27 Psychological Interventions in Suicide

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Abstract

Psychological treatments targeting suicidal behavior disorder (SBD) have been evaluated here in their efficacy through different diagnoses. In particular, transference-focused psychotherapy (TFP), mentalization-based treatment (MBT), interpersonal psychotherapy (IPT), dialectical behavior therapy (DBT), schema-focused therapy (SFT), mindfulness-based cognitive therapy (MBCT), mindfulness-based stress reduction (MBSR), acceptance and commitment therapy (ACT), and cognitive behavior therapy (CBT) were the main structured treatments considered here in association with their impact on SBD. Some of them showed higher efficacy in suicide (DBT and MBT). Moreover, some treatments have been primarily studied in a specific diagnosis: TFP, MBT, DBT, and SFT in borderline personality disorder and IPT and CBT in depression. Concerning new treatments, promising preliminary results have been reported (SFT, MBCT, MBSR, and ACT) as well. Summarizing, consistent reduction in suicidal and self-destructive phenomena through psychotherapeutic treatments has been found throughout methodologically heterogeneous trials, in particular focused on DBT and MBT. In conclusion, two movies by the Italian documentarist/director Alina Marazzi have been illustrated in their connection with SBD.

Abbreviations

ACT	Acceptance and commitment therapy
BD	Bipolar disorder
BPD	Borderline personality disorder

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CBT	Cognitive behavior therapy
DBT	Dialectical behavior therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
EMS	Early maladaptive schema
IPT	Interpersonal psychotherapy
MBCT	Mindfulness-based cognitive therapy
MBSR	Mindfulness-based stress reduction
MBT	Mentalization-based treatment
MDD	Major depressive disorder
NSSI	Non-suicidal self-injury
RCT	Randomized controlled trial
SBD	Suicidal behavior disorder
SFT	Schema-focused therapy
SPI	Safety planning intervention
TAU	Treatment as usual
TFP	Transference-focused psychotherapy

27.1 Introduction

> Un'ora sola ti vorrei
> Io che non so scordarti mai
> Per dirti ancor nei baci miei
> Che cosa sei per me
>
> Un'ora sola ti vorrei
> Per dirti quello che non sai
> Ed in quest'ora donerei
> la vita mia per te
>
> Io non vedo il mondo
> Quando penso a te
> Vedo gli occhi tuoi nei miei
> Ma se non mi vuoi
> Non è niente sai
> La vita mia per me
>
> Un'ora sola ti vorrei
> Io che non so scordarti mai
> Per dirti ancor nei baci miei
> Che cosa sei per me.[1] Bertini and Marchetti (1938)

[1] Literal translation: I'd wish you just for one hour/I am not able to forget you/To tell you again in my kisses/What you are for me. I'd wish you just for one hour/To tell you what you don't know/And during this hour I'd give/My life for you. I can't see the world/When I think of you/I see your eyes in mine/But if you don't want me/My life, you know/Doesn't mean anything to me. I'd wish you just for one hour/I am not able to forget you/To tell you again in my kisses/What you are for me.

The inclusion of suicidal behavior disorder (SBD) in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association 2013) highlights the need to deepen its knowledge and to identify new strategies that could be more effective for SBD prevention and treatment across different diagnoses. Psychiatric disorders related to suicidal thoughts and behaviors are mainly borderline personality disorder (BPD), major depressive disorder (MDD), bipolar disorder (BD), schizophrenia, anxiety disorders (posttraumatic stress, panic, and social anxiety disorders), and anorexia nervosa.

Generally, the clinical management of SBD patients requires a careful consideration of therapist interventions, with the focus on three main principles in the context of shared responsibilities for patient safety: the alliance between the patient and the clinician, the enhancement of curiosity about suicidal thoughts, and the enhancement of experience, expression, and understanding of intense emotions (Fowler 2013). These three principles should be developed in a collaborative relationship with the therapist in order to decrease the patient isolation in case of intense and overwhelming emotions.

Beyond broad clinical treatment principles, structured psychotherapy treatments have been found to be significantly beneficial for patients with suicidal thoughts and behaviors, obviously together with higher level of care, such as hospitalization and intense inpatient or outpatient treatments in acute phases. In particular, specific interventions targeting suicidality, including both short- and long-term treatments, have been found to be effective.

The primary aim of this chapter is to give to the reader an as much as possible complete overview of the main available psychological interventions that, to some extent, have been found to be effective in the treatment of SBD. So my aim was not to perform a systematic review of the literature but to include the most significant (e.g., published in high-impact factor journals) and recent studies only. The secondary aim of this work is to critically evaluate the spread survey of findings, trying to suggest ways of integrating the overall results. Since the literature state of the art is quite scattered, this chapter might represent a starting summarizing point and a way to give some recommendations for future studies.

27.2 Methods

A literature web search was performed to identify studies focusing on psychological interventions in SBD. PubMed database was used to search articles published until August 2015 using the word combinations "psychological interventions" or "psychotherapy" or words specifically indicating psychotherapeutic models (e.g., "transference-focused psychotherapy") and "suicide." Only papers in English language were included. The reference lists of the identified studies and reviews were checked for further relevant articles as well. Concerning the primary aim of this chapter, studies were included if (1) they focused on psychological interventions in SBD; (2) they focused on psychiatric patients; (3) they considered adolescents, adults, or elderly patients; and (4) they examined every kind of psychological

interventions. Studies were excluded if (1) they did not consider suicidal behavior or self-harm as an outcome and (2) they were focused on treatments different from structured psychological ones (e.g., clinical management, implementation of emergency call centers, programs in schools, information campaigns). Further studies have been included if interesting for the secondary aim of this chapter.

Since this is not a systematic review of the literature, the most significant and recent studies have been included only. When a recent review on a specific topic was published, I referred to that one, without reporting each single previous study.

27.3 Transference-Focused Psychotherapy

The transference-focused psychotherapy (TFP) is a psychodynamic object relations approach introduced by Clarkin et al. (1999) and Kernberg et al. (2008). TFP's primary focus is the dominant affects that emerge in the relationship between patient and therapist. This therapeutic approach is prominent in the treatment of BPD considered as a level of psychic functioning, an organization, and not a clinical syndrome like in DSM. Moreover, TFP is described in its specificity for the treatment of characterologically based suicidal and parasuicidal tendencies in the context of the patient's personality disorder (Kernberg 2001). Kernberg focused on the self-destructiveness of these patients, which could lead to suicidal behavior, differentiating them from patients affected by depression (Kernberg 2014): in personality disorder patients, the suicidal behavior could represent an unconscious triumph on the treatment, while in depression it is expression of guilt. This should be repeatedly underlined with these patients and with their families as well. Another point is the unconscious identification with a sadistic object and its interpretation during treatment and not only the focus on the patient as a victim of trauma. More generally, the therapist should deal with the negative affects in the countertransference relation. The therapist should be able to recognize antitherapeutic defense mechanisms as repression, turning against himself, reaction formation, projection, distortion, and denial of countertransference hate that might increase the danger of suicide (Maltsberger and Buie 1974).

