appropriate "If all children acted like me, the educational system would change, everyone should learn what they want."

V manifested altered emotional behavior characterized by emotional lability, highlighted especially by the discrepancy between periods of sadness, "pure suffering and despair," which involved lack of appetite, self-destructive behaviors, self-mutilation, suicidal thoughts, suicide attempts, and periods of expansiveness characterized by hypersexuality, antisocial behaviors and the symbolic struggle for justice.

Could be noted the disinhibition of the expression of needs and impulses without taking into account the consequences or the social conventions. This aspect was manifested by sex and alcohol consumption in public areas, the manipulation of his partner and his attempt to turn G against her father, the violence against G's father, the disturbance of classes, absenteeism, filing appeals regarding the restraining order and involuntary hospitalization and violation of the restraining order. These things were done in the absence of remorse, guilt or criticism, a specific manifestation of an antisocial personality, and in the presence of a sense of superiority, grandeur, and an emphatic attitude, thus stated that he is the only one who acts correctly, justly, establishing justice.

The excessive preoccupation with the theme of "justice," specific to its paranoid side, could be observed at V by referring to his inclination and vast knowledge in the field of law, to the pleasure he found in the courts, in search of truth and establishing justice.

Despite some traumatic experiences the patient went through during the period of development and structuring of his personality, he claimed that the experiences he went through changed him for the better, and after that he put a lot of emphasis on living the moment, anchoring in the present and lack of critical attitude. "The trauma I went through with courts, hospital, and scandal forced my conscience to wake up, I have a full acceptance of everything that exists, I apply the principle of non-criticism, acceptance of everything that exists as it is."

It symbolized the need to forget the past and his need to live the events, the desire to go through exciting situations, without barriers, not knowing when to end or critically analyze what was happening around him.

"From my inability not to know when to end things." There was a constant lack of criticism regarding the severity of his behavior and the situations in which he engaged. He needed the establishment of external barriers in order to function optimally in society. "I would have stopped at any time if the girl dared to tell me that."

4.1. Psychodynamics of Borderline Personality Disorder

In V's case, the split of the self was achieved by compartmentalizing his feelings, their integration not being possible. This cleavage manifested by the division of people around in “totally good" and “totally bad" led to the activation of emotional and behavioral responses of contempt for people characterized as negative. "I further accentuated my hatred for her family," which hindered the ambivalent integration of his interpersonal contacts.
The primitive idealization, found in the relationship with his last partner, revealed the attribution of an almost ideal description to the interaction between them. "I noticed that I have sex at discretion, affection, could not be better than that."

Projective identification was used in relationships with people for whom he had strong feelings of love by assigning positive idealized traits. This intrapsychic defense mechanism was observable in the patient's discourse about his relationship with G. “When this identification was broken, my identity was gone. Who am I without her?”

V's fear of abandonment has been present since childhood when he was forced by his parents to stop living with his grandfather, who represented his figure of attachment, the patient's attitude was one of hostility and aggression. This perceived abandonment was not completed in a secure way and migrated later in his relationships during adolescence when the separation from M occurred. This incident was felt like a second abandonment because he did not want the separation, his pain materializing through a suicide attempt, and culminated in his first psychiatric diagnosis. These sequences were amplified by his impulsive side, which facilitated his aggressive and self-destructive tendencies.

Given the specificity of the affective and behavioral responses that V manifested in relation to the people invested by him with strong feelings of love, it could be noticed a possible unresolved subphase of the process of separation-individualization within the theory of M. Mahler [Predescu, 1989]. This led to the failure of structuralization and internal control, aspects manifested both by instinctual discharges with a rich negative emotional coloration and by the continuous search for a person to attach to in order to maintain his emotional peace " What brings me to the extreme situation is identifying with an external source of psychological gratification. When there is a risk of loss or change, thoughts generate a great deal of resistance that creates emotions that create thoughts that never end.”

In V's case, the return against himself was achieved through suicide attempts, thus trying to materialize the emotional suffering. The lack of positive coping mechanisms led him to the inability to manage the accumulation of sadness felt in certain unfavorable contexts, even wanting to endanger his own person. Also, the lack of self-protection led him to involvement in activities that could have negative repercussions on him, this aspect was visible by initiating aggressive outbursts and violating the restraining order.

4.2. Psychodynamics of the paranoid personality

In V's case, shame was a characteristic that accentuates the attention he paid to his self-image, having strong feelings of shame when something was not in line with how he wanted to be seen by others. This aspect was present since childhood when his father had to accompany him daily to school to supervise him, so his psycho-affective response to this period was imbued with feelings of shame for the fact that he was the only child accompanied by his parents at school. This attitude was also adopted in adolescence when his father came under the influence of alcohol to visit him at the hospital. Thus, V's attempt to maintain an appearance as close as possible to the ideal one made him show feelings of shame in situations that could damage the desired image.

The unresolved separation and autonomy issues were key factors in understanding the whole process. The separation from the grandfather represented the loss of the attachment figure who cared for him until the age of 7

being achieved without his consent, which accentuated the subsequent emotional suffering. This episode had repercussions not only on the affective level but also on the behavioral one of the patients. This was manifested by the aggressive outburst that led to his hospitalization, the revolting attitude towards the objects in the classroom being the way in which he expressed his dissatisfaction with the separation from his grandfather and, implicitly, going to school far away from him. The very place where the incident happened, the school, could be the reason for both the outburst under the impulse and his subsequent hostile attitude towards educational institutions, believing that school was the factor that led to unwanted separation from his grandfather.

