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Removing immediate access to lethal means
may give the patient time to reconsider a
suicide attempt or nonsuicidal self-injury



YOND THREATS

Risk factors for suicide in BORDERLINE PERSONALITY DISORDER

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Manipulative, "just threats," or suicide gestures are terms you may have heard or used to label suicidal thoughts and behavior in individuals with borderline personality disorder (BPD). These terms imply that the risk of injury or death is low, but evidence shows that BPD patients are at high risk for completed suicide¹⁻³—and clinicians who use these labels may underestimate this risk and respond inadequately.

BPD is the only personality disorder to have suicidal or self-injurious behavior among its diagnostic criteria.² A prospective study showed a 3.8% completed suicide rate in a sample of borderline patients at 6-year follow-up.² Earlier studies reported rates from 8% to 10%—approximately 50 times greater than the general population.¹

Recent suicide attempts by individuals with BPD have shown:

- the same degree of lethality and intent to die (*Box 1, page 34*)⁵⁻⁷ as recent suicide attempts by individuals without BPD⁸
- no differences in degree of intent to die compared with attempts by persons experiencing a major depressive episode or persons with both BPD and depression.⁹

Moreover, patients with BPD (including those with comorbid depression) have reported greater lethality for their most serious lifetime suicide attempt than those with depression alone.⁹

Based on the literature and our clinical experience, this article offers recommendations for assessing and treating suicidal behavior in BPD patients. We review risk factors for suicide and suicide attempts and suggest strategies for safety management, psychotherapy, and pharmacotherapy. Because of the high-risk nature of this population, we recommend that all clinicians working with suicidal BPD patients obtain consultation and supervision as needed when using these strategies.

continued



Borderline personality disorder

Clinical Point

Nonsuicidal self-injury behaviors require active intervention because of the possibility of serious injury

Box 1

Self-injury: Address all potentially harmful behaviors

Self-injurious behavior in borderline personality disorder (BPD) patients can be divided into 2 categories: suicide attempts and nonsuicidal self-injury.

- Suicide attempts are performed with some evidence of intent to die.⁵
- Nonsuicidal self-injury behaviors (NSIB) are performed without intent to die.⁶

How can clinicians respond effectively when suicidal behaviors are repetitive and performed both with and without the intent to die? Although patients may perform NSIB for reasons other than intent to die (such as to express anger, punish oneself, or relieve distress),⁷ these behaviors require active intervention because of the possibility of serious injury (intentional or accidental). Also, the intent of a self-injurious behavior may change as the patient performs the behavior; what started as a nonsuicidal act may turn into a suicide attempt.⁶ Therefore, address all potentially harmful behaviors.

Risk factors for suicidal behavior

Several risk factors for suicide attempts and completed suicide among individuals diagnosed with BPD have been identified. Previous suicide attempts are one of the strongest predictors of completed suicide and suicide attempts in individuals with BPD.¹⁰⁻¹² In general, clinicians cannot accurately predict which individuals will die by suicide.^{10,13} Suicide risk factors identified in BPD (*Table 1*)¹²⁻¹⁶ are similar to those in persons without the BPD diagnosis. In BPD patients, risk factors for attempted and completed suicide largely overlap.

In a case-control study, BPD patients who died by suicide were reported by surviving relatives to have greater impulsivity and aggression and more comorbid diagnoses of antisocial personality disorder than control patients who did not commit suicide.¹⁶ More prospective studies are needed to differentiate risk factors for suicide completion vs attempts.

Individuals with BPD may be distinguished by elevated risk factors for suicidal behavior as compared with suicide attempters without the BPD diagnosis. In a study comparing recent suicide attempt-

Table 1

Common risk factors for suicidal behavior in BPD

Behavioral factors

Previous suicide attempts
 Impulsivity
 Aggression
 Poor social problem-solving skills
 Poor social adjustment

Cognitive/emotional factors

Affective instability
 Hopelessness

Comorbid diagnoses

Major depressive disorder
 Antisocial personality disorder
 Substance abuse disorders

Psychosocial/psychiatric history

Childhood physical abuse
 Childhood sexual abuse
 Psychiatric hospitalizations

BPD: borderline personality disorder
 Source: References 12-16

ers with and without BPD, those with BPD showed greater severity across a number of risk factors, including overall psychopathology, depression, hopelessness, suicide ideation, past suicide attempts, and social problem solving skills.⁸

Remove lethal means

When working with patients with a history of suicidal behavior, it is critical to ensure the safety of the patient's environment. Restricting access to lethal means has been shown to be an effective form of suicide prevention.¹⁷ Direct all patients with a history of recent suicidality or nonsuicidal self-injurious behavior (NSIB) to remove lethal means and means of self-harm from their homes and possession (*Table 2*). Continue to monitor access to lethal means throughout treatment, as patients may acquire new means or reveal possession of items they had previously concealed.

