

# The manipulative self-harmer

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## How would you handle this case?

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Involuntarily admitted to a forensic unit, Ms. L often tests the staff by hurting herself and making suicidal gestures. Which treatments would you try?

### **CASE** Self-destructive behaviors

After being acquitted of 4 counts of second-degree forgery for writing checks from her mother's bank account, Ms. L, age 52, is sent to the state hospital for a forensic examination to determine competency. Two years later she is granted conditional release from the hospital, transferred to our not-for-profit community mental health center, and enrolled in an intensive inpatient treatment program to monitor forensic patients. She is legally required to comply with treatment recommendations.

At admission, Ms. L is diagnosed with major depression, recurrent, and borderline personality disorder (BPD). She has no history of antisocial behavior or criminal acts other than forging checks and has never spent time in prison, which makes it unlikely she has comorbid antisocial personality disorder (*Table 1*).<sup>1</sup>

Over the next 5 years Ms. L tests limits with the treatment team and acts out by engaging in self-harming behaviors. In 1 instance, she cuts her forearm deeply, stuffs the wound with mayonnaise and paper towels, and wraps her arm with a bandage. She wears a long-sleeved shirt to hide her wound, which is not discovered until a severe infection develops.

Ms. L has difficulty with coping skills and interpersonal relationships. She approaches others with ambivalence and mistrust and consistently expects them to demean or take advantage of her. Ms. L is manipulative, at times

injuring herself after perceived wrongdoings by staff. For example, after her therapist reschedules a meeting because of an emergency, Ms. L pours scalding water on her foot.

### How would you address Ms. L's manipulative self-harm?

- confront her in therapy to process transference issues
- help her develop less destructive coping skills
- help her identify patterns of irrational thoughts that contribute to self-harm
- ignore the acts

### The authors' observations

Ms. L consistently displays 3 common constructs of BPD:

- primitive defense mechanisms
- identity diffusion
- generally intact reality testing.<sup>2</sup>

Defense mechanisms are psychological attempts to deal with intrapsychic stress. Splitting—vacillating between extremes of idealization and devaluation—is a fundamental primitive defense mechanism that is the root of BPD.<sup>2</sup> Identity diffusion causes confusion about life goals and val-

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Table 1

## Cluster B personality disorders: Differential diagnosis

Diagnosis	Features
Borderline personality disorder	Self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and loneliness
Histrionic personality disorder	Attention seeking, manipulative behavior, and rapidly shifting emotions
Antisocial personality disorder	Manipulative to gain profit, power, or other material gratification

**Source:** Reference 1

ues and feelings of boredom and emptiness. This internal world leads a patient to have the same perception of the external world, which explains many symptoms of BPD, such as rapidly shifting moods, intense anger, lack of clear sense of self, fear of abandonment, and unstable and intense interpersonal relationships.<sup>2</sup>

Early in treatment, Ms. L had difficulty breaking a cycle of self-defeating behavior, such as destroying personal items, trying to hang herself, and gluing an ear plug in her ear. During an argument with a staff member, Ms. L punched a wall and fractured her left hand. BPD patients sometimes will “up the ante” when acting out. For example, one of our patients claimed to have planted a bomb in an elementary school and another swallowed inedible objects, including spoons, forks, and butter knives. In Ms. L’s case, we addressed her self-harm behavior by helping her:

- develop less destructive coping skills such as drawing or painting
- identify irrational thoughts that contribute to self harm.

### HISTORY Troubled past

Raised by her biologic parents, Ms. L met all developmental milestones. She denies a history of childhood abuse but reports experiencing “depression and memory loss” and relationship problems with her parents during adolescence. As a child she often missed school because she “did not want anyone to know what a disgusting person I was” and “I

should have my head cut open and cut into little pieces for thinking such mean thoughts.” Ms. L dropped out of school in the twelfth grade but obtained her general educational development certificate.

Notes and letters Ms. L wrote while in treatment consistently refer to her negative self-image. Ms. L writes that she feels she does not deserve to “be a part of this world,” is “never good enough for anyone,” and “should be thrown away with the garbage.”

Ms. L vacillates between desiring a closer relationship with her parents, especially her mother, and wanting to “cut them out of my life for good.” She has minimal contact with her older sister. Ms. L is divorced and has 2 adult sons. She was involved sporadically in her sons’ lives when they were children, but now has no contact with them.