After a preliminary uncontrolled trial on TFP supporting its positive impact on suicidal behavior (Clarkin et al. 2001), the same team of research compared three treatments for BPD: TFP, dialectical behavior therapy (DBT), and dynamic supportive treatment (Clarkin et al. 2007); both TFP and DBT were significantly associated with improvement in suicidality. The efficacy of TFP treatment in the reduction of suicidality has been reported as well when comparing it with treatment by experienced community psychotherapists (Doering et al. 2010).

27.4 Mentalization-Based Treatment

The mentalization-based treatment (MBT) (Bateman and Fonagy 2004, 2006) is a psychodynamic treatment rooted in attachment and cognitive theory. Mentalization is a deeply social construct, the process by which a subject has a sense of identity

and is able to make sense of the other person in terms of subjective states and mental processes and consequently to have good relationships (Bateman and Fonagy 2010). The word mentalization derives from the Ecole Psychosomatique de Paris (Leslie 1987), and it was used for the first time by Fonagy in relation to mental disorders (Fonagy 1989). This concept is different from the one of introspection since it consists in an unconscious implicit automatic awareness instead of a conscious one. Deficits of this mentalization capacity can be found in most mental disorders, including suicidal behavior, which implies the tendency to misinterpret other peoples' motivations. This misinterpretation is hypothesized to be due to the lack of a mirroring response of the caregiver, which might contribute, together with other factors, to the inactivation of the mentalization capacity in the child.

MBT is focused on strengthening patients' capacity to understand their own and others' mental states. Since it requires limited training, with moderate levels of supervision, it represents a cost-effective treatment for suicidal behavior. MBT efficacy on suicidal and self-destructive phenomena has been investigated in BPD patients. Patients randomly assigned to 18-month MBT showed a consistent reduction in suicide attempts, severe incidents of self-harm, and hospitalization in comparison with structured clinical treatment (Bateman and Fonagy 2009). Self-harm improved more slowly with MBT than with structured clinical treatment, although with a final more remarkable reduction. Interestingly, even 5 years after discharge, 18-month MBT showed clinical and statistical superiority to treatment as usual (TAU) on suicidality (Bateman and Fonagy 2008). Also when specifically considering self-harm in adolescent population, MBT was found to be more effective than TAU (Rossouw and Fonagy 2012).

In a Norwegian study, a naturalistic longitudinal comparison of treatment effects for BPD patients before (patients were admitted to a psychodynamic treatment program) and after transition to MBT has been performed (Kvarstein et al. 2015). A decrease in suicidal/self-harming acts and hospital admissions has been reported during both treatments. However, considering further outcomes (symptom distress, interpersonal problems, and global functioning), MBT seemed to be more effective than psychodynamic treatment. A positive impact on both suicide attempts and self-harm acts has been also reported in the Netherlands (Bales et al. 2012).

Summarizing, MBT has been found to be effective on suicide and self-harm mainly in BPD. Since mentalization disturbances are involved in psychotic disorders (Brent et al. 2014; Brent 2009), further studies specifically investigating the impact on suicide in these (and further) disorders are needed.

27.5 Interpersonal Psychotherapy

Interpersonal psychotherapy (IPT) has been developed in the New Haven-Boston Collaborative Depression Research Project by Klerman and Weissman (Klerman et al. 1974; Weissman et al. 1979), being inspired by Sullivan's psychodynamic interpersonal theory (Sullivan 1953). IPT focuses on identifying and helping to solve interpersonal difficulties which cause or exacerbate psychological distress.

In particular, addressed problems fall into four categories: interpersonal disputes or conflicts, role transitions, grief, and interpersonal deficits.

IPT has been specifically evaluated concerning suicide: patients who had deliberately poisoned themselves and had received IPT reported a higher reduction in suicidal ideation at 6-month follow-up compared with those of the TAU control group (Guthrie et al. 2001). More recently, IPT appeared to be a safe treatment for unipolar depressive patients with past suicide attempts (Rucci et al. 2011).

IPT efficacy has been also evaluated in different populations in relation to suicide. In depressed adolescents with suicidal risk, it has been found to be effective in comparison with TAU in reducing suicidal ideation, hopelessness, and severity of depression and anxiety (Tang et al. 2009). Furthermore, IPT has been adapted for elderly individuals (over 60 years) at risk for suicide (current suicide ideation, death ideation, and/or recent self-injury) in a Canadian uncontrolled pre- to posttreatment psychotherapy trial (Heisel et al. 2014). After 16 IPT sessions, patients were found to report decreased suicide ideation, death ideation, and depressive symptom severity and increased perceived meaning in life, social adjustment, perceived social support, and other psychological well-being variables.

27.6 Psychodynamic Psychotherapy

Since we know little about the therapeutic process and mechanisms of change associated with recovering from suicidal behaviors, Canadian Perry's team focused on it in the context of a long-term psychodynamic psychotherapy trial (Perry et al. 2013). In general a consistent reduction of suicidal behaviors has been reported. Patients with suicidal ideation used to stay in treatment longer and with a higher rate of sessions than those without suicidal ideation. So, suicidal ideation was not only an indicator of both symptom severity and treatment duration but also of the possibility of improvement and recovery. Moreover, suicidal patients reported higher rates of negative reactions to treatment, reflecting their higher level of expression of negative affects. The improvement was linked to the capability for patients to express these negative affects in the therapeutic dialogue. In fact it is relevant that the mobilization of negative affects was found to be related with symptom improvement. Concerning therapeutic alliance, suicidal ideation has been found to be associated with higher rate of difficulties in the early participation and in the exploration of topics. However, these difficulties diminished during the first 6 months of follow-up. Hence, negative affects toward the therapist (e.g., negative countertransference) are not necessarily problematic, but an instrument to be used in the direction of recovery. Consequently, it is possible to conclude that the expression of negative affects in the treatment of suicidal patients is strictly linked to the recovery process and that the therapists should actively inquire these affects and/or address defenses inhibiting them (e.g., repression).

The effectiveness of combined treatment (medication plus psychodynamic psychotherapy) versus only psychodynamic psychotherapy on both suicidality and impulsivity has been evaluated in inpatients with severe personality disorder (Vaslamatzis et al. 2014): predictably combined treatment was more effective in suicidality.

27.7 Dialectical Behavior Therapy

DBT is a treatment for suicidal behavior and BPD (Linehan and Wilks 2015; Linehan 1993a, b). Furthermore, preliminary evidence that DBT could be efficacious in BPD-related disorders as PTSD (Harned et al. 2012), binge eating disorder and bulimia nervosa (Chen et al. 2008), and substance abuse disorders (van den Bosch et al. 2005) has been reported as well.

BPD has been seen as a primary dysfunction of the emotion regulation system. BPD patients attempted suicide since it appears to them to be a behavioral solution to intolerably painful emotions. Three essential strategies of a DBT session have been recognized: structuring the content of the session, core strategies of problem-solving and validation, and dialectical strategies and worldview (Bedics et al. 2013).

