Chapter 21
Chronic Suicidality and Personality Disorders

Pallavi Sinha, Amit Khanna, Prerna Khanna, Deepak Moyal and Shailesh Jha

The word suicide was first devised by Sir Thomas Brown in 1963 and used in his book Religio Medici (Barraclough & Shepherd, 1994). Self-injurious behaviours would serve to include both suicidal and non-suicidal self-harm. Stengel identified differences between people who completed suicide and those who attempted suicide but survived (Stengel, 1964). He suggested that a degree of suicidal intent was present in both. Suicidal behaviour is usually defined as a self-destructive behaviour with the intent to die (Gerson & Stanley, 2002). Aborted suicidal attempt was defined as an event in which an individual comes close to attempting suicide but does not complete the act and thus sustains no injury (Barber, Marzuk, Leon, & Portera, 1998). The range of suicidal behaviours like suicidal ideation, gestures, attempts and completed suicide are considered to be on a continuum having a common biological etiology. However, there are many nonfatal suicidal acts that are not related to actual suicide and whose dynamics and biology are different (Arie, Haruvi-Catalan, & Apter, 2005). Kreitman introduced the term 'parasuicide' to refer to a nonfatal act of deliberate self-injury (Kreitman, Philip, Greer, & Bagley, 1969). The differentiating feature of parasuicide from suicide is that the former is

P. Sinha · A. Khanna (✉) · D. Moyal · S. Jha
Department of Psychiatry, Institute of Human Behaviour and Allied Sciences (IHBAS), Delhi, India
e-mail: amik1981@gmail.com

P. Sinha
e-mail: pallavisinha0102@gmail.com

D. Moyal
e-mail: deepak.moyal@gmail.com

S. Jha
e-mail: dr.shaileshk.jha@gmail.com

P. Khanna
Department of Psychiatry, Max Superspeciality Hospital, Vaishali, Delhi-NCR, India
e-mail: prernakhannacp@gmail.com

© Springer Nature Singapore Pte Ltd. 2017

U. Kumar (ed.), *Handbook of Suicidal Behaviour*,
DOI 10.1007/978-981-10-4816-6_21

not fatal. Intent is difficult to evaluate and has therefore been left out of major research on parasuicide (Arie et al., 2005). Therefore both suicidal attempts and deliberate self-harm would both be subsumed under the rubric of parasuicide (Gerson & Stanley, 2002). Thus medication overdose, self-cutting, burning, attempting to hang will be subsumed under parasuicide. However, since parasuicide clubs together all forms of self-injury, this can lead to a misunderstanding of the differences in the function, dangerousness and treatment of self-injurious behaviours. Deliberate self harm similar to parasuicide includes all types of self-injurious behaviour, including suicide attempts and non-suicidal self-injury (Turecki & Brent, 2015). Distinct from the group of suicidal behaviours, self-mutilation comes under the category of non-suicidal self-injury. Feldman further defined self-mutilation as intentionally damaging a part of the body without a conscious attempt to die (Feldman, 1988). Non-suicidal self-injury implies to self-destructive behaviours with no intent to die. These are often triggered by distress and tend to serve an internal purpose to the person. However, there continues to be lack of consistency amongst the various definition and terminologies describing suicidal behaviours and non-suicidal self-injury.

Epidemiology

Chronic suicidal ideation can be best understood within the construct of personality. Personality refers to all of the characteristics that distinguish a constantly developing, self organizing human being from predictable machine-like objects. Personality disorders are characterized by enduring, pervasive and maladaptive patterns of behaviour, cognitions and inner experiences that are exhibited across different contexts and deviate significantly from those accepted by the individual's culture. The most prevalent personality disorder found in the community was Obsessive-Compulsive personality disorder (7.88%), followed by Paranoid personality disorder (4.41%), Antisocial personality disorder (3.63%), Schizoid personality disorder (3.13%), Avoidant personality disorder (2.36%), Histrionic personality disorder (1.84%) and Dependent personality disorder (0.49%) (Grant et al., 2004). In a British study, the weighted prevalence of personality disorder was found to be 4.4% (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006) while the prevalence in psychiatric outpatient settings range from 12.9 to 59% (Bodlund, Grann, Ottosson, & Svanborg, 1998; Casey & Tyrer, 1990; Fabrega, Ulrich, Pilkonis, & Mezzich, 1993).

Suicidal ideation both acute and chronic is perhaps the most troubling symptom complex with affective, cognitive and behavioural manifestations for those ailing from it. Personality disorders have been linked to a lifetime of increased risk of suicide. The American Psychiatric Association estimates lifetime rates of suicide ranging from 3 to 9% (American Psychiatric Association, 2003). In one of the researches, the estimated risk for suicide was about seven times greater in persons with personality disorder when compared with the general population, (Harris &

Barraclough, 1997) and about 13-fold for formerly hospitalized patients with personality disorders (Black & Winokur, 1986; Zilber et al., 1989).

Conversely, in a study done in Asian population, a high proportion of persons who completed suicide suffered from ICD-10 personality disorder (46.7–76.7%), and the most prevalent category was Emotionally Unstable personality disorder (26.7–56.7%). The risk for suicide was significantly associated with Emotionally Unstable personality disorder. Comorbidity amongst personality disorders along with comorbidity of personality disorder with other psychiatric disorders, particularly severe depression was also significantly associated with suicide risk (Cheng, Mann, & Chan, 1997).

