

HALF IN LOVE WITH DEATH: Managing Chronic Suicidality

Joel Paris, MD
McGill University,
Montreal, Canada

Do We Know How to Predict or Prevent Suicide?

- The empirical literature suggests that prediction is not yet possible
- If you cannot predict you cannot prevent

Completers vs. Attempters

- Partially overlapping but distinct populations
- Differences in risk factors, age, gender, and methods

PROFILE OF COMPLETERS

- Older
- Male
- Lethal methods (guns, hanging)
- Die on first attempt

PROFILE OF ATTEMPTERS

- Younger
- Female
- Less lethal methods (overdoses)

PSYCHOLOGICAL AUTOPSY STUDIES

- Lesage et al (1994): Less than a third of completers had been in treatment; many were never evaluated
- Hawton et al (1999): only 22% had ever been in treatment
- While 2/3 have primary care contacts, only half of suicides are ever seen in the mental health system

RELATION OF ATTEMPTS TO COMPLETION

- Hawton et al (n=11,583): when attempters were followed long-term, 3% died by suicide (6% of repeated attempters)
- Most other studies yield rates of 5%
- Rates can be somewhat higher in hospitalized samples, depending on criteria for admission
- Rates are about 7% for medically serious attempts

Can Completion be Predicted in Attempters?

- **Two studies (Pokorny et al, 1982; Goldstein et al, 1991) following large numbers of hospitalized patients with attempts found that even when all well-established risk factors were considered, no individual case of completion could be identified by the algorithm.**

The Pokorny Study

- Pokorny et al: (N=4800) followed patients admitted to VA for a decade
- **Algorithm: attempted suicide, suicidal ideation, affective disorder or schizophrenia, depressed feelings, recent violence, low social interest, urge to do harmful things, fear of losing control, remorseful feelings, impatience, and feelings of failure**

No cases of completed suicide identified

The Goldstein Study

- Goldstein et al (n=1906) followed patients admitted to Iowa tertiary care
- Algorithm: number of prior suicide attempts, suicidal ideation on admission, bipolar affective disorder, gender, outcome at discharge, unipolar depressive disorder with family history of mania
- *No completions identified*

Measuring the Nature of Intent

- Scales include Beck's Suicide Intent Scale and Reasons for Living Inventory
- Finnish and British data show that SIS scores statistically predict completion
- But this relationship is not strong enough to be useful in clinical practice

ROLE OF DIAGNOSIS

- Increased rates of completion in schizophrenia, bipolar, melancholia, BPD, and alcoholism (somewhere between 5% and 10%)
- But since most patients in any category do not commit suicide, diagnosis does not aid clinical prediction

WHY SUICIDE PREDICTION IS DIFFICULT

- In relation to prevalence of attempts (5%) or ideation (15%), suicide is a rare event (.01%)
- Predicting suicide on the basis of attempts (or ideation) leads to a large number of *false positives*

Clinical Implications

- No evidence that suicide can be predicted, even in high risk groups
- Attempts are too common for accurate prediction
- Suicidal ideation is even less helpful
- What we have all been taught about clinical prediction of suicide is *wrong*, leading to false positives and wasted resources

PREVENTING SUICIDAL BEHAVIORS

- Suicide *attempts* have been shown to be reduced by many interventions (drugs, therapy) in clinical populations
- Yet the prevalence of ideation, gestures, and attempts has not decreased in the American population over 10 years (Kessler et al, 2004)

PREVENTING SUICIDE

- A review by Mann et al (JAMA, 2005) offered an optimistic picture
- Yet the actual evidence for prevention is slim
- Major interventions: pharmacological interventions, education of professionals and gatekeepers, reducing access to means, and restricting media coverage

PHARMACOLOGICAL PREVENTION

- Bipolar patients taking lithium have a lower suicide rate (Goodwin et al; Kessing et al)
- However it is not clear whether lithium compliance is a confounding variable

PHARMACOLOGICAL PREVENTION

- Suicide rates decreased at the same time as SSRIs were introduced
- Swedish study found that increases in prescriptions lowered rates in specific communities
- Black-box warnings or SSRIs correspond temporally to recent increase in youth suicide (2005-6)
- But causality is difficult to demonstrate

PHARMACOLOGICAL PREVENTION

- Clozapine treatment is associated with reduced suicide in schizophrenia (Meltzer)
- But is this a drug effect or a sampling bias?

