

IS HOSPITALIZATION USEFUL FOR SUICIDAL PATIENTS WITH BORDERLINE PERSONALITY DISORDER?

Joel Paris, MD

This article examines the value of hospitalization for chronically suicidal patients with borderline personality disorder (BPD). One in 10 of these patients will eventually complete suicide. However, this outcome is not readily predictable. Hospitalization is of unproven value for suicide prevention and can often produce negative effects. Day treatment is an evidence-based alternative to full admission. Chronic suicidality can best be managed in an outpatient setting.

Borderline patients chronically think about suicide, threaten to carry it out, and make multiple attempts (Gunderson, 2001; Soloff, Lynch, Kelly, Malone, & Mann, 2000). Clinicians often describe patients as “suicidal”, but this term confounds threats, attempts, and completions.

How often do ideas and attempts lead to completion? Long-term outcome studies have documented the rate of suicide in BPD. Long-term 15-year follow ups of borderline patients (Paris, Brown, & Nowlis, 1987; 1988; Stone, 1990) found suicide rates over 9%, and a 27-year follow up (Paris & Zweig-Frank, 2001) found that 10% of patients had died by suicide. McGlashan's (1986) 15-year follow up of 81 patients treated at Chestnut Lodge reported that only 3% completed suicide but other studies have also reported rates of 10% (see review in Paris, 2003). Although these findings are troubling, the upshot is that while most patients with BPD threaten suicide, 90% never complete it. Moreover, there was a pattern of long-term recovery in all studies, associated with a remission of suicidal ideation (Paris, 2002a).

One of the most interesting findings of research on the course of BPD concerns the time when suicide completions occur. Although threats and attempts peak early in the course of the disorder (i.e., when patients are in their 20s), this is not when most completions happen. In a 15-year follow up, suicide occurred at a mean age of 30 years (Stone, 1990), whereas in a 27-year follow up (Paris & Zweig-Frank, 2001), the mean age at suicide was 37. Thus, borderline patients do not usually kill themselves when they most

From the Department of Psychiatry at McGill University and the SMBD-Jewish General Hospital, Montreal.

Address correspondence to Joel Paris, MD, 4333 Côte Ste-Catherine, Montréal, Québec, Canada, H3T 1E4; E-mail: joel.paris@mcgill.ca.

alarm therapists, but later, if they fail to recover, or when a series of treatments have been unsuccessful.

One caveat should be registered: some completed suicides in BPD may never come to clinical attention. In a psychological autopsy study, nearly one-third of suicides between ages 18 and 35 years were diagnosed with BPD (Lesage et al., 1994); most of these completions occurred in males, and most were first attempts.

The patients with BPD that clinicians see, most of whom are females, have a pattern of multiple attempts (Soloff et al., 2000). Can we predict which patients are at high risk for completion? The problem is that there are few useful predictors. The number of previous attempts (Paris et al., 1989), and other indicators of high impulsivity, such as substance abuse (Stone, 1990), make suicide more likely. However, none of these predictors account for much of the variance in outcome. This is a general problem in suicide research because completions are rare events and they are difficult to predict with accuracy (Pokorny, 1982; Goldstein, Black, Nasrallah, & Winokur, 1991).

CHRONIC SUICIDALITY: A CRUCIAL FEATURE OF BPD

In population studies, suicide completers and attempters have been found to be relatively distinct (albeit overlapping) clinical populations (Beautrais, 2001). Although the typical suicide completer is older, male, nontreatment seeking, uses more lethal methods and dies on the first attempt, repetitive attempters are younger, female, treatment seeking, and use less lethal methods. Some attempters develop a pattern that Maris, Berman, and Silverman (2000) have termed a "suicidal career". This pattern of chronic suicidality is quite characteristic of BPD.

In patients with BPD, unlike those with major depressive episodes without personality disorder, both lowered mood and suicidality are chronic. BPD is associated with early-onset dysthymia, rather than with classical melancholia (Pepper et al., 1995). Depression associated with BPD is phenomenologically different from mood disorders, in that it does not show continuous lowering of mood (Gunderson & Phillips, 1991); affective instability is much more characteristic of BPD than is discrete episodes of depression (Koenigsberg et al., 2002). Moreover, depression in the presence of a personality disorder does not respond as well to antidepressants (Shea et al., 1990).

If chronic suicidality is characteristic of BPD, what function does it serve? Brown, Comtois, and Linehan (2002) reported that borderline patients describe attempts as a way of controlling their fate or of escaping pain. In addition, both threats and attempts may serve a communicative function (Paris, 2002b). These behaviors let significant others and the therapist know about the patient's level of distress, albeit in a dramatic way that "turns up the volume". Threats and minor overdoses also tend to occur in the context of troubled attachments; in contrast, completion usually reflects a loss of connection (Paris, 2004).