### BPD and crime

Ms. L is enrolled in the “911 program,” which monitors individuals who have been found not guilty by reason of mental defect. Individuals with BPD often are convicted of serious and violent crimes, which may be because of BPD features such as interpersonal hostility and self-harm. Impulsivity, substance abuse, and parental neglect—all of which are associated with BPD—can increase risk of criminality.<sup>3</sup> There is no evidence to suggest a direct link between BPD and criminality; however, over-representation of BPD in prison populations suggest that in severe cases it may increase criminogenic risk.<sup>1,3</sup>

### Clinical Point

**Impulsivity, substance abuse, and parental neglect—all of which are associated with BPD—can increase risk of criminality**

continued

Table 2

## Features of psychotherapeutic modalities for BPD

	Description	Mode of treatment	Skills taught
<b>Dialectical behavior therapy</b>	Manualized, time-limited, cognitive-behavioral approach based on the biosocial theory of BPD	Individual therapy, group skills training, telephone contact, and therapist consultation	Core mindfulness skills, interpersonal effectiveness skills, emotion modulation skills, and distress tolerance skills
<b>Systems Training for Emotional Predictability and Problem Solving</b>	Manual-based, group treatment that includes a systems component to train family members, friends, and significant others	20-week basic skills group and a 1-year, twice-monthly advanced group program; utilizes a classroom 'seminar' format	Awareness of illness, emotion management skills, and behavior management skills

BPD: borderline personality disorder

## Clinical Point

Pharmacotherapy typically targets affective dysregulation, impulsive-behavioral dyscontrol, and cognitive-perceptual symptoms

**TREATMENT** Worsened depression

When Ms. L arrives at our facility, her medication regimen includes fluoxetine, 80 mg/d, risperidone, 2 mg/d, and buspirone, 20 mg/d. Risperidone and buspirone are discontinued because of perceived lack of efficacy. Venlafaxine XR is added and titrated to 300 mg/d, and Ms. L receives lorazepam, 1 and 2 mg as needed. However, lorazepam carries risks because impulsivity and impaired judgment—which are common in BPD—can lead to dependence and abuse. We feel that in a supervised setting the risks can be managed.

Recently, staff witnessed Ms. L experiencing an episode that appeared to be a grand mal seizure. After Ms. L is evaluated at the local emergency room, her EEG is normal, but a neurologic consult recommends discontinuing fluoxetine or venlafaxine XR because they may have contributed to the seizure. We taper and discontinue venlafaxine XR but Ms. L complains bitterly that she is getting increasingly depressed. On several occasions she attempts to pit team members against each other.

Ms. L falls, injures her back, and begins to abuse opiates. After her prescription runs out, she obtains more from an intellectually limited patient in her treatment program. Ms. L says she is getting more depressed, threatens suicide, and is placed in a more restrictive inpatient setting. We consider adding pregabalin to address her pain and help with anxiety

and impulse control but the consulting neurologist prescribes carbamazepine, 400 mg/d, and her pain improves.<sup>5,6</sup>

**How would you treat Ms. L?**

- restart the higher dose of venlafaxine
- add a mood stabilizer, such as valproic acid or lithium
- add a second-generation antipsychotic, such as ziprasidone or olanzapine
- increase the frequency and intensity of psychotherapy sessions with an emphasis on setting limits on her self-injurious behavior.

**The authors' observations**

BPD treatment primarily is psychotherapeutic and emphasizes skill building (Table 2) with focused, symptom-targeted pharmacotherapy as indicated.<sup>4</sup> Pharmacotherapy typically targets 3 domains:

- affective dysregulation
- impulsive-behavioral dyscontrol symptoms
- cognitive-perceptual symptoms.

Patients with prominent anxiety may benefit from benzodiazepines, although research on these agents for BPD is limited. Recent studies show efficacy with fluoxetine, olanzapine, or a combination of both,<sup>7</sup> and divalproex.<sup>8</sup> Preliminary data supports the use of topiramate, quetiapine, risperidone, ziprasidone, lamotrigine, and