EDUCATIONAL PREVENTION

- Rutz et al: program for educating family MDs to recognize and treat depression in Gotland
- Rates went down but results not sustained
- The finding has not been replicated

EDUCATIONAL PREVENTION

- American Air Force Study (Knox et al) taught gatekeepers to recognize depression
- Suicide rates went down by a third
- But needs replication and causality difficult to demonstrate

RESTRICTING ACCESS TO MEANS

- Suicide rates higher in countries with lax gun control
- Reducing size of packages of pain medication □ lowers rates (Hawton)
- Reduced rates in Britain after changes in composition of gas for heating and cooking
- Recent epidemic suicide in China and India associated with easily available insecticides
- Some evidence for reduction after barriers put on bridges (Seiden)

SUICIDE "HOT LINES"

- Pioneered by Samaritans in UK
- But no evidence that rates are lower where such services exist
- Hotlines are used by ideators or attempters, not by potential completers

MEDIA COVERAGE

- Restrictions in force in many cities
- Some evidence for short-term reductions
- Long-term effects not known

PREVENTION STRATEGIES

- *High-risk strategy*: assessing and treating patients with suicidal ideation and attempts
- Some evidence for psychopharmacology
- No evidence for hospitalization
- Most suicides are not seen in the mental health system
- Overall: this strategy has little effect

PREVENTION STRATEGIES

- *Population-based strategy*: **better access to care, educating caregivers, reducing access to means**
- **Some evidence for that this strategy is effective, but more research is needed**

CONCLUSIONS

- Prevention programs, like clinical treatment, needs to be evidence-based
- Thus far the evidence is weak
- If we cannot predict suicide, we cannot prevent it
- Most of what psychiatrists and mental health professionals have been trained to do is ineffective for prevention

CLINICAL IMPLICATIONS

- Suicide is an emotional issue, but management must be based on data
- At least half of all clinicians will experience a completed suicide
- However clinicians should not feel guilty or unnecessarily frightened
- We should avoid doing things that create the appearance of "safety" without data to show that they work (and some may be counter-productive)

The Problem of Chronic Suicidality

- All suicide prevention programs target acute suicidal episodes
- But some patients are chronically suicidal, thinking about the option for years, while making multiple attempts

Borderline Personality Disorder

- Clinical picture of affective instability, impulsivity, unstable relationships, and cognitive symptoms
- Affects about 1% in community studies (Torgersen, Coid, Lenzenweger)
- Prevalence=10% in clinical populations (Zimmerman)

BPD and Suicidality

- Chronic suicidal ideation almost universal
- Multiple attempts common
- Lethality varies from pure gestures to life-threatening acts
- But while almost all patients show this pattern, only a minority eventually kill themselves

How Many Patients with BPD Kill Themselves?

- McGlashan (1987): 3%
- Stone (1990): 10%
- Paris et al (1989): 9%
- Silver and Cardish (1991): 10%
- Kjellstad (1991): 10%
- Links et al (1988): 7%
- Zanarini et al (2007): 4%

A 27-year Follow-up of BPD

(Paris & Zweig-Frank, 2001)

- **80 out of 100 subjects from a previous 15-year follow-up were contacted in 1999**
- **Overall rate of suicide was almost 10% of the original sample**

At What Age Do BPD Patients Kill Themselves?

- Stone (15-years): mean=30
- Paris and Zweig-Frank: mean=37 (SD=10)

In What Circumstances?

- Not when they are acutely suicidal and visiting ER frequently (in their 20's)
- Suicide occurs later in the course, usually when patients have had a long series of unsuccessful treatments
- Most not in therapy at the time

Clinical Implications

- **Suicide is a long-term risk in BPD, but we can be less concerned about younger, less chronic cases**
- **The patients who kill themselves will be older and treatment failures**
- **We do not need to take extraordinary measures to try to prevent suicide in younger more acute patients**

DEFINING "SUICIDALITY"

- Thoughts: common in all depressed patients, lifetime rate in the general population is 15%
- Thus by themselves, suicidal thoughts should not be a cause for alarm

DEFINING "SUICIDALITY"

- Attempts: occur only in some depressed patients; general population rate is 5%
- repetitive attempts occur in treatment seeking females; about half of these cases have BPD (Forman et al, 2004)

DEFINING "SUICIDALITY"

- Completions: more common in males, who are often successful on the first attempt
- community rate is 11/100,000 (about 1/500 the rate of attempts)

SUICIDE ATTEMPTS IN BPD

- --usually overdoses
- --motivation ambivalent; intent is to escape (Brown et al, 2002) and/or to communicate a message
- -- impulsive and recurrent
- --often after a quarrel
- --often in front of others
- --rescuers frequently contacted

Self-Injury

- these behaviors are *not* suicide attempts, intent differs from overdoses (Brown et al, 2002)
- cutting provides relief from dysphoria
- often repetitive and addictive

Functions of Suicidality in BPD

- Comforting idea that one can always escape from pain, emptiness, and hopelessness
- Offers a sense of control
- Communicates distress to significant others--and to therapists ("turning the volume up")

Clinical Implications

- Taking away chronic suicidality deprives patients of something they need
- Suicidal ideas may in any case disappear when the patient recovers
- In the meantime, therapists can indicate respect for the patient's options (while recommending patience)

What Not to Do

- 1) Hospitalization: accomplishes little, is counter-productive, and does not prevent suicide
- 2) There is no need to panic when patients threaten suicide, even if one cannot help but worry

DOES HOSPITALIZATION PREVENT SUICIDE IN BPD?