Functions of Self-injury

A review of literature shows that seven functions of self-injury have been consistently identified. These include affect-regulation, anti-dissociation, anti-suicide, interpersonal boundaries, interpersonal-influence, self-punishment and sensation-seeking (Klonsky, 2007). It is imperative to note that these functions are not mutually exclusive and there might be considerable overlap between these functions with each act of self-harm. The affect-regulation model of self-injury suggests that self-injury is a strategy to alleviate acute negative affect or affective arousal (Gratz, 2003). Linehan had theorized that early invalidation environments lead to poor coping skills and such individuals with biological dispositions for emotional instability were less effective in managing their emotions and are therefore prone to use self-injury as a maladaptive strategy for affect-regulation (Linehan, 1993). The anti-dissociation model posits self-injury as a response to episodes of dissociation or depersonalization that individuals might feel at the peak of their emotional state. The self injurious act might be used to terminate the periods of dissociation or depersonalization and feel real again (Klonsky, 2007). The anti-suicide model views self-injury as a mechanism to resist suicidal urges. It may be used to express suicidal desires without actually attempting a fatal act. The interpersonal-influence model stipulates that self-injury is used to influence the self-injurer's environment (Klonsky, 2007). The acts may be a cry for help or to avoid abandonment. Alternatively, the self-injurer may not have any desire to manipulate the environment, but the environment may be affected and reactive to the behaviour (Gerson & Stanley, 2002). The interpersonal boundaries model is based on the object relation's theory. Gunderson viewed self-harm as an attempt to re-establish contact with a lost object and to create an illusion of control over new objects (Gunderson, 2009). The self-punishment model suggests that self-injury is an expression of anger towards oneself. Linehan (1993) hypothesizes that self-injurers have learned from their environments to punish or invalidate themselves. Self-injury therefore would be ego-syntonic and soothing in the face of emotional distress. The sensation-seeking model considers self-injury as a mean of providing excitement. This model caries the least evidence compared to others (Laye-Gindhu & Schonert-Reichl, 2005).

Acute Versus Chronic Suicidality

Though it would be somewhat clinically artificial to dichotomize suicidal ideation into acute and chronic states; however, it has pragmatic values in terms of assessment and management. Acute suicidal ideation is characteristically an exceptional event in the life of an individual—typically abrupt or very recent in onset (Sansone, 2004). It usually manifests after an overwhelming stressor and can cause distress to manifest an axis I disorders like depression. It is usually assumed to be a response to a profound sense of despair and desire for death, which, if unsuccessful, usually results in a persistence of the depressed mood state. While acute suicidal ideation usually occurs in the face of stressors or axis I disorder like depression and psychosis, chronic suicidal ideation is an ongoing, protracted process usually associated with axis II disorders especially borderline personality disorder. Chronic suicidal ideation seems to be more episodic, transient and a regulator of the emotional state. Persons with borderline personality disorder often report that there is a gradual build-up of suicidal ideation, which, when acted on, result in improvement in the affective state and a release of pent-up emotions. Suicidal ideation in borderline personality disorder varies in intensity over time. Findings from the Collaborative Longitudinal Study of Personality Disorders showed that borderline personality symptoms tend to wax and wane, depending on life events (Grilo, McGlashan, & Skodol, 2000). Therefore a person with borderline personality disorders during a good phase may not elicit any suicidal ideation, while during a crisis phase may have exacerbation of borderline pathology and heightened suicidal ideation. While comorbidity of major depressive episode and borderline personality disorder is common (Yen et al., 2003), it does not account for chronic suicidality. Long-term affective instability with a high level of sensitivity to the environment is a key feature of borderline personality disorder, which is posited to be a key element in maintaining the chronic suicidality in such patients. It can be hypothesized that chronic suicidality has three functions. The first involves dealing with painful affects (Linehan, 1993). A second function of chronic suicidality in borderline personality disorder can be to communicate distress (Paris, 2002). The third function of chronic suicidality could be to gain a sense of control. Borderline patients characteristically complain a sense of emptiness along with a fear of abandonment. This internal state may result in suicidal behaviours in an attempt to gain control over one's own life. Thus while chronic suicidal ideation might be a hallmark of borderline personality disorder and other severe personality disorders, it becomes imperative to continue assessing for acute risk of suicide in these patients. There is no clear cut distinction between the two and this clinical judgment depends as much on the therapist's anxiety as on objective risk (Paris, 2002).

Personality Dimensions and Suicidality

Although a direct causal relation between personality traits and/or disorder with suicidal behaviour is complex; however, research since 1990s has suggested that certain personality features and/or disorders are related to suicidal behaviour and are independent of other known risk factors (Oldham, Skodol, & Bender, 2007). Research has shown that patients at risk of suicide have specific temperaments as well as personality and defense mechanism profiles (Pompili et al., 2008). Three sets of personality constellations have been consistently found in studies that are related with increased suicidality. Impulsive aggressiveness has been shown to have a strong association to a history of suicidal behaviour (Arie et al., 2005; Oldham et al., 2007; Pompili et al., 2008; Zouk, Tousignant, Seguin, Lesage, & Turecki, 2006). Biological studies have also supported the association between impulsivity and suicidality. Oquendo and Mann (2000) conducted a comprehensive review of animal and human studies evaluating the biology of impulsivity and suicidality. They noted that impulsive aggression was associated with lower serotonin levels. Gerson and Stanley (2002) summarized that self-injurious behaviour involved lower serotonin and abnormal dopamine levels while suicidal behaviours involve lower serotonin and enhanced dopamine and norepinephrine levels. On the other hand, individual who are perfectionists and vulnerable to narcissistic injury might also be at increased risk of suicide. Suicide attempts in narcissistic patients can arise because of their very fragile self-esteem and in response to perceived narcissistic injury (Oldham et al., 2007). The theoretical and empirical literature on adolescent suicide also point towards an association between depression, perfectionism, narcissism and suicidal behaviour (Arie et al., 2005). A third category of individual with consistently elevated risk of suicidal behaviours is those with emotional dysregulation. Linehan (1993), hypothesized that emotional dysregulation in conjunction with an invalidating environment explained the suicidal behaviour characteristic of individuals with borderline personality disorder. Emotional or affective dysregulation and impulsive aggression are considered as the two most relevant factors for suicidal or self-injurious behaviour in patients with borderline personality disorder (Oldham, 2006). Other traits that have been useful in predicting history of suicidal attempts are aggression, anxiety, neuroticism, extroversion, impulsivity, hostility and psychoticism (Brezo, Paris, & Turecki, 2006). Temperament has also been studied in the context of suicidality. In one study, irritable temperament and social introversion were the strongest predictors of suicide risk while hyperthymic temperament was found to be a protective factor both for hopelessness and suicide risk (Pompili et al., 2008). Specific affective temperament types (depressive, cyclothymic, hyperthymic, irritable and anxious) have also been found to have a strong relationship with suicidal behaviour (Kochman et al., 2005).