The effectiveness of DBT in reducing suicidal behavior has been extensively studied. It has been firstly reported by Linehan et al. (1991), with decreased suicide behaviors, less medically severe ones, and fewer inpatient psychiatric days, in comparison with TAU (Linehan et al. 1993). Moreover, 1 year of DBT has been compared to community treatment by experts (Linehan et al. 2006). DBT was associated with better outcomes. In particular, subjects receiving DBT were half as likely to attempt suicide, required lower rates of hospitalization for suicide ideation, and reported lower medical risk across both suicide attempts and self-injurious acts considered together. Furthermore, higher reduction of self-mutilating and self-damaging impulsive behaviors compared with TAU, in particular among patients with a history of frequent self-mutilation, has been detected (Verheul et al. 2003). It should be underlined that results are mostly referred to women. Interestingly, it has been specifically assessed if the effectiveness of DBT could be attributed to general factors associated with psychotherapy, and DBT appeared to have a unique efficacy in reducing suicide attempts (Linehan et al. 2006). Recently M. Linehan and colleagues evaluated the importance of the skills training component of DBT in a randomized trial and reported that interventions including DBT skills training were more effective than DBT without it for reducing suicide attempts and non-suicidal self-injury (NSSI) episodes (Linehan et al. 2015). In a Canadian 2-year prospective naturalistic follow-up study, BPD patients were randomly allocated to 1 year of either DBT or general psychiatric management. Both treatments showed similar and statistically significant improvements on suicidal and NSSI behaviors 2 years after discharge (McMain et al. 2012). Similar results have been previously reported by the same team of research after 1 year of treatment (McMain et al. 2009). The persistence of DBT efficacy after 2 years of follow-up has been reported as well (Kleindienst et al. 2008). Furthermore, in adolescents with self-harming/previous suicide attempt, DBT seemed to be an effective intervention to reduce self-harm, suicidal ideation, depression, and NSSI behavior (Mehlum et al. 2014; Fleischhaker et al. 2011) (for reviews on DBT on adolescents, see MacPherson et al. (2013) and Klein and Miller (2011)).

Considering the advantages of the group approach in terms of cost-effectiveness over individual treatment, a first attempt in showing that DBT in an outpatient group

setting can be effective in reducing psychiatric complaints has been performed with positive preliminary findings (Gutteling et al. 2012).

Summarizing, a consistent number of studies confirmed the efficacy of DBT in the treatment of suicidal behavior, and new highly cost-effective strategies might be further implemented.

27.8 Schema-Focused Therapy

Schema-focused therapy (SFT) is among the third-wave cognitive therapies together with mindfulness-based approaches and acceptance and commitment therapy (ACT). SFT combines elements of cognitive behavioral, attachment, object relations, and emotion-focused models (Young 1994). The construct of early maladaptive schema (EMS) corresponds to an early-developed pervasive emotional and cognitive pattern regarding the self and the relationships with others that is dysfunctional. There are four main EMSs that are the focus of SFT (Boulougouris et al. 2013): child modes, maladaptive coping modes, maladaptive parent modes, and a healthy adult mode.

SFT has been found to be effective in BPD (Nadort et al. 2009). Specifically concerning suicidal behavior, the relationship between SFT for suicide prevention and neurobiological models has been deepened (Boulougouris et al. 2013). In fact, authors underlined the existing link between the serotonergic system and temperamental traits and dysfunctional attitudes of suicidal patients, and they focused on the correlation between some of these temperamental traits and EMSs.

In a multicenter randomized trial, the effectiveness of SFT has been compared to the one of TFP in BPD patients (Giesen-Bloo et al. 2006). SFT group improved more than TFP one with respect to suicidal behavior. However, as suggested by the authors, it is possible to hypothesize that MBT and DBT are most efficacious for BPD patients with suicidal behavior, whereas TFP and SFT are mostly meaningful for the wide range of BPD patients.

Unfortunately, only a few studies considered SFT efficacy on suicide. For example, in a study supporting the efficacy of group SFT for BPD, all the included patients had a history of suicide attempts and self-injury in the previous 2-year period (Farrell et al. 2009), but outcome measures did not include suicidal behaviors.

27.9 Mindfulness-Based Approaches

The word mindfulness refers to a particular way of paying attention to the present moment consisting in a receptive and nonjudgmental attitude (Kabat-Zinn 1994). Mindfulness-based approaches are becoming broadly used for suicidal behavior patients (Williams et al. 2006; Williams and Swales 2004). In particular, mindfulness-based cognitive therapy (MBCT) effects on two aspects of mode of processing have been evaluated in suicidal depressed patients: patients having received MBCT

displayed differences in meta-awareness and specificity of memory compared with those having received TAU (Hargus et al. 2010). Furthermore, a preliminary study examined MBCT effects on thought suppression and depression in individuals with past depression and suicidality, reporting evidence that MBCT may reduce self-reported attempts to suppress thoughts in the previous week (Hepburn et al. 2009). Moreover, MBCT was found to decrease suicidal ideation in patients with residual depressive symptoms, and this effect seemed to be partially mediated by patients' enhanced capacity to distance themselves from worrying thoughts (Forkmann et al. 2014). Finally, significant reductions in suicidal ideation, anxiety, and depression were observed after mindfulness-based stress reduction (MBSR) training in veterans (Serpa et al. 2014).

Further studies are required to evaluate both MBCT and MBSR impact on suicide.

27.10 Acceptance and Commitment Therapy

ACT is a "third-wave" cognitive therapy that could be considered as consistent with mindfulness conceptualizations as well. It is an effective putative psychotherapeutic approach among new prevention and treatment strategies in SBD (Hayes et al. 2006). Indeed, it has been found to be efficient for the treatment of several psychiatric disorders – most of them associated with an increased suicidal risk – such as BPD, MDD, eating disorders, obsessive compulsive disorder, generalized anxiety disorder, psychosis, and substance use disorders. Interestingly, two case reports have suggested the ACT role in the prevention of suicidal reattempt at 1 year (Luoma and Villatte 2012). Moreover, in a recent pilot study, ACT was found to decrease suicidal ideation in patients with current SBD (Ducasse et al. 2014). Consequently, ACT seems to represent a promising adjunctive treatment for high-suicidal-risk patients.

27.11 Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is the best known structured form of psychotherapy. It is based on Beck's cognitive theory (Beck 1976). Two main mechanisms, poor problem-solving skills and a certain cognitive style characterized by overgeneralization, distortion, and lack of positive expectations, have been identified in suicidal patients (Schneider 2012). The behavioral modification includes the acquisition of skills for stress reduction and learning problem-solving. The cognitive modification encompasses modification of negative core beliefs (hopelessness), thought-stopping, examining options and alternatives, externalizing inner voices, and reattribution. In particular, hopelessness is viewed as one of the strongest contributing factors to suicidal ideation, and a large part of the treatment intends to restore hope.

It has been suggested that suicide risk linked to severe mental illness might be reduced by the improvement of the access to psychological/psychosocial

interventions, remarkably CBT (Foster 2013). Moreover, in an extremely interesting 7- to 19-year follow-up study, to have responded to CBT for anxiety during childhood conferred benefits later in life, in particular less chance to report both lifetime and current suicidal ideation in comparison to CBT nonresponders (Wolk et al. 2015).

