

Management and Treatment of Suicidality in Patients with Borderline Personality Disorder

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Big Clinical Questions in the care of suicidal individuals with BPD

- **1. How do I identify which of my BPD patients are at highest risk to kill themselves?**
 - How do I identify the potential completers from the “chronic attempters”?
- **2. How do I best manage “high” suicide risk?**
 - What is the role of “no harm” contracts?
Hospitalization? medication?
- **3. How do I protect myself from being sued?**
- **4. How do I handle the death of a patient from suicide?**

1. How do I identify which of my BPD patients are at highest risk to kill themselves?



Suicide completers and attempters are clinically distinct groups

	BPD Suicide completers	BPD non-completers
Previous hospitalization	XX	X
attempts	Violent methods	Non-violent methods
Cluster B co-morbidity (ASPD)	yes	No
Substance dependence	yes	No

BPD Suicide completers- who are they?

- *Most successful suicides occur on the first attempt**
- * associated with heightened levels of impulsivity, hostility and co-morbid cluster B antisocial personality disorder (ASPD), + drugs**

What else do we know about which patients with BPD successfully suicide?

- Longitudinal studies note:
 - suicide completions occurred after age 30,
 - later in the course of the illness,
 - after unsuccessful treatment efforts
 - when the patient is alone and
 - not involved in active treatment.
- despite multiple threats, younger females with BPD in treatment are at low risk of death by suicide.

Summary- Identifying Suicide Risk

- Risk factors for suicide attempts in BPD differ from risk factors for suicide completion.
- Many first-time attempters have a lethal outcome.
- Better identification and understanding of these individuals, most of whom are not in clinical care, is a priority as is further clarifying which 10% of the attempters will progress to completion over the course of their illness.

2. How do I best manage “high” suicide risk?

The Role of “No Harm” Contracts

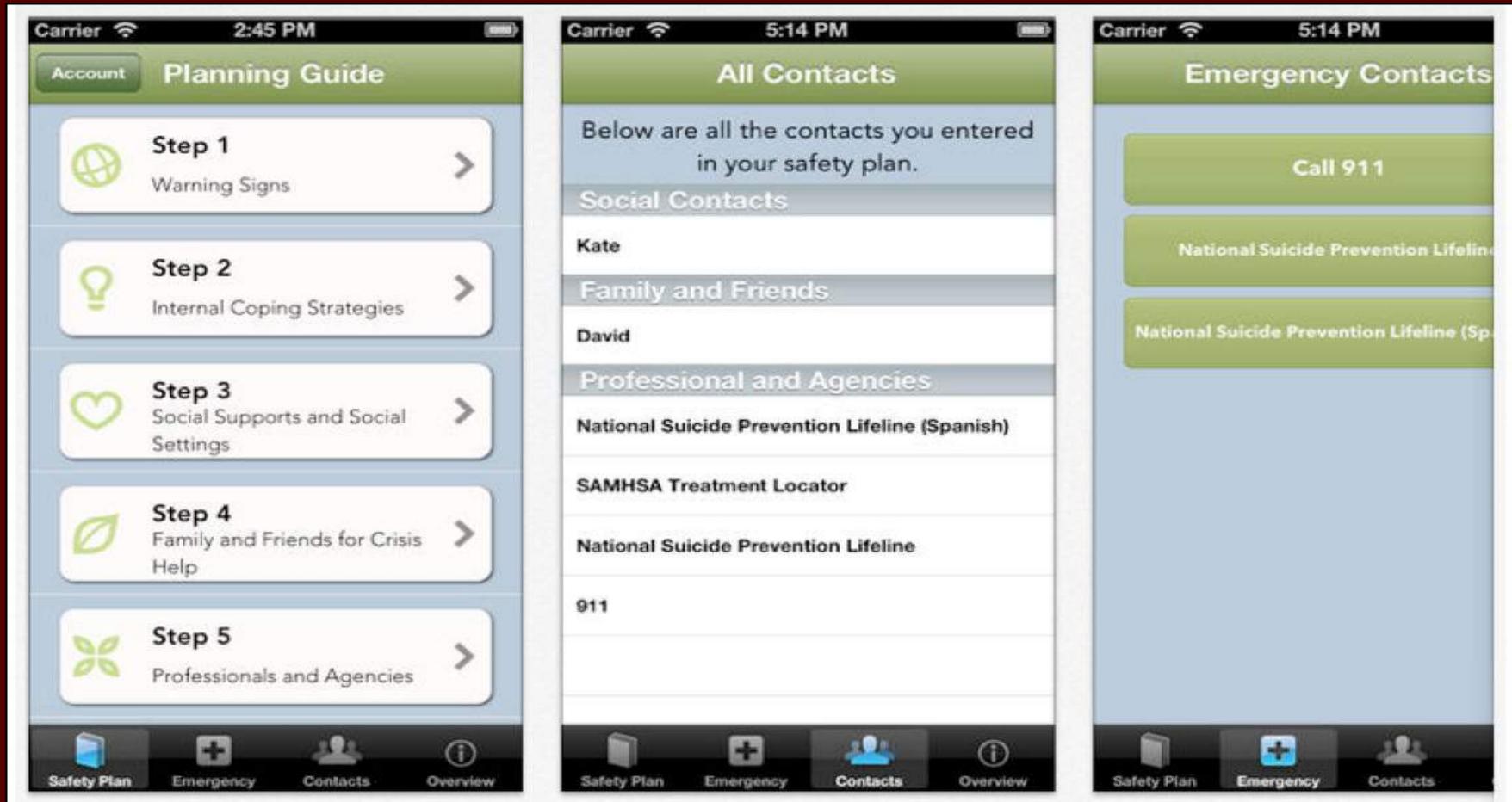
- The APA guidelines advocate for the judicious use of the therapeutic alliance to negotiate safety with skilled clinicians
 - but caution about using the contact as a substitute for a rigorous suicide evaluation of the patient.
- Others* believe that "no-harm" contracts can be useful
 - curtail the patient from using suicidal behaviors as a means of communication with the therapist,
 - clarify expectations and help prevent treatment sabotaging behaviors.
- Other expert's opinions caution that "no-harm" contracting should be done in the context of an established therapeutic connection with regular follow-up and detailed documentation.
- All recommendation regarding no-harm contracts are expert opinions as minimal empirical evidence exists.