Assessment for Suicide Risk

The assessment and management of suicidality in patients with borderline personality disorder can be challenging and frustrating for even the most experienced clinicians, yet it is possible to identify acutely increased risk and use interventions to establish a therapeutic alliance and de-escalate the crisis situation. A detailed psychiatric evaluation is the first and foremost step in assessment of risk of suicide. The purpose of this evaluation is to obtain information regarding patient's psychiatric and other medical history and current mental state about suicidal thinking and behaviour as well as through collateral source of information. This information enables the psychiatrist to identify specific factors influencing the risk for suicide or other suicidal behaviours and potential targets for interventions and in determining the setting for treatment of the patient. The use of suicide risk assessment scales can be used to assist the assessment but should not be used as a replacement to a thorough clinical assessment.

Many studies have identified risk factors at the population level, which are associated with an increased risk of suicidal behaviours. So extrapolation of these factors to an individual will allow categorization of the risk, but will be of less use in predicting suicide. The goal of a suicide assessment is therefore not to predict suicide, but rather to place a person along a putative risk continuum, to appreciate the basis of suicidality, and to allow for a more informed intervention (Jacobs, Brewer, & Klein-Benheim, 1999). Personality disorder may be a determinant of suicidal behaviour in many ways; by predisposing to major psychiatric disorders such as depression or alcoholism, by leading to difficulties in relationship and social adjustment, by precipitating undesirable life events, by impairing the ability to cope with a psychiatric or physical disorder and also by drawing a person into conflicts with family members and others (Kulkarni, Rao, & Begum, 2013). Persons with personality disorders have been associated with a subset of specific risk factors associated with increased suicidal behaviour. Some of these may be modifiable and therefore amenable to interventions. These are as follows:

Comorbid disorders. Empirical evidence shows that comorbid psychiatric and personality disorders in suicide attempters pose greater estimated risk of suicide than psychiatric disorders alone (Kulkarni et al., 2013). The estimated risk of suicide can be six times greater in persons with comorbid psychiatric and personality disorders than in person with psychiatric disorders alone (Foster, Gillespie, & McClelland, 1997). Most of the research in the field of comorbidity in personality disorders and suicidality has been done in the field on borderline personality disorder. Soloff, Fabio, Kelly, Malone and Mann (2005), found a higher level of lethality of suicide attempts in patients with comorbidity, compared to patients with borderline personality disorder alone. In another study on inpatients with borderline personality disorder, Soloff and colleagues (2000) reported that the comorbidity of borderline personality disorder and major depressive episode increased the number and seriousness of suicide attempts (Soloff, Lynch, Kelly, Malone, & Mann, 2000). They identified impulsivity and hopelessness as independent risk factors for

suicidal behaviours. Substance use has also been associated to be comorbid with personality disorders especially borderline personality disorder. This well-documented comorbidity of substance abuse with borderline personality disorder (Oldham, 2006; Oldham et al., 2007; Torgersen, Kringlen, & Cramer, 2001) increases patients' risk for impulsive suicidal behaviour and for impaired judgment. The impairment of judgment with substance use can lead to a low intent but high lethality suicidal attempt.

Recent life events. Adverse life events can be a tumultuous phase in any person's lifetime and these may push a vulnerable person towards suicide. In the stress diathesis model, suicidal behaviours occur when an individual with the diathesis is exposed to stress, which determines the behaviour's timing (Oquendo et al., 2004). In a study of persons with personality disorders attempting suicide, it was found that negative life events, particularly those pertaining to love, marriage or crime–legal matters, were significant predictors of suicide attempts, even after controlling for baseline diagnoses of borderline personality disorder, major depressive disorders, substance use disorders and a history of childhood sexual abuse (Yen et al., 2005). However, there has been contradictory evidence wherein life events after adjusting for borderline personality disorders and major depressive episode have not been predictive of suicidal attempt (Kelly, Soloff, Lynch, Haas, & Mann, 2000).

History of childhood abuse. A childhood history of sexual or physical abuse is common in borderline personality disorder and is linked with self-injurious behaviour in both clinical and nonclinical data. The history and severity of childhood sexual abuse but not physical abuse is also posited to predict adult suicidal behaviour independent of other known risk factors (Soloff, Lynch, & Kelly, 2002). These findings were further replicated recently wherein high levels of hostility and childhood history of sexual abuse led to an increased risk for suicidal behaviour in patients with borderline personality disorder (Ferraz et al. 2013).

In summary, patients with personality disorders especially borderline and anti-social personality disorders in the presence of the above mentioned risk factor show increased suicidal behaviours. The presence of comorbidity especially when acutely evident, may catapult these patients into acute suicidality.