Concerning depression, CBT has been so far considered as a first-line treatment both for adults (Jayasekara et al. 2014; Jakobsen et al. 2011; Sudak 2012) and adolescents (Nardi et al. 2013; De Silva et al. 2013). CBT is the most extensively studied psychological treatment in MDD, and, to our knowledge, this is one of the few psychological treatments that could have been analyzed through meta-analytic methodology (Jakobsen et al. 2011; Dubicka et al. 2010). In particular, randomized trials comparing CBT effects versus no intervention in MDD have been meta-analyzed. CBT effects on suicidality are far to be clear since only a few trials reported suicidal ideation, suicide attempts, and suicide deaths. Moreover, in adolescent depression no evidence of a significant benefit of combined treatment over antidepressants has been reported for suicidality (Dubicka et al. 2010). Consequently, despite the high number of CBT studies, further research is required on MDD and the other psychiatric disorders. Concerning BPD, evidence of efficacy on symptomatology is not robust (Stoffers et al. 2012), and suicide outcome should be more deeply investigated as well.

27.12 Comparison among Different Treatments across Different Diagnoses

Recent reviews have been published on the efficacy of psychotherapies in BPD (Lana and Fernandez-San Martin 2013; Paris 2010; Zanarini 2009; Rafaeli 2009; Stone 2006). Concerning BPD suicidality, DBT seemed to be one of the most efficacious treatments. For a clinical comparative description by four master clinicians of, respectively, TFP, MBT, DBT, and good psychiatric treatment in BPD, see Hopwood et al. (2014). The impact of less versus more intensive psychotherapies in reducing suicidal behavior and depression in BPD suicidal patients was examined assessing six trials focused on CBT, MBT, and DBT (Davidson and Tran 2014). Both different length therapies were found to significantly decrease suicidal behaviors. Two follow-up studies showed that this reduction is maintained over time. So, it has been suggested that all the treatments, which have several similarities, could be shortened to make them more accessible. An intriguing program for individuals diagnosed with personality disorders is the Chrysalis Community Day Treatment Program, which integrates aspects of three therapies: TFP, MBT, and DBT, with preliminary promising outcomes such as decreases in self-injurious behavior, suicide attempts, and psychiatric hospitalizations at a 1-year follow-up (Rivera and Darke 2012).

In a recent review of interventions for co-occurring BPD and substance use disorder, ten studies have been included (Lee et al. 2015): four studies examined DBT, three studies examined dynamic deconstructive psychotherapy (DDP), a treatment specifically tailored for BPD patients with co-occurring substance use disorders (see Gregory and Remen (2008)), and three studies examined dual-focused

SFT. Both DBT and DDP demonstrated reductions in suicidal/self-harm behaviors and substance use and improved treatment retention.

Concerning MDD treatment, previous randomized controlled trials (RCTs) and meta-analyses supported the efficacy of CBT, IPT, behavioral activation therapy, problem-solving therapy, supportive counseling, and possibly psychodynamic therapy (Weitz et al. 2014). Concerning suicidal ideation there is limited evidence to whether or not psychotherapy for MDD represents the best course of action. However, a consistent reduction in hopelessness has been reported. Internet-based CBT and IPT need further investigation. In particular IPT seems to be efficacious in different populations like adolescents and elderly. However, in a recent meta-analysis, sensitivity analyses revealed no differences between different types of psychological treatments (e.g., CBT, IPT) (van Zoonen et al. 2014). Third-wave cognitive therapy may be more effective than MBT for depressive symptomatology (Jakobsen et al. 2014; Jakobsen 2014).

Concerning BD, both psychosocial suicide crisis interventions and longer-term psychosocial treatments have been evaluated in their efficacy to reduce suicide risk (Chesin and Stanley 2013). Very short suicide prevention interventions include contacts, psychoeducation on warning signs, and CBT strategies. Regarding contacts, letters/messages sent on a regular schedule seemed to be efficacious in reducing suicide rates and further subsequent self-harm even after 2 years of follow-up; however, this kind of contact may work for specific subgroups of patients only. Moreover, short interventions providing educations on risk factors, coping skills, and treatment motivation enhancement seemed to be effective. The same could be said for the means restriction education, a short intervention for the parents of children and adolescents at suicide risk. The new Safety Planning Intervention (SPI) has been evaluated as well with promising preliminary results on its efficacy. It consists of a written, personalized safety plan for the reference of the patients in future suicidal crisis, given to patients after a single session. It has six steps: a detailed assessment of warning signs of the suicidal crisis, internal coping skills, social contacts that may distract from suicidal thoughts and urges, family members that may offer help, professional and agency contacts, and means restriction. Summarizing, short interventions seemed to be efficacious but showing better outcomes in the shorter term. Concerning longer interventions, the DBT obtained the largest evidence of efficacy. However, a validated psychosocial intervention targeting suicidality in BD patients should be developed.

Interestingly, a systematic review has been performed on suicide and self-harm through different diagnoses in young people (between 6 and 25 years) (De Silva et al. 2013). Promising interventions that need further investigation were school-based prevention programs with a skills training component, individual CBT, IPT, and attachment-based family therapy.

27.13 A Meta-analysis

A lack of consensus on the effectiveness of psychological interventions in suicidal behavior has been reported in meta-analyses as well. In a first one, the efficacy of a wide range of therapies – CBT, DBT, and problem-solving approaches – has been

reported in reducing suicidal behavior when it was considered as an extremely wide outcome variable, comprising different indicators (such as suicidal attempts, behaviors, plans, thoughts together with hopelessness and satisfaction with life measures) (Tarrier et al. 2008). On the contrary, psychosocial interventions following self-harm seemed not to have a marked effect on the likelihood of subsequent suicide death (Crawford et al. 2007).

A further recent interesting meta-analysis has been published on adolescents to evaluate the efficacy of therapeutic interventions (psychological, social, and pharmacological) in reducing any self-harm (suicide attempts, non-suicidal self-injury (NSSI), and/or self-harm with ambiguous intent) (nineteen included studies) and suicide attempts separately considered (eight included studies) (Ougrin et al. 2015). Evidence of efficacy was reported for the global category of self-harm, with high between-study heterogeneity, but not for suicide attempts.

Consequently, we performed a meta-analysis of RCTs assessing efficacy of psychological interventions in reducing suicidal attempts and NSSI (submitted). We included RCTs comparing psychotherapy interventions versus TAU in preventing suicidal attempts/NSSI across a wide range of psychiatric diagnoses. In the 32 included RCTs, 4114 patients were randomly assigned to receive psychotherapy ($n = 2106$) or TAU ($n = 2008$). Patients who received psychotherapy were less likely to attempt suicide during follow-up. Moreover, in sensitivity analyses the efficacy of psychotherapy on suicide attempts was found in particular in adults, BPD diagnosis, both previous suicidal patients and non-previous suicidal ones, both short- and long-term therapies, and MBT. No evidence of efficacy has been found in NSSI behaviors, with the exception of MBT; however, this sub-analysis was underpowered to lead to firm conclusions. Hence, psychotherapy seems to be effective in the prevention of suicide attempts. However, evidence of between-study heterogeneity and publication bias slightly tempers enthusiasm and optimism led by results.