- Lack of evidence that “safety” requires an admission (no RCTs)
- Many patients return to square on after discharge
- Completion rates are as high in hospital follow-ups as in out-patient samples

HOSPITALIZATION IN BPD

- Management largely consists of a “suicide watch”
- Unlike schizophrenia or severe mood disorders, there are no specific treatments that need to be carried out in hospital

“Adjusting” Medication in Hospital

- Not a useful procedure, since one can only expect marginal results (Cochrane report, 2006)
- Similar effects for all agents neuroleptics, SSRIs, mood stabilizers--all decrease impulsivity with little effect on affect
- One *never* sees remission of BPD with meds

Psychotherapy in Hospital

- Evidence from RCTs that several forms of therapy (DBT, MBT, schema therapy, TFP) are effective for BPD
- But none of these methods require hospitalization

Why are BPD Patients Admitted?

(Hull, 1996)

- psychotic episodes
- serious suicide attempts
- suicidal threats
- self-mutilation

What Makes Sense?

- Treating psychotic episodes rarely but occasionally requires an admission
- Re-evaluation after near-fatal attempts might be useful
- Admission for mild attempts or threats does not prevent suicide
- Self-injury is not suicidal behavior

NEGATIVE EFFECTS OF HOSPITALIZATION in BPD

- reinforcement of pathological behaviors
- malignant regressions

TESTIMONY OF A RECOVERED BORDERLINE PATIENT

- “When you as a service provider do not give the expected response to these threats, you’ll be accused of not caring. What you are really doing is being cruel to be kind. When my doctor wouldn’t hospitalize me, I accused him of not caring if I lived or died. He replied, referring to a cycle of repeated hospitalizations, ‘that’s not life’. And he was 100 percent right!” (Williams, 1999)

TESTIMONY OF A RECOVERED BORDERLINE PATIENT

- “Do not hospitalize a person with borderline personality disorder for more than 48 hours. My self destructive episodes--one leading right into another--came out only after my first and subsequent hospital admissions, after I learned the system was usually obligated to respond.” (Williams, 1999)

DAY TREATMENT

- structure leads to minimal regression
- efficacy supported by clinical trials (Piper, 1998; Bateman & Fonagy, 2001)

PRINCIPLES OF MANAGEMENT

- treatment should be ambulatory
- hospitalization should be avoided
- day treatment can be a backup

What the Literature Shows About Treating BPD

- Out-patient, well structured psychotherapies are the best documented treatments
- Medication is adjunctive
- Polypharmacy should be avoided

PRINCIPLES OF MANAGEMENT

- if patients threaten suicide, take an overdose or cut themselves, therapists should respond with empathy, curiosity, and maintain a problem-solving approach

WHAT IF I GET SUED?

- suicide occurs at least once in the careers of 50% of psychiatrists and psychologists (Chemtob et al, 1988)
- suicide accounts for 20% of all lawsuits in USA (20% are upheld)
- most involve early discharge of acutely depressed inpatients;
- few concern chronically suicidal patients

How to Prevent Lawsuits

- Involve the family
- Get a consultation
- Write careful records explaining your rationale and treatment plan

Involving the Family

- **Families are more likely to be angry if they were never consulted or involved**
- At the beginning of therapy, family members should be interviewed and brought in to Rx as partners
- It must be explained that suicide is always a possibility, even if treatment aims to make it less likely
- Also explain why admission would not be helpful

RECORD-KEEPING AND CONSULTATION

- Successful suits are based on a failure to evaluate and poor records (not the fact of suicide)
- You are always in a better position if another clinician has seen the patient and supports your plan.

THE VIEW OF AN EXPERT ON SUICIDE

- “We cannot afford to be so afraid of litigation as to deny our patients the right to learn to live”
(Rachlin, 1984)

Conclusions

- Psychiatrists do not know how to prevent suicide
- Even the best physician will have some suicides in the course of a career.
- The focus has to be on treating the patient, not on an impossible goal of suicide prevention

Conclusions

- Chronic suicidality makes treating BPD a challenge
- But repeated hospitalizations in response to threats and attempts are of no value
- Moreover, repetitive hospitalizations prevent therapy from taking place or “getting a life”

Clinical Implications

- Patients with BPD need evidence-based psychotherapy
- Whereas several methods (DBT, TFP, MBT) are supported by clinical trials, therapies informed by these ideas may also be effective
- BPD patients receive too many medications

Clinical Implications

- When patients are suicidal, concentrate on the problems that make them think along these lines
- Always remain empathic with the pain that makes people want to escape life
- Use the knowledge that most patients eventually get better.