In BPD, overdoses tend to be ambivalent in intent: someone has been telephoned, another person was present when the attempt was made, or at least

expected to arrive. In most cases, the attempter is saved and brought to the hospital. Completed suicide sometimes occurs more by accident than by intention. As Black, Blum, Pfohl, and Hale (2004) point out, these circumstances do not necessarily mean that patients are not seriously considering taking their lives, but suicide attempts in BPD can also be seen as a kind of Russian roulette, gambling with fate.

Although self-mutilation is sometimes seen as a form of suicidality, this behavior does not carry the same motivation as an overdose. Wrist cutting is not usually life threatening and patients who self-mutilate know it. Borderline patients who repetitively cut themselves report that their main goal is to relieve dysphoria (Brown et al., 2002; Leibenluft, Gardner, & Cowdry, 1987). To the extent that the behavior succeeds in accomplishing this goal, self-mutilation can become addictive.

All these observations have clinical implications. Although no sharp line exists between chronic and acute suicidality, therapists who treat chronically suicidal patients usually carry out continuous risk assessments. The problem with standard methods of evaluation is the implicit assumption that interventions can be based on them. Yet, no empirical evidence shows that clinical interventions have any systematic effect on completion. Even when clinicians believe they have prevented a completion, they cannot know whether it would actually have occurred.

DOES HOSPITALIZATION PREVENT SUICIDE IN BPD?

Hospitalization is an expensive resource that should be reserved for carrying out specific treatment plans. Common examples include neuroleptic therapy for acutely psychotic patients or either antidepressants or electroconvulsive therapy for patients with melancholic or psychotic depressions. Each of these are clear-cut therapies for clinical problems that cannot be administered practically outside the hospital setting. The efficacy of these treatments is well established and good results are common. In such scenarios, patients may also benefit from instituting suicidal precautions.

The management of chronic suicidality requires an entirely different set of principles (Fine & Sansone, 1990; Schwartz, Flinn, & Slawson, 1974). There is no specific treatment method that needs to be carried out in a hospital. Because patients are unlikely to recover as the result of an admission, a stay in the hospital can often be little more than a suicide watch. Although the term "safety" is often used to justify inpatient treatment, we do not know whether patients are actually more safe in the hospital. Although the follow up studies reviewed above did not find any patients with BPD who committed suicide while in the hospital, some patients still find ways to cut themselves, or even overdose, while on a ward.

The real problem is that the suicidal precautions used in hospital settings reinforce the very behavior one is treating (Linehan, 1993). The more suicidal precautions one introduces, the more patients tend to regress. The reason is that every suicidal action is rewarded with more, not less, nursing care. Even if suicidality is reduced by admission, BPD patients often continue to have chronic suicidal ideation after discharge.

Currently, the most common reasons why borderline patients are hospitalized include psychotic episodes, serious suicide attempts, suicidal threats, and self-mutilation (Hull, Yeomans, Clarkin, Li, & Goodman, 1996). Some of these indications make sense. If the patient has a brief psychosis, neuroleptic medication can provide symptom control. After a life-threatening suicide attempt, although there is no specific treatment to be carried out, admission can help the team to review the overall treatment plan.

The value of hospitalization is much more doubtful for suicidal threats, minor overdoses, or self-mutilation. One cannot justify admission as a way to administer pharmacotherapy for BPD. The effects of current agents on BPD is far from definitive (Soloff, 2000), largely consisting of reductions in impulsivity (Paris, 2003). In any case, prescribing these agents neither requires hospitalization, nor can one readily justify admission as a venue for conducting psychotherapy. Long-term admission is no longer practical, and in any case has never been shown to be effective for BPD patients. Moreover, the hospital environment in an acute ward is hardly ideal for taking new directions in therapy.

The most serious problem is that once introduced, admissions can be repetitive. This leads to a process of “psychiatrization” in which the patient learns to “work the system” and obtain admission whenever life is particularly difficult. It is difficult to understand to see how this pattern can be helpful for patients with BPD, who need to learn life skills outside the clinical setting. A patient who eventually recovered from BPD has written:

“Do not hospitalize a person with borderline personality disorder for more than 48 hours. My self-destructive episodes—one leading right into another—came out only after my first and subsequent hospital admissions, after I learned the system was usually obligated to respond . . . When you as a service provider do not give the expected response to these threats, you’ll be accused of not caring. What you are really doing is being cruel to be kind. When my doctor wouldn’t hospitalize me, I accused him of not caring if I lived or died. He replied, referring to a cycle of repeated hospitalizations, “That’s not life.” And he was 100 percent right!” (Williams, 1998, p. 174).