27.14 Discussion

The primary aim of this work was to provide an as much as possible complete overview of all the psychological interventions available that, to some extent, have been found to be effective in the treatment of SBD. To the best of our knowledge, current research suggests that there are several effective treatments for SBD. This might mean that they contain generic common elements which are responsible for their positive outcome. As suggested by Bateman and Fonagy, a specific focus using a coherent theoretical model is likely to improve outcomes (Bateman and Fonagy 2009). DBT in particular showed high efficacy in suicide even if the corresponding higher rate of studies performed on suicide outcome, in comparison with the ones on different treatments, should be taken into account in the evaluation of this conclusion. Interestingly, in our meta-analysis MBT was the only efficacious treatment for the prevention of both suicide attempts and NSSI, even if the fact that only two studies on MBT have been included represents a limitation of these findings.

Concerning the relation between adherence to therapy and its efficacy, even if the hypothesis that greater adherence to therapy is indicative of its efficacy has been broadly sustained, the reported great variability renders possible another hypothesis: considering the fact that therapists are obviously not blind to the treatment, it could be hypothesized that therapists trained in new therapies could tend to be more enthusiastic and to cope with difficulties with higher liveliness in comparison to those applying standard or unstructured treatments (Lana and Fernandez-San Martin 2013; National Collaborating Centre for Mental Health 2009). Therefore, in future studies, a higher consideration of the therapy specificity should be paid.

Several setting features extensively variable throughout the studies could have represented extremely relevant factors of heterogeneity.

(i) The trials' design: the case of naturalistic studies versus randomized controlled ones; the focus on extremely different outcomes, such as suicidal ideation, suicide attempt, NSSI, self-harm, and suicidal events (Posner et al. 2007); the lack of the focus on suicidal behavior, but the focus on a broader symptomatology until psychotherapeutic process (examination of session transcripts) – the majority of the included studies were not performed with the primary outcome of suicidal behavior; the lack of a deep consideration of a differentiation between suicide prevention studies and studies focused on patients after a suicide attempt; different population samples (adults, adolescents, elderly); individual versus group therapies; the inclusion/exclusion selection criteria of SBD patients; the focus on extremely different diagnoses (e.g., BPD versus MDD); and the unpowered sample size of the studies.

(ii) The therapist factor: the duration of the therapists' training and supervision, the mean year of his/her post-training experience, and the therapists' specific training on the treatment of SBD.

(iii) The treatment factor: a systematic therapy versus a nonsystematic one; the mean duration of psychotherapeutic treatment (short- versus long-term therapies) and the number of weekly sessions; the duration of the follow-up; the use of specific therapy manuals and/or supervision groups; the concomitant use of psychotropic drugs (pharmacological classes and dosages), concurrently or sequentially and the concomitant use of further therapeutic treatments (self-help groups, family or couples therapy, psychoeducational groups); and treatments specifically focused to target SBD or not.

When cost-effectiveness of treatments for BPD has been evaluated, most evidence has been found for DBT. CBT and SFT have been found to be cost-saving as well, with scarce evidence for other interventions (Brettschneider et al. 2014). Moreover, when cost-effectiveness of SFT versus TFP in treating BPD has been assessed, the SFT was found to be less costly and more effective than TFP for recovery (van Asselt et al. 2008). Summarizing, the economic evidence is not sufficient to draw robust conclusions for all treatments, with the exception of DBT and SFT. Consequently, further studies concerning the cost-effectiveness of treatments throughout different diagnoses and specifically focusing on suicidal behavior as an effect measure are necessary.

27.14.1 Limitations

Specific limitations of this literature review and conclusions could be linked to the previously listed limitations of the included studies. In particular, the variability observed in outcome variables could have modulated differences in the results on treatment efficacy. Furthermore, the multiple hypotheses of the majority of studies, not all clearly focused on a primary outcome, and the unpowered samples could have biased the findings. Limitations linked to bias of study selection and conclusions should be acknowledged as well: articles not written in English, not included here, could offer a consistent increase on the knowledge on psychotherapeutic treatments; moreover, not all treatments could have been included here but the most extensively studied only; finally, considering my psychoanalytic background, psychodynamic concepts might be better deepened and discussed.

27.14.2 Conclusions

Consistent reduction in suicidal and self-destructive phenomena through psychotherapeutic treatments has been found throughout methodologically heterogeneous trials, in particular focused on DBT and MBT. Hence, current research suggests that there are several effective treatments for SBD. This might mean that they contain generic common elements which are responsible for their positive outcome.

27.15 Alina

I would like to conclude this chapter on psychotherapeutic treatments in suicide with the story of Alina Marazzi, an Italian courageous woman who lost her suicidal mother when she was 7 years old. With her work as a documentarist/director, she guides us through her private way to deal with grief and mourning. She firstly realized a documentary entitled “For One More Hour with You” (“Un’ora sola ti vorrei”) (Marazzi 2002) entirely focused on her mother, Luisa (Liseli) Marazzi Hoepli, born in 1938. She was the granddaughter of Ulrico Hoepli (Tuttwil, Switzerland 1847 – Milan 1935), who, in 1870, had left Switzerland for Milan where he founded the publishing house which today still carries his name. The documentary is Alina’s attempt to collect the pieces of her mother’s life, who died in 1972 at 33. It is not possible to convey here the emotional patchwork of melodies (the film’s title is the one of an old Italian love song), home movies, and recordings that Alina selected for this documentary to recreate pictures of her mother. However, the pages of Liseli’s personal diaries allow putting together and describing her entire life in its different periods: the adolescence, the love, the children, and the depression. Some parts could be reported here to try to approach her. “I’d always slept comfortably in a sort of illusion of serenity where problems didn’t exist but even then it was as if I already knew that I would never

really manage to fit into the world." This sounds so visionary. Liseli suffered from postpartum depression, and she extensively referred to this thematic of need and worry in front of the relation with the other: "The first face we look at when we enter into the world is our mother face. It's the one we know and remember best"; "Dear mummy, thank you for everything you did for me. I didn't do anything for my children, in fact I have made them suffer cruelly. I hope I can make up for it soon"; "Mummy dearest, it seems ages since we last wrote. I miss you more and more." You would probably say: "You've got Martino, Alina, and Antonio." "Yes, you are right, but it's different. I have so many responsibilities now and this makes me feel so alone"; "I have a terrible urge to talk these days and to be listened too as well. But then they say I am boring and I am worried about a sort of stupid things." Alina explains presenting the film that this documentary is a gift to her mother, and to all children and parents, and I think it could be of interest for professionals of mental health as well that have to deal with the everyday care of the other.

With her last movie "All About You" ("Tutto parla di te") (Marazzi 2012), Alina does a further step toward the elaboration of her mother's loss, focusing on maternity and postpartum depression. This is the story of a mirrorlike relationship between two women, Pauline, a woman in her 60s, and Emma, a young mother in deep crisis since she does not know how to face motherhood. A relationship of complicity develops between them. The climax is reached and represented in a scene in which Emma is going to abandon her child in the street during a walk. In this moment she is totally disconnected from the world outside and off-scene a ringing phone shakes her and the viewer. It is Pauline calling Emma's house. As she could hear the ringing, Emma goes back to her child, and later she will be able to discover a meaningful sense of self in her new identity as a mother, so full of complexity and dramatic features. So, the meaning suggested by the phone call is the power of being kept in the mind of the other, not being left alone, and this is the final – simple but in the meantime delicate and important – message of Marazzi's work. Hence, the director, on the contrary of her dramatic personal experience, is able to trace a difference and to provide a lively epilogue resulting from the experience of interpersonal relation.