* refs: Hopko, et al, 2003

Suicide Safety Planning

- 1) The Suicide Prevention Resource Center (<http://www.sprc.org>) has designated the Suicide Safety Plan (SSP) as a ‘best practice’**
- 2) The Safety Plan instructs one to:**
 - recognize personal warning signs of suicide;
 - use internal coping strategies;
 - engage social contacts that can offer support and serve as distraction from suicidal thought;
 - contact family members or friends who may help resolve a crisis;
 - provide contact information for professionals to help
 - Keep environment safe
- 3) It can be a stand-alone intervention**

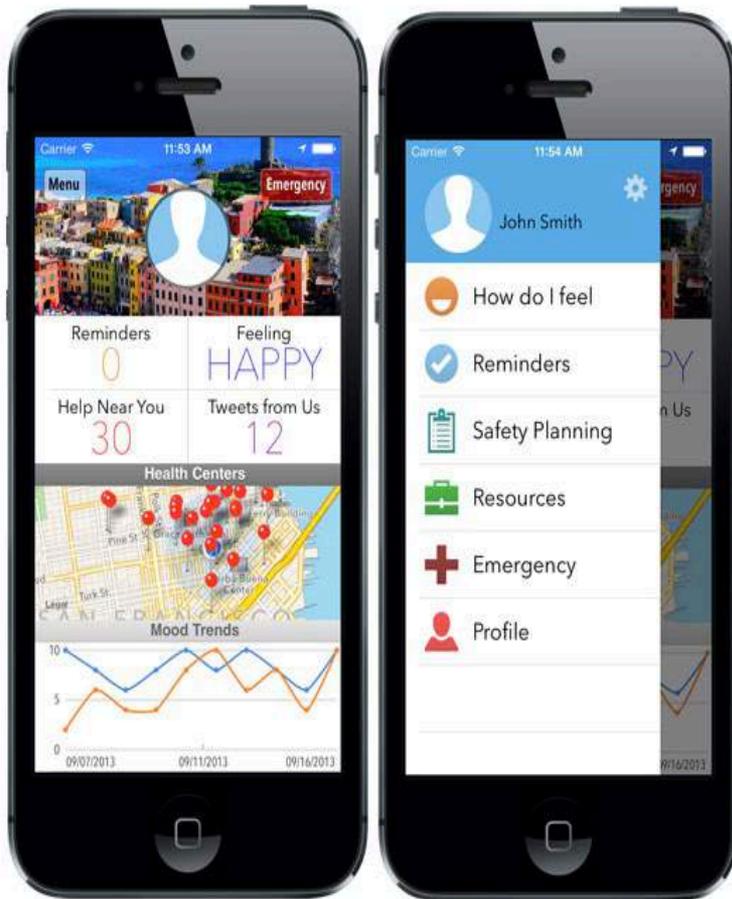
NY Office of Mental Health Suicide Safety Plan Mobile App



The free Safety Plan iPhone app is designed to help people cope with suicidal thoughts.

