Self-Bloodletting: An Unusual Form of Self-Mutilation in Adolescence

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Abstract
In this paper, we introduce an adolescent suffering from a rare form of self-mutilation, ‘self-bloodletting’, and discuss dynamics of this maladaptive behavior. Deliberate bloodletting is a rare, but not unheard of, form of self-mutilation associated with eating and personality disorders. Although there are already several case reports in the adult psychiatry literature regarding the clinical features of Lasthenie de Ferjol Syndrome or factitious anemia, this is the first reported adolescent case of self-bloodletting.

Key Words: Adolescence, eating disorder, Factitious anemia, Self-bloodletting, Self-harm, Personality disorder

Introduction
Deliberate self-harm is a common clinical problem in adolescence. Self-bloodletting (SBL), however, is a rare form of self-mutilation that refers to the act of draining one’s own blood by venipuncture or an intravenous cannula [1]. In the literature, this behavior is commonly associated with eating and personality disorders. The French literature describes this as a syndrome called “Lasthenie de Ferjol”, which is characterized by self-induced hemorrhage, anemia and a pathologic personality [2]. ‘Factitious anemia’ is another term to describe obscure anemia cases caused by SBL [3]. Fatalities have also been reported due to SBL. In this paper, we present the in-patient treatment of a 17-year-old female who was letting up to 250 cc of blood per day. To our knowledge, this is the first adolescent case reported.

Case History
E.B. is a 17-year-old girl studying at a nursing high school. She was referred to our clinic by a psychiatrist for hospitalization.

In the assessment session, we were informed that her problems began two years ago when she began high school. She initially complained of restlessness, especially at nights. Her first method of reducing distress was self-cutting, and she did this several times. As she began her training rotation in hospital wards, she discovered a new way of relieving herself: self-bloodletting. Initially, she took blood from her antecubital vein using a 5-ml syringe. The amount increased to 60 cc per day. In one incident, she used an IV cannula to let 250 cc of blood. Following this incident, she discarded blood or flushed it down the toilet. Although her primary aim was to reduce distress and experience relief, in the course of her illness, she also began to perceive bloodletting as an indirect and gradual type of suicide. Six months prior to admission to our clinic, E. B. fainted during her practice in the hospital, and her hemoglobin level was 5 g/dl. Clinicians did not find any sign of blood loss or bleeding from the gastrointestinal, urinary or reproductive systems. She was admitted to the internal medicine ward and received a blood transfusion. Nevertheless, in her second day in the ward, she left the hospital against doctors’ orders to hide the cause of her anemia. Following the advice of the intern doctors, her family decided to seek psychiatric help. E. B. talked about her bloodletting behavior in her mental state assessment and was admitted to our in-patient unit. In her initial assessment, E. B. told her clinician that in the last 6 months she felt upset, tired and had no interest in routine activities. She had also lost appetite and weight. She had suicidal thoughts and overdosed one month before admission.

E. B. had poor peer relationships but high academic performance, especially at her current high school. Her family had a low socioeconomic status; her father was a street vendor, who E. B. described as a distant and cold man. Her mother was a caring housewife. She had two siblings: a 19-year-old sister and a 14-year-old brother. She did not report any psychiatric illnesses, or drug or alcohol dependence in her personal or family psychiatric history. She had no remarkable medical history.

In E. B.’s initial blood test, her hemoglobin level was 11.7 g/dl. Pediatrics consulted with her, and she was prescribed medication for anemia. Other medical parameters such as drug tests, thyroid, urinary and liver functions were normal. EEG and MRI scans were both normal and her Hamilton Depression Rating Scale score was 29. Additional psychometric evaluations (such as the MMPI and TAT) could not be administered due to her poor cooperation.

The psychopharmacological section of her treatment began with 50 mg/day of sertraline for her depression, olanzapine 10 mg/day for impulse control and benzodiazepine-only if needed-to reduce distress. She attended group and personal therapy sessions twice a week.

Received: May 20, 2010 / Accepted: May 21, 2010
Summary of this manuscript presented in: 18th world congress of international association for child and adolescent psychiatry and allied professions
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doi:10.5152/eajm.2010.27
and all other therapeutic pursuits, except for out-clinic activities due to her high suicidal and destructive risk. During her stay, she showed clear borderline personality disorder behavioral trends. Her mood was unstable and we observed a rapid devaluation of her relationships with other young people and the staff in the unit. E. B. complained of feeling empty. While in a dissociative state, the unit team refused her request for a syringe; she then attempted to choke herself or cut her wrists with any sharp item she could find. These states would last nearly half an hour and could only be ended by chemical or physical restraints. After calming down, she would try to convince the unit team that she was in an unconscious state and did not remember what she had done and would promise not to repeat her behavior.