When assessing suicidal behaviour in the emergency department in a patient with chronic suicidality, it is useful to consider a model that describes "acute-on-chronic" risk (Oldham, 2006). This model suggests that acute stressors can increase a person with personality disorders' suicidal risk. Comorbidities such as a past or current major depressive episode, substance use disorders and history of sexual abuse can provide important information about a patient's chronic level of risk, whereas a current major depressive episode or increasing substance use can indicate acute-on-chronic risk (Zaheer, Links, & Liu, 2008). A detailed history of previous suicidal attempts including the mode, lethality, circumstances of attempt and access to means should be necessarily done. This helps in assessing the clinical risk of suicidal behaviour. Additional risk for suicide should be considered in patients with Cluster B personality disorder, schizotypal features, lifetime post-traumatic stress disorder and cognitive-perceptual symptoms which may further heighten the suicide risk (McGirr, Paris, Lesage, Renaud, & Turecki, 2007). This rigorous approach to

assessment should also ensure that the known risk factors for suicide like other axis I diagnosis, age, social support be also assessed in persons with personality disorders. In patients who present with the 'acute-on-chronic' suicide risk, it is important to evaluate for the factors that are specific for the prevailing emotional state as they may suggest a proximal risk factor for suicidality. Rudd et al. (2006), gave the concept of suicide warning signs which they described as the earliest detectable sign that indicates heightened risk for suicide in the near-term. Similarly Hendin and his colleagues (2001) described three signs that immediately precede the suicide of a patient: a precipitating event, intense affective state other than depression like severe anxiety or extreme agitation, and recognizable changes in behaviour patterns including speech or actions that suggest suicide along with deterioration in occupational or social functioning, and increased substance abuse (Hendin, Maltsberger, Lipschitz, Haas, & Kyle, 2001). It is equally important to enquire into other personality profiles associated with increased suicidal risk like affective instability, impulsivity and aggression particularly in borderline patients. One should keep in mind that although patients with borderline personality disorder are usually chronically suicidal, it is good practice to always assess for acute risk of suicide and manage it accordingly. Once a detailed evaluation of the suicide risk is made, clinicians should progress onto de-escalate the patient, establish a plan of safety, prepare a management plan and hospitalize the patient if necessary.

Setting

Treatment settings and conditions include a continuum of possible levels of care, from an inpatient setting to partial hospitalization and intensive outpatient programmes to occasional ambulatory visits. The choice of specific treatment setting depends not only on the psychiatrist's estimate of the patient's current suicide risk and potential for dangerousness to others, but also on other aspects of the patient's current status. In addition, the benefits of intensive interventions such as hospitalization must be weighed against their possible negative effects (e.g. disruption of employment, financial and other psychosocial stress, social stigma, etc.).

A history of past suicide attempts is one of the most significant risk factors for suicide, even in patients of personality disorders and this risk may be increased by more serious, more frequent or more recent attempts. Thus, it is very important to ask about past suicide attempts and self-destructive behaviours, including specific questioning about aborted suicide attempts.

A review of past history of treatment including the pharmacological and psychological treatments is also important and should include information on comorbid diagnoses, prior hospitalizations, suicidal ideation or previous suicide attempts.

A family history of suicide, mental illness and dysfunction should be obtained as well which must include suicide and suicide attempts as well as a family history of any psychiatric hospitalizations or mental illness, including substance use disorders. Also one should enquire about family organization and structure. The probing

should include a history of family conflict or separation, parental legal trouble, family substance use, domestic violence, and physical and/or sexual abuse.

The current psychosocial adversities or crisis faced by patient can also increase the risk of suicide viz financial or legal stressors, interpersonal conflicts or losses; homelessness; loss of job; failure in exams.

In persons with personality disorders significant contribution is made by hopelessness, aggression and impulsivity, all or none thinking, perfectionism with very high expectations from oneself. It is also helpful to determine the patient's tendency to engage in risk-taking behaviours as well as the patient's past responses to stress, including the capacity for reality testing and the ability to tolerate rejection, subjective loneliness, or psychological pain when his or her unique psychological needs are not met. As part of the suicide assessment it is essential to inquire specifically about the patient's grading of suicidal thoughts, plans, behaviours and intent. Another important part of assessment is the direct enquiry regarding suicidal ideation. Also the assessor should probe about the presence of suicide plan and any steps that have been taken towards enacting those plans. The persons with personality disorder always do not engage in only deliberate self harm but some of the attempts are actually steps taken to end life. A clinician should take into account of this fact and a high degree of sensitivity should be exercised.

The Relevance of Scales in Risk Assessment

A number of suicide assessment scales have been developed by researchers for use in suicidal patients. Self-report rating scales may sometimes assist in opening communication with the patient about particular feelings or experiences. In addition, the content of suicide rating scales, such as the Scale for Suicide Ideation (Beck, Kovacs, & Weissman, 1979) and the Suicide Intent Scale (Beck, Schuyler, & Herman, 1974), may be helpful to psychiatrists in developing a thorough line of questioning about suicide and suicidal behaviours. However, existing suicide assessment scales suffer from high false positive and false negative rates and have very low positive predictive values (Brown, 2002). As a result, such rating scales should not be used as substitutes for a detailed clinical evaluation for clinical estimations of suicide risk.

Management

The management of suicidal behaviour in personality disorders includes pharmacotherapy and psychological treatment in isolation or in combination.

Pharmacotherapy. The initial trials with first-generation antipsychotics were found to be effective in reduction of anger leading to the self injurious behaviours in person with borderline personality disorder. The comparisons of first-generation

antipsychotics (FGAs) with placebo yielded significant effects for haloperidol in the reduction of anger in two randomized controlled trials (Soloff et al., 1989, 1993) and flupentixol decanoate was found to be effective in the reduction of suicidal behaviour (Montgomery et al., 1979). Whereas initial studies favoured first-generation antipsychotics recent authors have focused more on atypical antipsychotics. Olanzapine was found to be significantly superior to placebo on the Clinical Global Impression scale for Borderline personality disorder (Bogenschutz & Nurnberg, 2004). Olanzapine emerged as a safe and effective agent in the treatment of women with borderline personality disorder, significantly affecting all four core areas of borderline psychopathology namely affect, cognition, impulsivity and interpersonal relationships (Zanarini & Frankenburg, 2001). Aripiprazole was found to have both significant effects in the reduction of the core pathological symptoms of borderline personality disorder and anger, psychotic symptoms, impulsivity, interpersonal problems, associated pathology (depression) anxiety and general severity of psychiatric pathology (Nickel et al., 2006). However, the results for suicidal ideation were inconsistent: two study estimates revealed a significantly lower decrease of suicidal ideation with olanzapine compared with placebo (Bogenschutz & Nurnberg, 2004; Lilly, 2007).