When repetitive hospitalization becomes a pattern, the therapeutic relationship may become characterized by “coercive bondage”(Hendin, 1981), in which the patient drives the treatment through fear. Moreover, the quality of the patient’s life can be compromised by overzealous concern (Maltzberger, 1994). In the words of Rachlin (1984, p. 306): “We cannot afford to be so afraid of as to deny our patients the right to learn to live.”

Dawson and MacMillan (1993), impressed with how often admissions can be both ineffective and counterproductive, have gone so far as to recommend that clinicians should never hospitalize borderline patients. It seems reasonable to conclude that at best, admission puts problems “on hold”. Linehan (1993) suggest that although one cannot entirely avoid hospitalization for patients with BPD, it should be as brief as possible, and not particularly comfortable. It has sometimes been suggested that pressures from insurance agencies and governments to keep admissions brief have been of great benefit to patients with BPD.

These conclusions contrast with those of the American Psychiatric Association Guidelines for the Treatment of Borderline Personality Disorder (Oldham et al., 2001), which recommends a fairly liberal use of hospitalization. However, the indications for admission listed in that document are not evidence based. Because no clinical trials have established whether inpatient treatment is effective, the burden of proof should lie with those who recommend a more costly and potentially hazardous approach.

What alternatives are there for clinicians treating BPD when outpatient treatment is not containing the patient or when therapy spirals out of control? In such cases, day treatment has empirically demonstrated effectiveness (Bateman & Fonagy, 1999; Piper, Rosen, & Joyce, 1996), and should be considered the main alternative to admission. Partial hospitalization may be particularly effective in BPD because it provides a highly structured program. Borderline patients typically show increased pathology in an unstructured environment (Gunderson, 2001). When activities are scheduled every hour, little time remains to slash one's wrists. Regression is further limited by the fact that the patient goes home at night. Given the absence of evidence that full hospitalization prevents completion, suicidal risk is not a contra-indication. The main obstacle to using this form of day treatment for BPD is availability; unlike wards, most programs have a waiting list.

MANAGING CHRONIC SUICIDALITY

The most conservative approach to chronic suicidality in BPD is outpatient therapy with day treatment as a back-up. But managing BPD in this way requires a different mind set. When patients present suicidal threats and behaviors, therapists need not be alarmed; after all, chronic suicidality "goes with the territory" of BPD. Instead, these ideas and behaviors are signals that can be used in therapy to address causes and consider solutions.

Linehan's (1993) dialectical behavioral therapy offers an interesting model: she recommends a form of behavioral 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. Very similar principles have been described by clinicians of other orientations (Gunderson, 2001).

Therapists should also be aware that their responses to suicidality can increase or decrease the frequency of both thoughts and attempts. Although clinicians need to respond to suicidal thoughts empathically, they may want to avoid overly anxious questions about intent. A more neutral response to suicidality might be, "You must be feeling particularly upset to be thinking along those lines. Let's figure out what is making things worse, and see if we can find a way of dealing with the problem".

Successful treatment has been shown to lead to a decrease in suicidality (Linehan, 1993; Bateman & Fongagy, 1999). Even in patients who are not in active treatment, BPD usually improves gradually over time (Paris, 2003). Until this happens, borderline patients may need to hold on to their suicidality.

Although many clinicians are aware of the limited value of hospitalizing patients with BPD, they may feel compelled to admit patients who threaten suicide. One factor is a fear of litigation. Death by suicide occurs at least once in the careers of psychiatrists and psychologists (Chemtob, Hamada, Bauer, & Torigoe, 1988a) and is a leading cause of lawsuits—even if only a small fraction of completions lead to litigation, and only a minority are eventually upheld (Gutheil, 1992).

Clinicians should be aware that courts will rarely find them to be responsible based on the fact of suicide alone (Gutheil, 1992). Instead, liability occurs when patients are not assessed carefully and when there are no adequate records documenting the management plan. Therapists can protect themselves by writing frequent notes that document the rationale for avoiding hospitalization in patients with BPD (e.g., lack of benefit for the long-term treatment plan and a danger of compromising the treatment). Therapists should also inform suicidal patients early in treatment that their families will be contacted if they are at risk (Packman & Harris, 1992).

CONCLUSION

Most clinicians have been trained to consider suicide prevention as a primary goal of treatment. However, models developed for acute suicidality may be counterproductive in patients with chronic suicidality. Attempts at active intervention, most particularly hospital admission, have never been shown to be effective in this population. Therapists treating patients with BPD may need to tolerate suicidality before they can begin to manage it.

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