I conclude with the last words by Liseli: "What should I do? How can I fill this void and face with, and keep it from swelling me and pushing me to such despair that I might do the most insane things? It's a question therapy hasn't found an answer to yet and I wonder what it will answer, if ever. So, I am still hoping that one day the answer will arrive and that I will find peace and serenity, not the wasteland of love and feelings."

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References

American Psychiatric Association (2013) Diagnostic and statistical manual of mental disorders, 5th edn. American Psychiatric Association, Washington, DC

Bales D, van Beek N, Smits M, Willemsen S, Busschbach JJ, Verheul R et al (2012) Treatment outcome of 18-month, day hospital mentalization-based treatment (MBT) in patients with severe borderline personality disorder in the Netherlands. J Personal Disord 26(4):568–582, PubMed eng

Bateman A, Fonagy P (2004) Psychotherapy for borderline personality disorder: mentalisation based treatment. Oxford University Press, Oxford

Bateman A, Fonagy P (2006) Mentalization based treatment: a practical guide. Oxford University Press, Oxford

Bateman A, Fonagy P (2008) 8-year follow-up of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual. Am J Psychiatry 165(5): 631–638, PubMed eng

Bateman A, Fonagy P (2009) Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. Am J Psychiatry 166(12):1355–1364, PubMed eng

Bateman A, Fonagy P (2010) Mentalization based treatment for borderline personality disorder. World Psychiatry 9(1):11–15, PubMed eng

Beck AT (1976) Cognitive therapy and the emotional disorders. International Universities Press, New York

Bedics JD, Korslund KE, Sayrs JH, McFarr LM (2013) The observation of essential clinical strategies during an individual session of dialectical behavior therapy. Psychotherapy 50(3): 454–457, PubMed eng

Bertini U, Marchetti P (1938) Un'ora sola ti vorrei. Nazionalmusic, Edizioni Musicali, Milan

Boulougouris V, Malogiannis I, Lockwood G, Zervas I, Di Giovanni G (2013) Serotonergic modulation of suicidal behaviour: integrating preclinical data with clinical practice and psychotherapy. Exp Brain Res 230(4):605–624, PubMed eng

Brent B (2009) Mentalization-based psychodynamic psychotherapy for psychosis. J Clin Psychol 65(8):803–814, PubMed eng

Brent BK, Holt DJ, Keshavan MS, Seidman LJ, Fonagy P (2014) Mentalization-based treatment for psychosis: linking an attachment-based model to the psychotherapy for impaired mental state understanding in people with psychotic disorders. Isr J Psychiatry Relat Sci 51(1):17–24, PubMed eng

Brettschneider C, Riedel-Heller S, Konig HH (2014) A systematic review of economic evaluations of treatments for borderline personality disorder. PLoS One 9(9):e107748, PubMed eng

Chen EY, Matthews L, Allen C, Kuo JR, Linehan MM (2008) Dialectical behavior therapy for clients with binge-eating disorder or bulimia nervosa and borderline personality disorder. Int J Eat Disord 41(6):505–512, PubMed eng

Chesin M, Stanley B (2013) Risk assessment and psychosocial interventions for suicidal patients. Bipolar Disord 15(5):584–593, PubMed eng

Clarkin JF, Yeomans FE, Kernberg OF (1999) Psychotherapy for borderline personality. Wiley, New York

Clarkin JF, Foelsch PA, Levy KN, Hull JW, Delaney JC, Kernberg OF (2001) The development of a psychodynamic treatment for patients with borderline personality disorder: a preliminary study of behavioral change. J Personal Disord 15(6):487–495, PubMed eng

Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF (2007) Evaluating three treatments for borderline personality disorder: a multiwave study. Am J Psychiatry 164(6):922–928, PubMed eng

Crawford MJ, Thomas O, Khan N, Kulinskaya E (2007) Psychosocial interventions following self-harm: systematic review of their efficacy in preventing suicide. Br J Psychiatry: J Ment Sci 190:11–17, PubMed

Davidson KM, Tran CF (2014) Impact of treatment intensity on suicidal behavior and depression in borderline personality disorder: a critical review. J Personal Disord 28(2):181–197, PubMed eng

De Silva S, Parker A, Purcell R, Callahan P, Liu P, Hetrick S (2013) Mapping the evidence of prevention and intervention studies for suicidal and self-harming behaviors in young people. Crisis 34(4):223–232, PubMed eng

Doering S, Horz S, Rentrop M, Fischer-Kern M, Schuster P, Benecke C et al (2010) Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: randomised controlled trial. Br J Psychiatry: J Ment Sci 196(5):389–395, PubMed eng

Dubicka B, Elvins R, Roberts C, Chick G, Wilkinson P, Goodyer IM (2010) Combined treatment with cognitive-behavioural therapy in adolescent depression: meta-analysis. Br J Psychiatry: J Ment Sci 197(6):433–440, PubMed eng

Ducasse D, Rene E, Beziat S, Guillaume S, Courtet P, Olie E (2014) Acceptance and commitment therapy for management of suicidal patients: a pilot study. Psychother Psychosom 83(6): 374–376, PubMed

Farrell JM, Shaw IA, Webber MA (2009) A schema-focused approach to group psychotherapy for outpatients with borderline personality disorder: a randomized controlled trial. J Behav Ther Exp Psychiatry 40(2):317–328, PubMed eng

Fleischhaker C, Bohme R, Sixt B, Bruck C, Schneider C, Schulz E (2011) Dialectical Behavioral Therapy for Adolescents (DBT-A): a clinical trial for patients with suicidal and self-injurious behavior and borderline symptoms with a one-year follow-up. Child Adolesc Psychiatry Ment Health 5(1):3, PubMed eng

Fonagy P (1989) On tolerating mental states: theory of mind in borderline patients. Bull Anna Freud Cent 12:91–115

Forkmann T, Wichers M, Geschwind N, Peeters F, van Os J, Mainz V et al (2014) Effects of mindfulness-based cognitive therapy on self-reported suicidal ideation: results from a randomised controlled trial in patients with residual depressive symptoms. Compr Psychiatry 55(8): 1883–1890, PubMed

Foster TJ (2013) Suicide prevention as a prerequisite for recovery from severe mental illness. Int J Psychiatry Med 46(1):15–25, PubMed eng

Fowler JC (2013) Core principles in treating suicidal patients. Psychotherapy 50(3):268–272, PubMed eng

Giesen-Bloo J, van Dyck R, Spinhoven P, van Tilburg W, Dirksen C, van Asselt T et al (2006) Outpatient psychotherapy for borderline personality disorder: randomized trial of schema-focused therapy vs transference-focused psychotherapy. Arch Gen Psychiatry 63(6):649–658, PubMed eng

Gregory RJ, Remen AL (2008) A manual-based psychodynamic therapy for treatment-resistant borderline personality disorder. Psychotherapy 45(1):15–27, PubMed

Guthrie E, Kapur N, Mackway-Jones K, Chew-Graham C, Moorey J, Mendel E et al (2001) Randomised controlled trial of brief psychological intervention after deliberate self poisoning. BMJ 323(7305):135–138, PubMed eng