Mood stabilizers are also being evaluated for management of overall symptom complex of borderline personality disorder. Supporting evidence has been found with divalproex sodium, lamotrigine and topiramate, but not for carbamazepine (Fuente, 1994). Divalproex sodium has shown significant effects on reduction of interpersonal problems and depressive symptoms (Frankenburg & Zanarini, 2002; Hollander et al., 2001). Lamotrigine has been tested to reduce impulsivity and was found significantly superior to placebo for the reduction of impulsivity and anger (Tritt et al. 2005). Topiramate has been tried and has been found to have significant effects on interpersonal problems, decrease in anger symptoms especially in the female population (Loew et al., 2006; Nickel et al., 2004, 2005). Associated psychopathology was also found to be significantly affected by topiramate (Loew et al., 2006). Antidepressants have long been proposed for use in persons with borderline personality disorder for varying core symptoms. However, a recent meta-analysis suggested selective serotonin reuptake inhibitors (SSRI) should only be used in persons with comorbid depression or other axis one disorder with indication for SSRI use. It also went on to recommend that antidepressants can no longer be considered as first line agents for affective dysregualtion and impulsive aggression in borderline personality disorder (Lieb, Völlm, Rücker, Timmer, & Stoffers, 2010).

Psychotherapy. The main goal for persons dealing with suicidal individuals is to decrease suicidal behaviour by easing the psychalgia and reducing the psychiatric symptoms. The diagnosis of personality disorder has always been associated with psychotherapy as psychotherapy has been the pillar of treatment for personality disorders. Individual psychotherapy has been a mainstay of treatment and these can be long-term and short-term psychotherapy. Regardless of the type of therapy, overall successful treatment has been shown to decrease suicidality in patients with personality disorder especially with Borderline personality (Linehan, 1993; Bateman & Fonagy, 1999). The current evidence-based approaches for treating

suicidal patients include the following four psychosocial interventions: intensive follow-up treatment, cognitive behaviour therapy, interpersonal psychotherapy and dialectic behaviour therapy (Cukrowicz, Smith, & Schlegel, 2010). Intensive follow-up treatment consists of services provided to a patient following emergency room or inpatient psychiatric services for a suicide attempt. Motto and Bostrom (Motto & Bostrom, 2001) hypothesized that professionals' maintenance of long-term contact with persons who are at risk of suicide can exert a suicide-prevention influence. Their systematic programme of contact with persons who were at risk of suicide and who refused to remain in the health care system appeared to have a significant preventive influence on the risk of suicide for at least a period of 2 years.

The principles of cognitive and behavioural therapy have been used to devise various psychological treatment approaches to deal with suicidality. The cognitive behavioural problem-solving interventions identify problems, generate solutions, obtain goal outcomes and allow greater cognitive flexibility. Brown and colleagues (Brown et al., 2005) studies the effectiveness of a ten-session cognitive therapy intervention designed to prevent repeated suicide attempts in adults who have recently attempted suicide. Their randomized controlled trial showed that cognitive therapy resulted in greater reductions in depressive symptoms at 6, 12, 18 months, and hopelessness at 6 months. Guthrie et al. (2001), studied the effects of a brief psychological intervention (brief psychodynamic interpersonal therapy) in 113 patients after deliberate self-poisoning compared with treatment as usual. The study showed that there was a significant reduction in the group receiving psychotherapy at 6 month follow up.

Linehan's (1993) dialectical behavioural therapy offers an interesting model: she recommends a form of behavioural analysis, in which the therapist listens to the emotional content of suicidality, validates dysphoric feelings that tempt the patient to act impulsively, identifies the circumstances leading the patient to experience dysphoria and develops alternative solutions to life problems. This mode of therapy was specially developed for borderline personality disorder and includes both individual therapy in addition to group skill training. A variety of strategies are used during these therapy sessions including validation, balancing acceptance and change, behavioural chain analysis, contingency management, examining cognitions and behavioural exposure (Cukrowicz et al., 2010). Across multiple randomized controlled trials, DBT has been found to significantly reduce self- harm, suicide attempts, and suicide ideation (Linehan et al., 2006, 1999; Verheul et al., 2003). Another type of therapy which has been found useful is Mentalization-based therapy (MBT). MBT (Bateman & Fonagy, 2004, 2006) is a psychodynamic treatment rooted in attachment and cognitive theory. It requires limited training with moderate levels of supervision for implementation by generic mental health professionals. It aims to strengthen patients' capacity to understand their own and others' mental states in attachment contexts in order to address their difficulties with affect, impulse regulation and interpersonal functioning, which act as triggers for

acts of suicide and self-harm (Linehan, 1993). MBT delivered by generic mental health professionals in the context of a partial hospital programme has been found to be cost-effective and superior to treatment as usual over a period of 36 months (Bateman & Fonagy, 2001, 2003, 2008).

Psychotherapy

Conclusions

In summary, this chapter aims to acquaint the reader with the concept of chronic suicidality in the context of various psychiatric disorders especially borderline personality disorder. It then proceeds to differentiate between acute and chronic suicidality and the subsequent assessment and management of such patients. Patients with chronic suicidal behaviour though may appear to be a sub-group of patients appearing to have a sense of therapeutic nihilism; however, all efforts should be made by the health professional to provide them the best of evidence-based practice.