Table 3

## Pharmacotherapy for BPD: What the evidence says

Study	Design	Results
Hollander et al, 2003 <sup>9</sup>	96 patients with Cluster B personality disorders randomized to divalproex or placebo for 12 weeks	Divalproex was superior to placebo in treating impulsive aggression, irritability, and global severity
Hilger et al, 2003 <sup>10</sup>	Case report of 2 women with BPD and severe self-mutilation receiving quetiapine monotherapy	Quetiapine resulted in a marked improvement of impulsive behavior and overall level of function
Rizvi, 2002 <sup>11</sup>	Case report of a 14-year-old female with borderline personality traits admitted to an inpatient facility for suicide attempt, impulsive behavior, and mood lability. Lamotrigine was started at 25 mg/d and titrated to 200 mg/d. At admission, she was receiving clonazepam, valproic acid, quetiapine, and fluoxetine, which were tapered and discontinued	Over 6 months of inpatient treatment, suicidal behavior and ideation diminished and impulse control and mood lability improved; continued improvement at 1-year follow up
Rocca et al, 2002 <sup>12</sup>	15 BPD outpatients with aggressive behavior given risperidone (mean dose 3.27 mg/d) in an 8-week open-label study	Risperidone produced a significant reduction in aggression based on AQ scores, reduction in depressive symptoms, and an increase in energy and global functioning
Philipsen et al, 2004 <sup>13</sup>	14 women with BPD given oral clonidine, 75 and 150 µg, while experiencing strong aversive inner tension and urge to commit self-injury	Clonidine significantly decreased aversive inner tension, dissociative symptoms, and urge to commit self-injury as measured by self-rated scales
Pascual et al, 2004 <sup>14</sup>	A 2-week open-label study of 10 females and 2 males presenting to psychiatric emergency service for self-injurious behavior, aggression/hostility, loss of impulse control, and severe anxiety/depressive symptoms received IM ziprasidone, 20 mg, followed by flexible oral dosing between 40 mg/d and 160 mg/d	9 patients who completed the study showed statistically significant improvements on CGI-S, HAM-D-17, HAM-A, BPRS, and BIS

AQ: Aggression Questionnaire; BIS: Barratt Impulsiveness Scale; BPD: borderline personality disorder; BPRS: Brief Psychiatric Rating Scale; CGI-S: Clinical Global Impressions-Severity of Illness; HAM-A: Hamilton Anxiety Rating scale; HAM-D-17: 17-item Hamilton Depression Rating scale

clonidine (Table 3).<sup>9-14</sup> A recent review and meta-analysis showed efficacy with topiramate, lamotrigine, valproate, aripiprazole, and olanzapine.<sup>15</sup>

For Ms. L, we restart venlafaxine at a lower dose of 50 mg/d and titrate it to 150 mg/d, which is still lower than her previous dose of 300 mg/d. She has no recurrence of seizures and her depression improves.

### OUTCOME Some improvement

Ms. L has no dramatic suicidal gestures for 3 years. Although she continues to engage in

self-injurious behaviors, the intensity and frequency are reduced and she does not inflict any serious injury for 18 months. Her mood and behavior continue to oscillate; she is relatively calm and satisfied 1 week, angry and assaultive the next. This stormy course is expected given her BPD diagnosis.

Initially, Ms. L resided in a locked residential unit and was minimally compliant with treatment recommendations and unit policies. As treatment progressed she moved to a different locked unit and eventually to an apartment. Recently, she was placed in a more restrictive setting because her hostile and self-destructive behavior escalated.

### Clinical Point

A recent review and meta-analysis showed efficacy with topiramate, lamotrigine, valproate, aripiprazole, and olanzapine

## Clinical Point

It is not clear if the gains Ms. L made within a very structured treatment setting would have been possible if she was living on her own

## Related Resources

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### Drug Brand Names

Aripiprazole • Abilify	Lorazepam • Ativan
Bupropion • Buspar	Olanzapine • Zyprexa
Carbamazepine • Tegretol	Quetiapine • Seroquel
Clonidine • Catapres	Pregabalin • Lyrica
Divalproex • Depakote	Risperidone • Risperdal
Fluoxetine • Prozac	Topiramate • Topamax
Fluoxetine-olanzapine • Symbyax	Valproic acid • Depakene
Lamotrigine • Lamictal	Venlafaxine XR • Effexor XR
Lithium • Eskalith, Lithobid	Ziprasidone • Geodon

### Disclosures

Dr. Hashmi is on the speakers bureau for AstraZeneca, Eli Lilly and Company, and Janssen.

Dr. Vowell reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

### The authors' observations

Ms. L is no different from most Axis II Cluster B disordered patients. During treatment she shows improvement by refraining from self-destructive behaviors for up to 18 months, but she then briefly reverts back to maladaptive behaviors. Ms. L resides in a very structured treatment setting. It is not clear if the gains she made in treatment would have been possible if she was living on her own in the community.

One year after finishing the court-mandated "911 program," Ms. L lives in the community, draws and paints quite well, attends weekly individual and group

therapy, and refrains from self-mutilation. She still experiences volatile moods, but can handle them without inflicting self injury.

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## Bottom Line

Patients with severe borderline personality disorder (BPD) often exhibit hostility, impulse dyscontrol, and self-harm behaviors, which can lead treating clinicians to feel frustrated, helpless, and angry. BPD treatment is primarily psychotherapeutic, but pharmacotherapy may relieve specific symptoms.