Gutteling BM, Montagne B, Nijs M, van den Bosch LM (2012) Dialectical behavior therapy: is outpatient group psychotherapy an effective alternative to individual psychotherapy?: Preliminary conclusions. Compr Psychiatry 53(8):1161–1168, PubMed eng

Hargus E, Crane C, Barnhofer T, Williams JM (2010) Effects of mindfulness on meta-awareness and specificity of describing prodromal symptoms in suicidal depression. Emotion 10(1): 34–42, PubMed eng

Harned MS, Korslund KE, Foa EB, Linehan MM (2012) Treating PTSD in suicidal and self-injuring women with borderline personality disorder: development and preliminary evaluation of a Dialectical Behavior Therapy Prolonged Exposure Protocol. Behav Res Ther 50(6): 381–386, PubMed eng

Hayes SC, Luoma JB, Bond FW, Masuda A, Lillis J (2006) Acceptance and commitment therapy: model, processes and outcomes. Behav Res Ther 44(1):1–25, PubMed eng

National Collaborating Centre for Mental Health (2009) Borderline personality disorder: treatment and management. British Psychological Society, Leicester

Heisel MJ, Talbot NL, King DA, Tu XM, Duberstein PR (2015) Adapting interpersonal psychotherapy for older adults at risk for suicide. Am J Geriatr Psychiatry 23(1):87–98, PubMed Eng

Hepburn SR, Crane C, Barnhofer T, Duggan DS, Fennell MJ, Williams JM (2009) Mindfulness-based cognitive therapy may reduce thought suppression in previously suicidal participants: findings from a preliminary study. Br J Clin Psychol 48(Pt 2):209–215, PubMed eng

Hopwood CJ, Swenson C, Bateman A, Yeomans FE, Gunderson JG (2014) Approaches to psychotherapy for borderline personality: demonstrations by four master clinicians. Personal Disord 5(1):108–116, PubMed eng

Jakobsen JC (2014) Systematic reviews of randomised clinical trials examining the effects of psychotherapeutic interventions versus "no intervention" for acute major depressive disorder and a randomised trial examining the effects of "third wave" cognitive therapy versus mentalization-based treatment for acute major depressive disorder. Dan Med J 61(10):B4942, PubMed eng

Jakobsen JC, Hansen JL, Storebo OJ, Simonsen E, Gluud C (2011) The effects of cognitive therapy versus 'no intervention' for major depressive disorder. PLoS One 6(12):e28299, PubMed eng

Jakobsen JC, Gluud C, Kongerslev M, Larsen KA, Sorensen P, Winkel P et al (2014) Third-wave cognitive therapy versus mentalisation-based treatment for major depressive disorder: a randomised clinical trial. BMJ Open 4(8):e004903, PubMed eng

Jayasekara R, Procter N, Harrison J, Skelton K, Hampel S, Draper R et al (2014) Cognitive behavioural therapy for older adults with depression: a review. J Ment Health 30:1–4, PubMed Eng

Kabat-Zinn J (1994) Wherever you go, there you are: mindfulness meditation in everyday life. Hyperion, New York

Kernberg OF (2001) The suicidal risk in severe personality disorders: differential diagnosis and treatment. J Personal Disord 15(3):195–208, discussion 9-15. PubMed eng

Kernberg OF (2014) An overview of the treatment of severe narcissistic pathology. Int J Psychoanal 95(5):865–888

Kernberg OF, Yeomans FE, Clarkin JF, Levy KN (2008) Transference focused psychotherapy: overview and update. Int J Psychoanal 89(3):601–620, PubMed eng

Klein DA, Miller AL (2011) Dialectical behavior therapy for suicidal adolescents with borderline personality disorder. Child Adolesc Psychiatr Clin N Am 20(2):205–216, PubMed eng

Kleindienst N, Limberger MF, Schmahl C, Steil R, Ebner-Priemer UW, Bohus M (2008) Do improvements after inpatient dialectical behavioral therapy persist in the long term? A naturalistic follow-up in patients with borderline personality disorder. J Nerv Ment Dis 196(11): 847–851, PubMed eng

Klerman GL, Dimascio A, Weissman M, Prusoff B, Paykel ES (1974) Treatment of depression by drugs and psychotherapy. Am J Psychiatry 131(2):186–191

Kvarstein EH, Pedersen G, Urnes O, Hummelen B, Wilberg T, Karterud S (2015) Changing from a traditional psychodynamic treatment programme to mentalization-based treatment for patients with borderline personality disorder – does it make a difference? Psychol Psychother 88(1): 71–86, PubMed Pubmed Central PMCID: 4344810

Lana F, Fernandez-San Martin MI (2013) To what extent are specific psychotherapies for borderline personality disorders efficacious? A systematic review of published randomised controlled trials. Actas Esp Psiquiatr 41(4):242–252, PubMed eng

Lee NK, Cameron J, Jenner L (2015) A systematic review of interventions for co-occurring substance use and borderline personality disorders. Drug Alcohol Rev 28, PubMed

Leslie AM (1987) Pretense and representation. The origins of 'theory of mind'. Psychol Rev 94:412–426

Linehan MM (1993a) Cognitive-behavioral treatment of borderline personality disorder. Guilford Press, New York

Linehan MM (1993b) Skills training manual for treating borderline personality disorder. Guilford Press, New York

Linehan MM, Wilks CR (2015) The course and evolution of dialectical behavior therapy. Am J Psychother 69(2):97–110, PubMed

Linehan MM, Armstrong HE, Suarez A, Allmon D, Heard HL (1991) Cognitive-behavioral treatment of chronically parasuicidal borderline patients. Arch Gen Psychiatry 48(12):1060–1064, PubMed eng

Linehan MM, Heard HL, Armstrong HE (1993) Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. Arch Gen Psychiatry 50(12):971–974, PubMed eng

Linehan MM, Comtois KA, Murray AM, Brown MZ, Gallop RJ, Heard HL et al (2006) Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. Arch Gen Psychiatry 63(7): 757–766, PubMed eng

Linehan MM, Korslund KE, Harned MS, Gallop RJ, Lungu A, Neacsiu AD et al (2015) Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder: a randomized clinical trial and component analysis. JAMA Psychiatry 72(5):475–482, PubMed

Luoma JB, Villatte JL (2012) Mindfulness in the treatment of suicidal individuals. Cogn Behav Pract 19(2):265–276, PubMed Eng

MacPherson HA, Cheavens JS, Fristad MA (2013) Dialectical behavior therapy for adolescents: theory, treatment adaptations, and empirical outcomes. Clin Child Fam Psychol Rev 16(1): 59–80, PubMed

Maltsberger JT, Buie DH (1974) Countertransference hate in the treatment of suicidal patients. Arch Gen Psychiatry 30(5):625–633, PubMed eng

Marazzi A (2002) For one more hour with you. Italy. p 55 minutes

Marazzi A (2012) All about you. Italy. p 86 minutes

McMain SF, Links PS, Gnam WH, Guimond T, Cardish RJ, Korman L et al (2009) A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. Am J Psychiatry 166(12):1365–1374, PubMed eng

McMain SF, Guimond T, Streiner DL, Cardish RJ, Links PS (2012) Dialectical behavior therapy compared with general psychiatric management for borderline personality disorder: clinical outcomes and functioning over a 2-year follow-up. Am J Psychiatry 169(6):650–661, PubMed eng