References

American Psychiatric Association. (2003). Practice guideline for the assessment and treatment of patients with suicidal behaviours. *American Journal of Psychiatry, 160*(11 Suppl), 1–60.

Arie, M., Haruvi-Catalan, L., & Apter, A. (2005). Personality and suicidal behaviour in adolescence. *Clinical Neuropsychiatry, 2*(1), 37–47.

Barber, M. E., Marzuk, P. M., Leon, A. C., & Portera, L. (1998). Aborted suicide attempts: A new classification of suicidal behaviour. *The American Journal of Psychiatry, 155*(3), 385–389.

Barraclough, B., & Shepherd, D. (1994). A necessary neologism: The origin and uses of suicide. *Suicide and Life-Threatening Behaviour, 24*(2), 113–126.

Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: A randomized controlled trial. *American Journal of Psychiatry, 156*(10), 1563–1569.

Bateman, A., & Fonagy, P. (2001). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: An 18-month follow-up. *American Journal of Psychiatry, 158*(1), 36–42.

Bateman, A., & Fonagy, P. (2003). Health service utilization costs for borderline personality disorder patients treated with psychoanalytically oriented partial hospitalization versus general psychiatric care. *American Journal of Psychiatry, 160*(1), 169–171.

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

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

Bateman, A., & Fonagy, P. (2008). 8-year follow-up of patients treated for borderline personality disorder: Mentalization-based treatment versus treatment as usual. *American Journal of Psychiatry, 165*(5), 631–638.

Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intention: The scale for suicide ideation. *Journal of Consulting and Clinical Psychology, 47*(2), 343–352.

Beck, A. T., Schuyler, D., & Herman, I. (1974). Development of suicidal intent scales. In A. T. Beck, H. L. P. Resnik, & D. J. Lettieri (Eds.), *The prediction of suicide* (pp. 45–56). Bowie: Charles Press Publishers, MD.

Black, D. W., & Winokur, G. (1986). Prospective studies of suicide and mortality in psychiatric patients. *Annals of the New York Academy of Sciences, 487*(1), 106–113.

Bodlund, O., Grann, M., Ottosson, H., & Svanborg, C. (1998). Validation of the self-report questionnaire DIP-Q in diagnosing DSM-IV personality disorders: A comparison of three psychiatric samples. *Acta Psychiatrica Scandinavica, 97*(6), 433–439.

Bogenschutz, M. P., & Nurnberg, H. G. (2004). Olanzapine versus placebo in the treatmentof borderline personality disorder. *Journal of Clinical Psychiatry, 65*(1), 104–109.

Brezo, J., Paris, J., & Turecki, G. (2006). Personality traits as correlates of suicidal ideation, suicide attempts, and suicide completions: A systematic review. *Acta Psychiatrica Scandinavica, 113*(3), 180–206.

Brown, G. K. (2002). *A review of suicide assessment measures for intervention research with adults and older adults*. National Institute of Mental Health: Rockville, MD.

Brown, G. K., Have, T. Ten, Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. *JAMA, 294*(5), 563–570.

Casey, P. R., & Tyrer, P. (1990). Personality disorder and psychiatric illness in general practice. *The British Journal of Psychiatry, 156*(2), 261–265.

Cheng, A. T., Mann, A. H., & Chan, K. A. (1997). Personality disorder and suicide. A case-control study. *The British Journal of Psychiatry, 170*(5), 441–446.

Coid, J., Yang, M., Tyrer, P., Roberts, A., & Ullrich, S. (2006). Prevalence and correlates of personality disorder in Great Britain. *The British Journal of Psychiatry, 188*(5), 423–431.

Cukrowicz, K. C., Smith, P. N., & Schlegel, E. F. (2010). *Managing suicidality. Handbook of clinical psychology competencies*. New York: Springer.

De la Fuente, J., & Lotstra, F. (1994). A trial of carbamazepine in borderline personality disorder. *European Neuropsychopharmacology, 4*(4), 479–486.

Fabrega, H., Jr., Ulrich, R., Pilkonis, P., & Mezzich, J. (1993). Personality disorders diagnosed at intake at a public psychiatric facility. *Psychiatric Services, 44*(2), 159–162.

Feldman, M. D. (1988). The challenge of self-mutilation: A review. *Comprehensive Psychiatry, 29* (3), 252–269.

Ferraz, L., Portella, M. J., Vállez, M., Gutiérrez, F., Martín-Blanco, A., Martín-Santos, R., Subirà, S. (2013). Hostility and childhood sexual abuse as predictors of suicidal behaviour in Borderline Personality Disorder. *Psychiatry Research, 210*(3), 980–985.

Foster, T., Gillespie, K., & McClelland, R. (1997). Mental disorders and suicide in Northern Ireland. *The British Journal of Psychiatry, 170*(5), 447–452.

Frankenburg, F. R., & Zanarini, M. C. (2002). Divalproex sodium treatment of women with borderline personality disorder and bipolar II disorder: A double-blind placebo-controlled pilot study. *The Journal of clinical psychiatry, 63*(5), 442–446.

Gerson, J., & Stanley, B. (2002). Suicidal and self-injurious behaviour in personality disorder: Controversies and treatment directions. *Current Psychiatry Reports, 4*(1), 30–38.

Grant, B. F., Hasin, D. S., Stinson, F. S., Dawson, D. A., Chou, S. P., Ruan, W. J., Pickering, R. P. (2004). Prevalence, correlates, and disability of personality disorders in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *The Journal of clinical psychiatry, 65*(7), 948–958.

Gratz, K. L. (2003). Risk factors for and functions of deliberate self-harm: An empirical and conceptual review. *Clinical Psychology: Science and Practice, 10*(2), 192–205.