We have found the following metaphor useful in discussing with patients the rationale for removing lethal means: "If you were on a diet, would it make sense to have a chocolate cake in the house?" Objections to removing lethal means often reveal important therapeutic issues. For example,

those unwilling to relinquish lethal means may not be fully committed to giving up suicide or NSIB as an option. This would become a critical treatment goal.¹⁸

Tell patients to remove or discard firearms, knives, razors, and pills, as well as other items used in past suicide attempts/NSIB. Although patients can acquire new lethal means, removing immediate access lowers the possibility of an impulsive suicide attempt or NSIB and may give the patient time to reconsider.

Address overdose risk. Some physicians are reluctant or refuse to prescribe medication to BPD patients out of fear that it will be used to attempt suicide. A more productive approach is to ensure through informed choice of medications and strict management of their distribution that the patient safely and consistently receives necessary treatment.

Avoid prescribing psychiatric medications in quantities that could be lethal in overdose. Also determine whether the patient has other potentially lethal medications. If possible, have a friend or family member keep and administer the patient's medications. If this is not possible, consider prescribing medications 1 week at a time.

Monitor as needed. If a patient continues to refuse to part with lethal means:

- involve family members or friends in removing and monitoring the patient's lethal means
- assess the degree of imminent danger and if the individual can be safely managed as an outpatient.

Monitoring and removal of lethal means are recommended until you feel confident the patient has obtained control over self-harm behaviors. Be sensitive about conveying distrust in the patient's improvement when inquiring about access to lethal means when the patient is no longer experiencing suicidal thoughts or impulses. To avoid triggers of relapse, the most conservative approach may be for individuals with a history of suicidality to indefinitely restrict their access to lethal means. We find most patients accept this rationale and appreciate our concern for their safety.

Table 2
7 clinical tips for managing safety in BPD patients

Work with the patient in every session to remove all potentially lethal means (guns, knives, razors, pills) from his or her home and possession
Create a detailed safety plan to use during a suicidal crisis
Assess suicide risk in every session
Involve family and friends if possible to help monitor the patient and to call you or 911 if the patient appears to be in imminent danger of suicidal behavior
Create a 'hope kit' (Box 2, page 39) as a companion to the safety plan
Consider hospitalization if the patient is in imminent danger of suicidal behavior or has engaged in suicidal behavior requiring medical attention
Consult with other clinicians about crucial safety management decisions, such as whether or not to hospitalize a patient
BPD: borderline personality disorder

Create a safety plan. Every BPD patient with a history of suicidality needs a detailed safety plan for what to do when suicidal (Table 3, page 38).^{19,20} Inform family members (and friends, when appropriate) of the safety plan, and involve them as needed to monitor a patient at risk. Give your BPD patients clear instructions about when you will be available by phone and emergency contacts for when you are not available.

Assess suicide risk

In every session, assess suicidal ideation, plans, intent, and urges to engage in NSIB. Consider using:

- self-monitoring forms, such as a dialectical behavior therapy (DBT) "diary card," on which the patient each day records urges to self-harm or attempt suicide¹⁸
- Beck Depression Inventory (which contains a question about suicidal ideation).²⁸

Also monitor use of psychiatric medications and substance use/abuse.¹⁹⁻²⁰

Risk assessment is not always straightforward. We have found that patients do not always provide consistent and/or accurate

Clinical Point

Every borderline personality disorder patient with a history of suicidality needs a detailed safety plan for what to do when suicidal



Borderline personality disorder

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We recommend admission if the suicidal patient is in imminent danger or has engaged in self-injury requiring medical treatment

Table 3

Lifeline for suicidal patients: What to include in a safety plan

Warning signs of a suicidal crisis for that individual (such as increased depression or negative thinking)

Coping skills the patient can perform on his or her own

Family members and friends the patient can contact in an emergency

Therapist's contact information

Phone numbers of emergency services available 24 hours daily (such as 911, suicide hotlines)

Source: References 19,20

information about their degree of suicidality, making it difficult to know how to intervene.

Reasons may include:

- fear of hospitalization
- uncertainty about whether or not they will attempt suicide
- desire to conceal a planned suicide attempt.