New York state Office of Mental Health

Additional Apps: ReliefLink & Virtual Hope Box



The ReliefLink app won the \$50,000 first prize in an App Challenge sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).



Developed by Nadine Kasnow, PhD

Developed by Nigel Bush, PhD

Role of Hospitalization for Chronic Suicidality in BPD

Hospitalization

PROS: Supported by APA Practice Guidelines for Suicidal Behavior

Keep patients safe

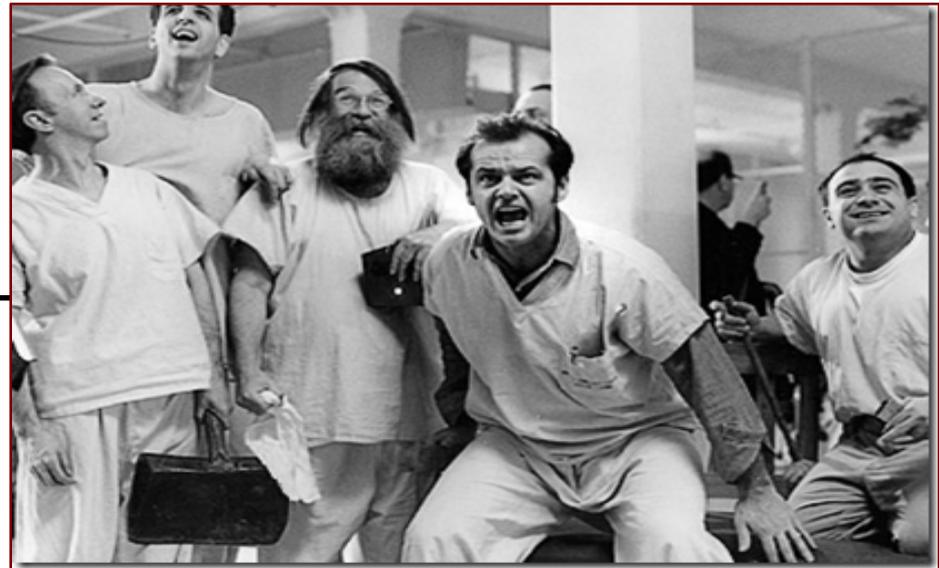
Appropriate for treatment of Co-morbid Axis I exacerbations, diagnostic questions, medication adjustments

CONS: biggest critics (Paris, Linehan, Dawson and MacMillan)
Minimal evidence exists supporting hospitalization/unproven effect

“little more than a suicide watch”

Can result in negative consequences such as- behavioral regression, reinforce behaviors clinicians are trying to limit

Hospitalization for Suicidality in BPD



- **Controversial!**
- **Our recommendations serves as an integration:**
 - prudent use of hospitalization.
 - If admission is necessary, keep it brief
- **Managed care's pressure for shortened hospital stays has inadvertently benefited hospitalized suicidal individuals with BPD.**

* **Vijay and Links (2007);
Goodman et al, 2012**

Psychotherapy and Suicide cont.

All the efficacious psychotherapies for suicide teach patients how to:

- 1) manage suicidal urges,
- 2) reduce the reinforcements of self-destructive behavior
- 3) maintain the integrity/structure of the treatment in spite of crisis.

■ (Weinberg et al, 2010)



Psychotherapy and Suicide

- Evidence base of psychotherapy approaches include: cognitive behavior therapy (CBT), Collaborative Assessment and Management of Suicide (CAMS), dialectical behavioral therapy (DBT).
- Yet need for the development of briefer and less resource intense treatment
 - Systems Training for Emotional Predictability and Problem Solving (STEPSS) program Stanley's brief DBT

References:

CBT: Brown et al, 2005; Rudd et al, 2004;

2015. CAMS: Jobes et al, 2009; 2012.

DBT: Linehan, 1993; new manual 2014;

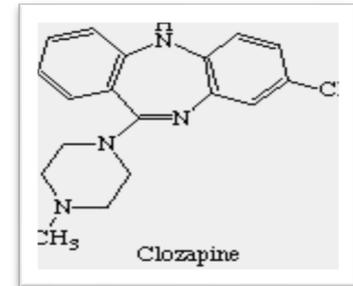
Stanley et al., 2007.

STEPSS Blum et al, 2008.