Grilo, C. M., McGlashan, T. H., & Skodol, A. E. (2000). Stability and course of personality disorders: The need to consider co-morbidities and continuities between axis I psychiatric disorders and axis II personality disorders. *The Psychiatric Quarterly, 71*(4), 291–307.

Gunderson, J. G. (2009). *Borderline personality disorder: A clinical guide*. Washington, DC: American Psychiatric Publishing.

Guthrie, E., Patton, G. C., Kapur, N., Mackway-Jones, K., Chew-Graham, C., Moorey, J., Tomenson, B. (2001). Randomised controlled trial of brief psychological intervention after deliberate self poisoning commentary: Another kind of talk that works? *British Medical Journal, 323*(7305), 135–137.

Harris, E. C., & Barraclough, B. (1997). Suicide as an outcome for mental disorders. A meta-analysis. *The British Journal of Psychiatry, 170*(3), 205–228.

Hendin, H., Maltsberger, J. T., Lipschitz, A., Haas, A. P., & Kyle, J. (2001). Recognizing and responding to a suicide crisis. *Suicide and Life-Threatening Behaviour, 31*(2), 115–128.

Hollander, E., Allen, A., Lopez, R. P., Bienstock, C. A., Grossman, R., Siever, L. J., Stein, D. J. (2001). A preliminary double-blind, placebo-controlled trial of divalproex sodium in borderline personality disorder. *The Journal of clinical psychiatry, 62*(3), 199–203.

Jacobs, D. G., Brewer, M., & Klein-Benheim, M. (1999). Suicide assessment: An overview and recommended protocol. In *The Harvard Medical School guide to suicide assessment and intervention* (pp. 3–39). San Francisco, CA: Jossey-Bass.

Kelly, T. M., Soloff, P. H., Lynch, K. G., Haas, G. L., & Mann, J. J. (2000). Recent life events, social adjustment, and suicide attempts in patients with major depression and borderline personality disorder. *Journal of Personality Disorders, 14*(4), 316–326.

Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review, 27*(2), 226–239.

Kochman, F. J., Hantouche, E. G., Ferrari, P., Lancrenon, S., Bayart, D., & Akiskal, H. S. (2005). Cyclothymic temperament as a prospective predictor of bipolarity and suicidality in children and adolescents with major depressive disorder. *Journal of Affective Disorders, 85*(1), 181–189.

Kreitman, N., Philip, A. E., Greer, S., & Bagley, C. R. (1969). Parasuicide. *The British Journal of Psychiatry, 115*(523), 746–747.

Kulkarni, R. R., Rao, K. N., & Begum, S. (2013). Comorbidity of psychiatric and personality disorders in first suicide attempters: A case-control study. *Asian Journal of Psychiatry, 6*(5), 410–416.

Laye-Gindhu, A., & Schonert-Reichl, K. A. (2005). Nonsuicidal self-harm among community adolescents: Understanding the “whats” and “whys” of self-harm. *Journal of Youth and Adolescence, 34*(5), 447–457.

Lieb, K., Völlm, B., Rücker, G., Timmer, A., & Stoffers, J. M. (2010). Pharmacotherapy for borderline personality disorder: Cochrane systematic review of randomised trials. *The British Journal of Psychiatry, 196*(1), 4–12.

Lilly, E. (2007). Efficacy and safety of olanzapine in patients with borderline personality disorder: A randomized, flexible-dose, double-blind comparison with placebo (Summary ID 6257. clinical study summary: study F1D-MC-HGKL). *Eli Lilly*, *200*.

Linehan, M. M. (1993). *Cognitive behavioural therapy of borderline personality disorder*. New York, DC: Guilford.

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behaviour therapy vs therapy by experts for suicidal behaviours and borderline personality disorder. *Archives of general psychiatry, 63*(7), 757–766.

Linehan, M. M., Schmidt, H., Dimeff, L. A., Craft, J. C., Kanter, J., & Comtois, K. A. (1999). Dialectical behaviour therapy for patients with borderline personality disorder and drug-dependence. *The American journal on addictions, 8*(4), 279–292.

Loew, T. H., Nickel, M. K., Muehlbacher, M., Kaplan, P., Nickel, C., Kettler, C., Bachler, E. (2006). Topiramate treatment for women with borderline personality disorder: A double-blind, placebo-controlled study. *Journal of Clinical Psychopharmacology, 26*(1), 61–66.

McGirr, A., Paris, J., Lesage, A., Renaud, J., & Turecki, G. (2007). Risk factors for suicide completion in borderline personality disorder: A case-control study of cluster B comorbidity and impulsive aggression. *The Journal of Clinical Psychiatry, 68*(5), 721–729.

Montgomery, S. A., Montgomery, D. B., Janyanthi, R. S., Roy, P. H., Shaw, P. J., McAuley, R. (1979). Maintenance therapy in repeat suicidal behaviour: A placebo controlled trial. In *Proceedings of the 10th International Congress of Suicide Prevention and Crisis Intervention* (pp. 227–229). Ottawa, ON: International Association for Suicide Prevention

Motto, J. A., & Bostrom, A. G. (2001). A randomized controlled trial of postcrisis suicide prevention. *Psychiatric services, 52*(6), 828–833.

Nickel, M. K., Muehlbacher, M., Nickel, C., Kettler, C., Francisco Pedrosa Gil, M. D., Bachler, E., Anvar, J. (2006). Aripiprazole in the treatment of patients with borderline personality disorder: A double-blind, placebo-controlled study. *American Journal of Psychiatry, 163*(5), 833–838.

Nickel, M. K., Nickel, C., Kaplan, P., Lahmann, C., Mühlbacher, M., Tritt, K., … Loew, T. H. (2005). Treatment of aggression with topiramate in male borderline patients: A double-blind, placebo-controlled study. *Biological psychiatry, 57*(5), 495–499.