Also, the separation from M happened without his will, which led to his attitude of non-acceptance, his subsequent behavioral response being followed by his first psychiatric hospitalization. The two moments of separation were similarly internalized by the patient, who in both situations had an attitude of revolt towards abandonment, which could be interpreted as evidence of unresolved autonomy from childhood. "I seek gratification through a relationship with someone else."

The defensive mechanisms he used frequently were denial, denying both the existence of the disorder and the severity of the behaviors and situations. "My problem is the only problem of humanity, namely unconsciousness;" and rationalization, considering that his behaviors were due to the circumstances or other people. "She brought me the money. It is not stupid who receives, it is stupid who gives."

4.3. Psychodynamics of antisocial traits

V's actions were dominated by impulses, their control being minimal or even non-existent in situations that triggered in him the desire to act immediately on negative external stimuli.

Thus, his behavioral response during the meeting with G's father was an aggressive drive, which was not preceded by a careful thought process, which could be interpreted as a deficit of the patient's ego.

The inability to show trust in his interpersonal contacts was noticeable by the presence of suspicion indices, "I admit that their desire to hurt me seemed too exaggerated." And the desire to fight for fairness, which was manifested in his struggle with the system.

Aggressive elements were present in contexts that caused him feelings of insecurity and contradicted his own expectations projected on external reality. Also, their association could be analyzed both with the self-destructive acts that appeared after the separation from M and with the narcissistic elements present in the attempt to stabilize his emotional life.

4.4. Psychodynamics of narcissistic features

In V's case, the narcissistic traits could be interpreted as defense mechanisms, which made it easier for him to maintain a positive self-image, even in unfavorable contexts. Thus, the attitudes of superiority could represent the patient's prerogative, being used to increase self-satisfaction, emphasizing through both interpersonal qualities. "I had the power of influence." and intellectual ones, "I was aware of my intelligence."

The narcissistic traits could be related to feelings of shame that appeared when various aspects seem discrepant with the ideal apparent self-image, feeling in these contexts a violation of his desire to be seen by others in accordance with his own expectations.

4.5. Differential diagnosis for Borderline

The patient presents the following symptoms: notes of mistrust, hostility, aggression, superior behavior, and attitude. These may indicate Antisocial Personality Disorder, Narcissistic Personality Disorder, and Paranoid Personality Disorder.

Antisocial personality disorder - This diagnosis is manifested mainly through aggressive impulses and hostile attitudes, which are present since childhood.

Narcissistic personality disorder - In V's case, the symptoms are manifested in order to form a stable self-identity, which would allow him to maintain high self-esteem, and can represent a defense mechanism.
Paranoid personality disorder - The manifestation of this side of his personality is present in the form of intense and constant suspicion, which leads him to a series of actions carried out with the aim of fulfilling justice, observable through the fight for justice in court proceedings.

Patients with borderline personality disorder can be problematic because they may have "storms of affection" and require considerable attention [Kaplan & Sadock, 2001]. The American Psychiatric Association's practice guide recommends psychotherapy as the primary treatment for Borderline personality disorder, with pharmacotherapy as an adjuvant to treatment [APA, 2001].

In V's case, treatment could involve mixed, supportive, and exploratory psychotherapy to support the process of stabilizing symptoms. This can lead to the formation of positive coping mechanisms to help him with the management of situations that may be stressful, thus facilitating the management of both emotional and behavioral reactions. Also, setting boundaries and overcoming suicidal ideation requires increased attention in this approach. Thereby, controlling aggressive impulses and minimizing sensitivity to rejection can be beneficial steps towards a better adaptation to external factors. It may also be necessary to be prescribed a psychopharmacological treatment to stabilize the emotional state and control his impulses, in order to provide a complete therapeutic approach.

The risk of suicide is increased in borderline patients, their self-harming behavior including impulsive behavior that is potentially dangerous (excessive alcohol consumption, risky sexual behaviors), deliberate self-harming behavior (shallow cutting or burning), suicide attempts, and successful suicide [Oldham, 2006], that is why it is necessary to implement a therapeutic approach focused on developing positive defense mechanisms, which would allow him to overcome situations with negative repercussions.

4.6. Conclusion

The patient presents a Borderline personality structure with obvious paranoid features, narcissistic tendencies, and elements specific to an antisocial personality. The development of the diagnosis was facilitated by both the presence of the heredocolateral antecedents, and a series of traumas such as the rigid living environment, family quarrels, and alcohol consumption from an early age. Also, these aspects were doubled by the unwanted separation from his attachment figure at a young age, which made him negatively internalize the separations from his partners during adolescence, outlining his fear of abandonment. These elements formed an emotional instability for the patient on the basis of which his actions, dominated by impulses, non-compliance, aggressive and self-destructive tendencies, were manifested.

In this case, can be observed V's reluctance regarding the diagnosis, not being convinced of its truth value. This reluctance is doubled by the lack of insight about his own behavior and contraventions, as well as the seriousness of his current situation, to which is added the permissive attitude of his parents. All these aspects are maintained by the lack of adequate treatment, thus greatly increasing the risk of adopting dysfunctional behaviors and committing aggressive acts, harming himself and others.

Considering, the patient's self-destructive behaviors, impulsiveness, and multiple addictions, in the absence of appropriate treatment, psychotherapy, and/or pharmacological treatment, several future complications may occur, that is why it is necessary to implement a therapeutic approach focused on developing positive defense mechanisms, which would allow him to overcome situations with negative repercussions, preventing future problems with the law, self-harm, aggressive and maladaptive behaviors, and even suicide attempts.

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