E. B.’s eating pattern was another concern. Although her symptoms did not fulfill the criteria for a DSM IV eating disorder, she suffered from severe eating problems. In addition to her poor appetite (which was related to her depression), she also refused food. She lost 2.7 kilograms in the first week in our unit. She later managed to convey that refusing food was also a type of self-harming behavior, perhaps with the goal of a painful death.

In spite of all the therapeutic interventions she received, E. B.’s self-destructive behaviors did not diminish during her 2-week stay. Ensuring her safety and maintaining treatment for both her and other patients became impossible; the unit team decided to refer her to a more secure unit. E. B. showed no clinical improvement at discharge.

**Discussion**

Bloodletting, the behavior that our patient found to reduce her distress, is one of the oldest medical interventions. The belief that bloodletting had therapeutic value in a wide range of diseases was widespread no later than the forth century B.C. Hippocrates, Diocles, Menesitheus and Praxagoras all practiced phlebotomy. Although they practiced before the father of anatomy, Herophilus (335–280 BC; born in Chalcedon-now Kadıköy, a district of Istanbul) is regarded as the founder of bloodletting as a treatment. We also found bloodletting behavior in religious texts: “Hijema” is the name of a bloodletting process still used in Islamic countries, which is thought to heal a number of diseases, including mental illness. Even some Christian writings mention the therapeutic role of bloodletting, advising it on All Saints Day. The therapeutic role of bloodletting endured for centuries and is summarized in a couplet by Faust:

*For spirits sinking, spirits rising
The one cure is phlebotomizing*

In modern psychiatric literature, SBL behavior is a rare form of self-mutilation that is generally comorbid with eating and personality disorders, particularly borderline personality disorder [4, 5]. This was the case of our patient. Although she did not fulfill the criteria for an eating disorder according to the DSM-IV, she had severe eating problems such as food refusal and was diagnosed with borderline personality disorder.

The association between eating disorders and SBL is unclear. Although some authors have suggested that this behavior is a form of purgation similar to bulimia [5], in most cases no direct relationship has been shown. Some authors believe that SBL indicates a personality disorder, rather than an eating disorder based on the cases in which no eating disorder is noted [2] and the high co-morbidity of eating and personality disorders [6]. Our case also supports the idea that bloodletting is a feature of a personality disorder because E. B. clearly used bloodletting to harm herself, and she was diagnosed with a borderline psychopathology.

The majority of SBL cases are female and healthcare workers. This explains the choice of SBL as the method of self-harm. Most cutters feel relieved when they see their blood. Using a mundane, safe and less scarring method may give the same feeling to healthcare workers. Eating disorders, most personality disorders and incidents of self-mutilation are more common in women [7, 8]. Thus, it is no surprise the same holds for SBL.

The ages of reported SBL cases vary between 20 and 50. To our knowledge, this is the first SBL adolescent case report. In Turkey, nursing education starts at the high school level in specialist schools; this may explain the presence of an adolescent SBL case.

The treatment course for our patient was similar to previously published cases. Determining SBL behavior is anecdotal. Patients are prone to deny self-mutilation. The anemia caused by SBL is known as “factitious anemia” and can be difficult to detect and diagnose [3]. Lasthenia de Ferol is the name of a French novel heroine who bled herself using 18 needles, pined away and died slowly after she was sexually abused and became pregnant. Bernard took this name for the syndrome he described consisting of a personality disorder as well as self-induced hemorrhaging and anemia [2]. This syndrome is also classified as a factitious disorder.

SBL’s response to psychiatric treatment is generally poor [9], due to the severity of its psychopathology. The co-morbidity of eating disorders and personality disorders is relevant to the severity of its psychopathology [10]. Warren suggested that bloodletting should be considered a non-specific indicator of the underlying personality disorder’s severity [2]. No specific medication has been shown to improve bloodletting behavior; however, psychotherapy is still the first choice despite unfavorable outcomes.

In conclusion, the severity of psychopathology associated with SBL and its risk of fatality must be considered before deciding how to treat patients. As we experienced, providing for the patient’s security and protecting other patients from the disruptive effects of SBL is the most important component of the treatment strategy. Finally, a hematological follow up and clinical consultation with pediatricians are needed. To treat these types of cases, psychiatric and pediatric cooperation is important.

**Conflict interest statement:** The authors declare that they have no conflict of interest to the publication of this article.

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