In this situation, we suggest avoiding a prolonged interrogation or debate with the patient, which can make assessment even more confusing and harm the therapeutic relationship. Try to assess if other suicide risk factors are elevated, and use those to guide decision-making. Patients may be more forthcoming in self-report measures than in a verbal interview. For patients who often have difficulty quantifying their suicidality, an advance agreement can be useful (such as, "If you cannot accurately report your level of risk to me, I will take that as a sign you are in danger and need to be hospitalized").

Hospitalize for suicidality?

If possible, consult with other professionals when making difficult decisions about hospitalizing a patient. These decisions often are subjective and open to influence by therapists' emotional reactions. Psychotherapies for BPD emphasize the importance of consulting with other clinicians when working with this population. DBT requires a therapist consultation meeting,

and cognitive therapies also have recommended consultation.¹⁸⁻²⁰

If you work alone in private practice, consider consulting by phone with colleagues experienced with working with BPD patients. Document this consultation to help protect yourself from liability should an adverse outcome occur.

Little evidence supports hospitalization as an effective treatment for suicidality in BPD.²⁴ It has been argued that hospitalization might increase future suicidal behavior when the patient perceives it as a positive experience or a means of escaping problems.¹⁸ The patient's safety must remain a top priority, however, and we recommend admission if the patient is in imminent danger or has engaged in self-injurious behavior requiring medical attention.

The length of a hospital stay should be determined on a case-by-case basis. In general, it has been recommended that hospitalization for BPD patients be crisis-oriented and brief to avoid reinforcing suicidal behavior and to promote coping with suicidality in the natural environment.^{18,24} Also take into account acute exacerbation of comorbid Axis I diagnoses when determining the duration of hospitalization.

'No-suicide' contracts. Be careful not to rely on "no-suicide" contracts. They have no legal standing and may give you a false sense of security. Clearly, a patient may attempt suicide despite promising not to do so.

Asking if the patient can commit to staying safe for a specified time can be useful in assessing his/her level of suicidality and motivation to behave safely, but this is no substitute for a thorough clinical evaluation. Consider increasing the level of care and degree of monitoring or hospitalization if other suicide risk factors are elevated, even if the patient has "contracted for safety."

Validated psychotherapies

Psychotherapy is the primary treatment for BPD, according to American Psychiatric Association (APA) guidelines.¹ DBT,²¹⁻²² transference-focused therapy,²⁵ and mentalization-based therapy²⁶ are 3 validated

psychotherapeutic approaches for BPD that have been shown to reduce suicide attempt rates in randomized clinical trials (RCTs). DBT has the greatest number of RCTs supporting its efficacy. We advise clinicians who work frequently with BPD patients to become familiar with these effective, empirical treatments.

A recent open trial of cognitive therapy for BPD demonstrated a decrease in self-harm behaviors.²⁷ Cognitive therapy for recent suicide attempters—including those with BPD—decreased subsequent suicide attempts by approximately 50% over 18 months of follow-up in a RCT.²⁸

Target suicidality. For all patients with a recent suicide attempt, make suicidal behavior the primary treatment target.¹⁸⁻²⁰ Work with the patient on skills to reduce suicidal behavior, rather than assuming the behavior will resolve after you treat the psychiatric disorder (such as depression or BPD).

Throughout treatment, make suicidality or NSIB the priority in sessions whenever it occurs.¹⁸ This ensures that self-harm behavior is adequately addressed and provides an aversive consequence for this behavior. The patient cannot talk about other topics he/she might want to discuss until the suicidal behavior is addressed.¹⁸

Also target risk factors for suicidal behavior, such as depression, hopelessness, substance abuse, impulsivity, affective instability, social adjustment, and social problem-solving skills.

Teach coping skills. Because suicide attempts and NSIB in BPD often occur as maladaptive means of coping with distress, teach your patient alternatives such as distraction and self-soothing techniques, relaxation, positive self-statements, problem-solving skills, and how to use social support.¹⁸⁻²⁰ The patient is likely to be flooded with affect when suicidal, so teach simple, easy-to-perform coping skills. Because self-harm behaviors in BPD patients often occur impulsively, create a written safety plan in advance. A “hope kit” can be an extremely useful part of the safety plan (*Box 2*).^{18,19,27}

Box 2**‘Hope kit’ can help patients cope with suicidal crises**

A ‘hope kit’ can be an extremely useful intervention with recent suicide attempters.^{18,19} In a randomized, controlled trial, use of a hope kit as part of cognitive therapy for recent suicide attempters decreased suicide attempt rates by approximately 50%, compared with treatment as usual plus case management.²⁷

Instruct the patient to fill a box or container with tangible reminders of reasons to live (such as photos of loved ones) and cues to use coping skills (a relaxation tape, a comic book, music, positive written self-statements). Tell the patient to keep the hope kit easily accessible and use it to guide positive coping during a suicidal crisis.