Pharmacological/biological agents helpful in reducing suicide risk

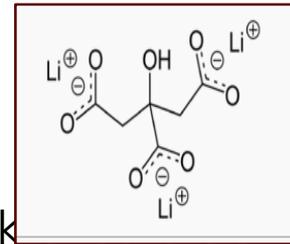
Empirical data exists for several agents, **but none specific for suicide in BPD.**



1. **Clozapine** is the first FDA approved anti-suicide indication for schizophrenia.

■ **quetiapine** 300-600mg has been reported to be effective in reducing suicidal ideation in bipolar depression

2. **Lithium** in bipolar disorder evidence of a 5 fold decrease in risk attempts in bipolar disorder & reduced suicidal lethality in the attempts that occurred.



■ Effects seen after a year of treatment

3. **SSRIs.** Previous concerns about black box warnings. New recommendations are to use but monitor for increases in agitation, akathesia and suicidal ideation.

Refs: quetiapine- Thase et al, 2006; Calabrese et al, 2005; lithium- Baldessarini et al, 2006.

Pharmacological/biological agents helpful in reducing suicide risk cont.

These two agents helpful for “acute” suicidal ideation

4. **ECT.** Helpful in reducing suicidal urges quickly in inpt setting.
5. **Ketamine.** A glutamate *N*-methy-*D*-aspartate (NMDA) receptor antagonist. Expanding interest.
 - Helpful in refractory MDD
 - IV infusion with rapid resolution of suicidal thinking lasting few days.
 - Unclear effects of longer term use, addiction potential?

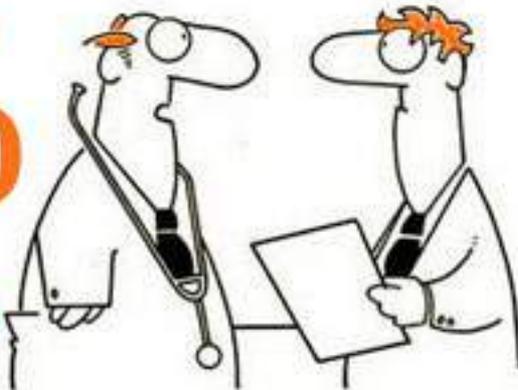
References: ECT- Kellner et al, 2005; Ketamine- Price et al, 2014

3. How do I protect myself from being sued?

- Fear of litigation can inappropriately influence clinical decision making.
- In a group of clinicians working with adult BPD patients, >80% admitted that within the last year, they had practiced in a manner that was not likely to be in their patients' best interest, but would protect them from medicolegal repercussions.

83%

physicians practice
"defensive" medicine



(Krawita & Btacheler, 2006)

“professionally indicated short-term risk-taking”

- **Thorough assessment and risk assessment**
- **documented chronic pattern of suicidality and/or self-harm.**
- **well-documented comprehensive treatment plan.**
- **A longitudinal risk assessment and risk-benefit analysis must be carefully developed, individualized, documented and regularly reviewed along with the treatment plan.**
- **importance of documenting the reasons why the specific plan was selected and considered to be the best means of minimizing risk to the patient.**
- **Additionally, obtaining second opinions and consultation are often useful also must be well-documented.**
 - **It is also important to include the patient directly in this process and family/peers/etc in establishing the plan**
 - **documentation of patient and family agreement and understanding is similarly essential.**

4. How do I handle the death of a patient from suicide?

- Death of a patient by suicide is a devastating and unnerving experience
- 50% risk of losing a pt to suicide during one's career.
- 38% of psychiatrists who lose a pt to suicide experience extreme distress. Best to seek consultation and support should it occur.

Chemtob et al, 1988;
Hendin et al, 2004.

RESOURCES



Resources

- For residents (or any clinician) who loses a patient to suicide:

<http://www.psych.org/Mainmenu/educationalcareerdevelopment/residentsmembersintraining/index.aspx>

Expert Opinion on Treatment of Suicide

- Great Britain's National Institute of Health, Clinical Experience (NICE) guidelines (2009)
 - conclude that medications should not be used specifically for BPD or the behaviors associated with the disorder and instead advocate for a structured and integrated clinical approach to BPD,
 - comment on the lack of appropriately trained clinicians in these interventions.



Expert Opinion

Resources cont.

Expert Opinion on Treatment of Suicide

APA guidelines for the Assessment and Treatment of Patients with Suicidal Behavior (2003)

provide specific indications for psychiatric hospitalization for suicide risk and advocate particular agents to target components of suicide risk.

Practice Parameter for the Assessment and Treatment of Children and Adolescents With Suicidal Behavior (2001)

Specific recommendations regarding risk & treatment guidelines, But outdated.

THANK YOU FOR YOUR ATTENTION!

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