Nickel, M. K., Nickel, C., Mitterlehner, F. O., Tritt, K., Lahmann, C., Leiberich, P. K., … Loew, T. H. (2004). Topiramate treatment of aggression in female borderline personality disorder patients: A double-blind, placebo-controlled study. *Journal of Clinical Psychiatry, 65*(11), 1515–1519.

Oldham, J. M. (2006). Borderline personality disorder and suicidality. *The American Journal of Psychiatry, 163*(1), 20–26.

Oldham, J. M., Skodol, A. E., & Bender, D. S. (2007). *The american psychiatric publishing textbook of personality disorders*. Washington, DC: American Psychiatric Publishing.

Oquendo, M. A., Galfalvy, H., Russo, S., Ellis, S. P., Grunebaum, M. F., Burke, A., Mann, J. J. (2004). Prospective study of clinical predictors of suicidal acts after a major depressive episode in patients with major depressive disorder or bipolar disorder. *The American Journal of Psychiatry, 161*(8), 1433–1441.

Oquendo, M. A., & Mann, J. J. (2000). The biology of impulsivity and suicidality. *The Psychiatric Clinics of North America, 23*(1), 11–25.

Paris, J. (2002). Chronic suicidality among patients with borderline personality disorder. *Psychiatric Services, 53*(6), 738–742.

Pompili, M., Rihmer, Z., Akiskal, H. S., Innamorati, M., Iliceto, P., Akiskal, K. K., Girardi, P. (2008). Temperament and personality dimensions in suicidal and nonsuicidal psychiatric inpatients. *Psychopathology, 41*(5), 313–321.

Rudd, M. D., Berman, A. L., Joiner, T. E., Nock, M. K., Silverman, M. M., Mandrusiak, M., Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behaviour, 36*(3), 255–262.

Sansone, R. A. (2004). Chronic suicidality and borderline personality. *Journal of Personality Disorders, 18*(3), 215–225.

Soloff, P. H., Cornelius, J., George, A., Nathan, S., Perel, J. M., & Ulrich, R. F. (1993). Efficacy of phenelzine and haloperidol in borderline personality disorder. *Archives of General Psychiatry, 50*(5), 377–385.

Soloff, P. H., Fabio, A., Kelly, T. M., Malone, K. M., & Mann, J. J. (2005). High-lethality status in patients with borderline personality disorder. *Journal of Personality Disorders, 19*(4), 386–399.

Soloff, P. H., George, A., Nathan, R. S., Schulz, P. M., Cornelius, J. R., Herring, J., Perel, J. M. (1989). Amitriptyline versus haloperidol in borderlines: Final outcomes and predictors of response. *Journal of Clinical Psychopharmacology, 9*(4), 238–246.

Soloff, P. H., Lynch, K. G., & Kelly, T. M. (2002). Childhood abuse as a risk factor for suicidal behaviour in borderline personality disorder. *Journal of Personality Disorders, 16*(3), 201–214.

Soloff, P. H., Lynch, K. G., Kelly, T. M., Malone, K. M., & Mann, J. J. (2000). Characteristics of suicide attempts of patients with major depressive episode and borderline personality disorder: A comparative study. *The American Journal of Psychiatry, 157*(4), 601–608.

Stengel, E. (1964). *Suicide and attempted suicide*. Oxford, England: Penguin Books.

Torgersen, S., Kringlen, E., & Cramer, V. (2001). The prevalence of personality disorders in a community sample. *Archives of General Psychiatry, 58*(6), 590–596.

Tritt, K., Nickel, C., Lahmann, C., Leiberich, P. K., Rother, W. K., Loew, T. H., Nickel, M. K. (2005). Lamotrigine treatment of aggression in female borderline-patients: A randomized, double-blind, placebo-controlled study. *Journal of Psychopharmacology, 19*(3), 287–291.

Turecki, G., & Brent, D. A. (2015). Suicide and suicidal behaviour. *The Lancet, 387*(10024), 1227–1239.

Verheul, R., van den Bosch, L. M., Koeter, M. W., De Ridder, M. A., Stijnen, T., & Van Den Brink, W. (2003). Dialectical behaviour therapy for women with borderline personality disorder. *The British Journal of Psychiatry, 182*(2), 135–140.

Yen, S., Pagano, M. E., Shea, M. T., Grilo, C. M., Gunderson, J. G., Skodol, A. E., Zanarini, M. C. (2005). Recent life events preceding suicide attempts in a personality disorder sample: Findings from the collaborative longitudinal personality disorders study. *Journal of consulting and clinical psychology, 73*(1), 99–105.

Yen, S., Shea, T., Pagano, M., Sanislow, C. A., Grilo, C. M., McGlashan, T. H., Morey, L. C. (2003). Axis I and axis II disorders as predictors of prospective suicide attempts: Findings from the collaborative longitudinal personality disorders study. *Journal of Abnormal Psychology, 112*(3), 375–381.

Zaheer, J., Links, P. S., & Liu, E. (2008). Assessment and emergency management of suicidality in personality disorders. *The Psychiatric Clinics of North America, 31*(3), 527–543.

Zanarini, M. C., & Frankenburg, F. R. (2001). Olanzapine treatment of female borderline personality disorder patients: A double-blind, placebo-controlled pilot study. *The Journal of clinical psychiatry, 62*(11), 849–854.

Zilber, N., Schufman, N., & Lerner, Y. (1989). Mortality among psychiatric patients-the groups at risk. *Acta Psychiatrica Scandinavica, 79*(3), 248–256.

Zouk, H., Tousignant, M., Seguin, M., Lesage, A., & Turecki, G. (2006). Characterization of impulsivity in suicide completers: Clinical, behavioural and psychosocial dimensions. *Journal of Affective Disorders, 92*(2), 195–204.