Symptom-guided medication

Use pharmacotherapy to complement psychotherapy for BPD and to address comorbid Axis I conditions. The BPD symptom domains targeted by medications may be sorted into 3 categories: (*Table 4, page 40*):¹

- affective dysregulation
- impulsive behavioral dyscontrol
- cognitive and perceptual problems.

Because impulsivity, comorbid major depression, and affective instability are risk factors for suicidal behavior in BPD patients, adjunctive pharmacology is critical in managing the safety of these patients.

Recommendations for pharmacologic management in BPD are based on a relatively small number of studies. Medication can decrease symptoms and increase the patient’s ability and willingness to engage in therapy. However, no drug has been proven effective or received FDA approval to treat BPD. Thus, our prescribing recommendations—though based on available evidence—are off-label uses.

In our experience, BPD patients often are prescribed multiple medications, probably because no single medication targets all symptoms of the disorder. To avoid the accumulation of medications that have lost or have not demonstrated therapeutic effect, we recommend caution when addressing BPD pathology with polypharmacy.

Medication classes used for treating BPD

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Whenever suicidality or self-injury has occurred, make this the priority of the therapy session, before any other topics are discussed



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APA guidelines consider SSRIs first-line treatment for affective dysregulation and impulsive behavior in patients with BPD

Table 4

Symptom-guided approach to medication for BPD patients

Symptom domain	Medication(s)
Affective dysregulation	SSRI (first-line) or mood stabilizer (second-line)
Impulsive behavioral dyscontrol	SSRI and/or low-dose atypical antipsychotic
Cognitive and perceptual problems, acute dissociation/psychotic symptoms	Low-dose atypical antipsychotic
Acute anxiety (severe)	Low-dose atypical antipsychotic
Chronic anxiety	SSRI

BPD: borderline personality disorder; SSRI: selective serotonin reuptake inhibitor
Source: Reference 1

symptoms are described below. Because of BPD symptom heterogeneity (in quality and quantity), we cannot recommend specific dosages. In general, we suggest starting with the lowest dosage recommended for a particular symptom and increasing slowly if needed.^{1,29-34}

Antidepressants. APA guidelines suggest a selective serotonin reuptake inhibitor (SSRI) as the first-line initial treatment for affective dysregulation and impulsive behavioral dyscontrol.^{1,35-37} Because reports have shown increased risk of suicidal thoughts and behaviors with SSRI use in children, adolescents, and young adults,³⁸ follow FDA guidelines for monitoring these populations during the first 12 weeks of therapy.³⁹

Antipsychotics. Over the long term, low-dose atypical antipsychotics are the treatment of choice for cognitive and perceptual problems in BPD. Clozapine, olanzapine, risperidone, and aripiprazole also have been reported as useful in reducing impulse behaviors and ameliorating severe NSIB.²⁹⁻³⁴

Dosages typically are lower than those used to treat Axis I psychotic disorders. Because of clozapine's complex maintenance and potential for side effects, consider using it only after trials of other antipsychotics have failed. Also consider short-term antipsychotic use to manage acute symptoms such as dissociation, intense paranoia, hostility, or severe anxiety.

Agents to consider with caution. Because of the potential for abuse, tolerance,

overdose, and behavioral disinhibition, be very cautious when using benzodiazepines to treat chronic and acute anxiety in BPD patients.¹

Mood stabilizers may be effective for mood symptoms and to decrease the severity of impulsive aggression. You might use them as a second choice after failed attempts with SSRIs and/or antipsychotics, while very carefully considering the likelihood of overdose.¹

Tricyclic antidepressants and monoamine oxidase inhibitors are at times recommended for medication-resistant patients. Avoid these drugs in highly suicidal BPD patients because of the potential for lethal overdose.

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Related Resources

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Drug Brand Names

Aripiprazole • Abilify	Olanzapine • Zyprexa
Clozapine • Clozaril	Risperidone • Risperdal

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Bottom Line

Patients with borderline personality disorder are at high risk for suicide attempts and completed suicide. Take their suicidal ideation and behavior seriously, and target it directly via safety management, psychotherapy, and pharmacotherapy.

Clinical Point

Over the long term, low-dose atypical antipsychotics are the treatment of choice for cognitive and perceptual problems in BPD