Mehlum L, Tormoen AJ, Ramberg M, Haga E, Diep LM, Laberg S et al (2014) Dialectical behavior therapy for adolescents with repeated suicidal and self-harming behavior: a randomized trial. J Am Acad Child Adolesc Psychiatry 53(10):1082–1091, PubMed eng

Nadort M, Arntz A, Smit JH, Giesen-Bloo J, Eikelenboom M, Spinhoven P et al (2009) Implementation of outpatient schema therapy for borderline personality disorder with versus without crisis support by the therapist outside office hours: a randomized trial. Behav Res Ther 47(11):961–973, PubMed eng

Nardi B, Francesconi G, Catena-Dell'osso M, Bellantuono C (2013) Adolescent depression: clinical features and therapeutic strategies. Eur Rev Med Pharmacol Sci 17(11):1546–1551, PubMed eng

Ougrin D, Tranah T, Stahl D, Moran P, Asarnow JR (2015) Therapeutic interventions for suicide attempts and self-harm in adolescents: systematic review and meta-analysis. J Am Acad Child Adolesc Psychiatry 54(2):97–107, e2. PubMed

Paris J (2010) Effectiveness of different psychotherapy approaches in the treatment of borderline personality disorder. Curr Psychiatry Rep 12(1):56–60, PubMed eng

Perry JC, Bond M, Presniak MD (2013) Alliance, reactions to treatment, and counter-transference in the process of recovery from suicidal phenomena in long-term dynamic psychotherapy. Psychother Res 23(5):592–605, PubMed eng

Posner K, Oquendo MA, Gould M, Stanley B, Davies M (2007) Columbia Classification Algorithm of Suicide Assessment (C-CASA): classification of suicidal events in the FDA's pediatric suicidal risk analysis of antidepressants. Am J Psychiatry 164(7):1035–1043, PubMed

Rafaeli E (2009) Cognitive-behavioral therapies for personality disorders. Isr J Psychiatry Relat Sci 46(4):290–297, PubMed eng

Rivera M, Darke JL (2012) Integrating empirically supported therapies for treating personality disorders: a synthesis of psychodynamic and cognitive-behavioral group treatments. Int J Group Psychother 62(4):500–529, PubMed eng

Rossouw TI, Fonagy P (2012) Mentalization-based treatment for self-harm in adolescents: a randomized controlled trial. J Am Acad Child Adolesc Psychiatry 51(12):1304–1313, e3. PubMed

Rucci P, Frank E, Scocco P, Calugi S, Miniati M, Fagiolini A et al (2011) Treatment-emergent suicidal ideation during 4 months of acute management of unipolar major depression with SSRI pharmacotherapy or interpersonal psychotherapy in a randomized clinical trial. Depress Anxiety 28(4):303–309, PubMed eng

Schneider B (2012) Behavioural therapy of suicidality. Eur Arch Psychiatry Clin Neurosci 262(Suppl 2):S123–S128, PubMed eng

Serpa JG, Taylor SL, Tillisch K (2014) Mindfulness-Based Stress Reduction (MBSR) reduces anxiety, depression, and suicidal ideation in veterans. Med Care 52(12 Suppl 5):S19–S24, PubMed

Stoffers JM, Vollm BA, Rucker G, Timmer A, Huband N, Lieb K (2012) Psychological therapies for people with borderline personality disorder. Cochrane Database Syst Rev 8:CD005652, PubMed eng

Stone MH (2006) Management of borderline personality disorder: a review of psychotherapeutic approaches. World Psychiatry 5(1):15–20, PubMed eng

Sudak DM (2012) Cognitive behavioral therapy for depression. Psychiatr Clin N Am 35(1): 99–110, PubMed eng

Sullivan HS (1953) The interpersonal theory of psychiatry. Norton, New York

Tang TC, Jou SH, Ko CH, Huang SY, Yen CF (2009) Randomized study of school-based intensive interpersonal psychotherapy for depressed adolescents with suicidal risk and parasuicide behaviors. Psychiatry Clin Neurosci 63(4):463–470, PubMed eng

Tarrier N, Taylor K, Gooding P (2008) Cognitive-behavioral interventions to reduce suicide behavior: a systematic review and meta-analysis. Behav Modif 32(1):77–108, PubMed

van Asselt AD, Dirksen CD, Arntz A, Giesen-Bloo JH, van Dyck R, Spinhoven P et al (2008) Outpatient psychotherapy for borderline personality disorder: cost-effectiveness of schema-focused therapy v. transference-focused psychotherapy. Br J Psychiatry: J Ment Sci 192(6):450–457, PubMed eng

van den Bosch LM, Koeter MW, Stijnen T, Verheul R, van den Brink W (2005) Sustained efficacy of dialectical behaviour therapy for borderline personality disorder. Behav Res Ther 43(9):1231–1241, PubMed eng

van Zoonen K, Buntrock C, Ebert DD, Smit F, Reynolds CF 3rd, Beekman AT et al (2014) Preventing the onset of major depressive disorder: a meta-analytic review of psychological interventions. Int J Epidemiol 43(2):318–329, PubMed eng

Vaslamatzis G, Theodoropoulos P, Vondikaki S, Karamanolaki H, MiliaTsanira M, Gourounti K (2014) Is the residential combined (psychotherapy plus medication) treatment of patients with severe personality disorder effective in terms of suicidality and impulsivity? J Nerv Ment Dis 202(2):138–143, PubMed eng

Verheul R, Van Den Bosch LM, Koeter MW, De Ridder MA, Stijnen T, Van Den Brink W (2003) Dialectical behaviour therapy for women with borderline personality disorder: 12-month, randomised clinical trial in The Netherlands. Br J Psychiatry: J Ment Sci 182:135–140, PubMed eng

Weissman MM, Prusoff BA, Dimascio A, Neu C, Goklaney M, Klerman GL (1979) The efficacy of drugs and psychotherapy in the treatment of acute depressive episodes. Am J Psychiatry 136(4B):555–558, PubMed eng

Weitz E, Hollon SD, Kerkhof A, Cuijpers P (2014) Do depression treatments reduce suicidal ideation? The effects of CBT, IPT, pharmacotherapy, and placebo on suicidality. J Affect Disord 167C:98–103, PubMed Eng

Williams JM, Swales M (2004) The use of mindfulness-based approaches for suicidal patients. Arch Suicide Res: Off J Int Acad Suicide Res 8(4):315–329, PubMed eng

Williams JM, Duggan DS, Crane C, Fennell MJ (2006) Mindfulness-based cognitive therapy for prevention of recurrence of suicidal behavior. J Clin Psychol 62(2):201–210, PubMed eng

Wolk CB, Kendall PC, Beidas RS (2015) Cognitive-behavioral therapy for child anxiety confers long-term protection from suicidality. J Am Acad Child Adolesc Psychiatry 54(3):175–179, PubMed Pubmed Central PMCID: 4344955

Young JE (1994) Cognitive therapy for personality disorders: a schema-focused approach. Professional Resource Press, Sarasota

Zanarini MC (2009) Psychotherapy of borderline personality disorder. Acta Psychiatr Scand 120(5):373–377, PubMed eng