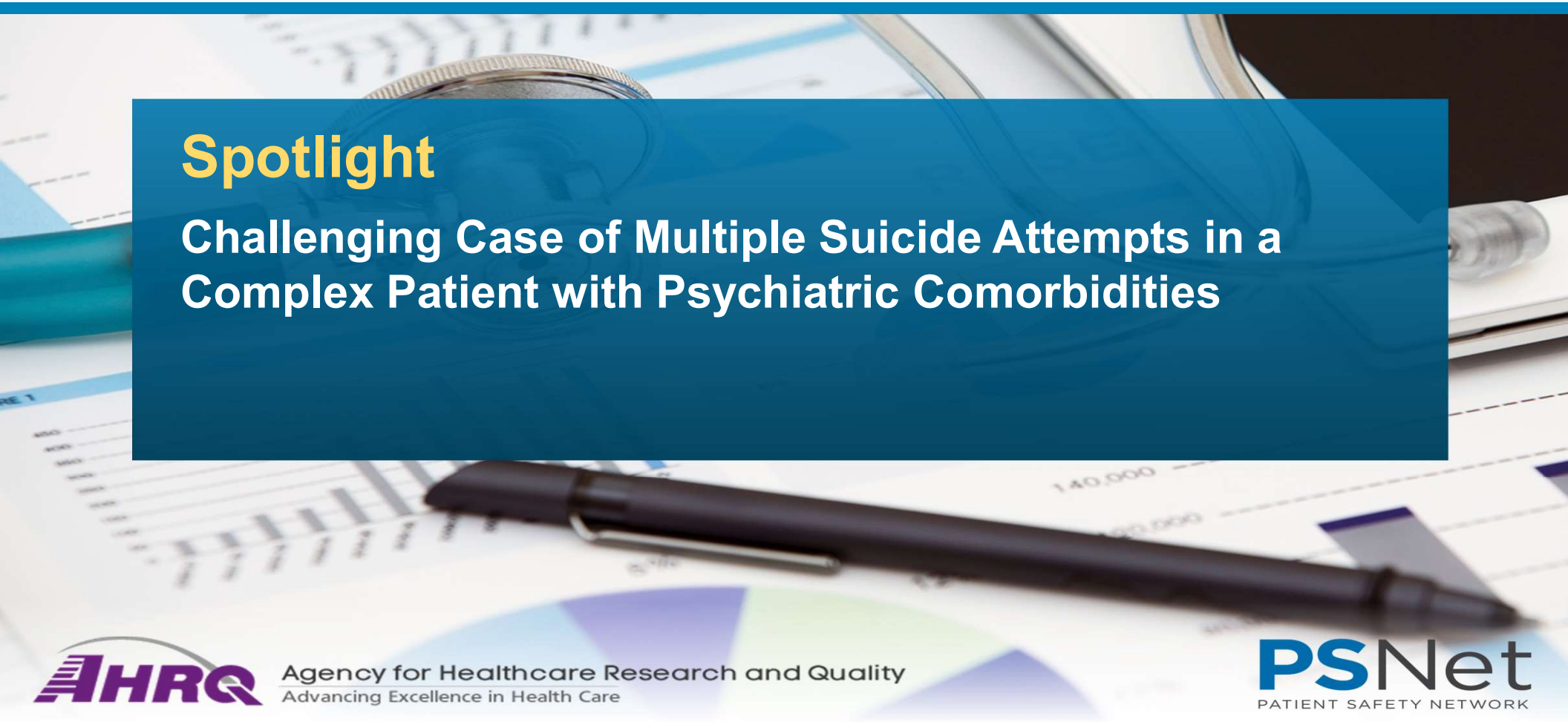
WebM&M

Morbidity and Mortality Rounds on the Web



Spotlight

Challenging Case of Multiple Suicide Attempts in a Complex Patient with Psychiatric Comorbidities

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

PSNet PATIENT SAFETY NETWORK

Source and Credits

- This presentation is based on the March 2023 AHRQ WebM&M Spotlight Case
  - See the full article at https://psnet.ahrq.gov/webmm
  - CME credit is available
- Commentary by: James A. Bourgeois, OD, MD. and Glen Xiong, MD
- AHRQ WebM&M Editors in Chief: Patrick Romano, MD, MPH and Deb Bakerjian, PhD, APRN, RN
  - Spotlight Editors: Patrick Romano, MD, MPH and Ulfat Shaikh, MD
  - Managing Editor: Meghan Weyrich, MPH
- *Editor's Note: this case was adapted from Capozzola DD, Terrence J. Appellate Court Affirms $806k Verdict for Failure to Treat Psychotic Symptoms, Suicide Attempt. Published October 1, 2022.*

Objectives

At the conclusion of this educational activity, participants should be able to:

- Outline the challenges in assessing suicide risk in patients with complex psychiatric histories and identify several known risk factors.
- Describe key differences between the presentations of bipolar disorder and borderline personality disorder.
- Describe effective communication and teamwork between psychiatric consultants and other medical team members.
- Identify preferred pharmacotherapy options and follow-up treatment recommendations after suicide attempts.

CHALLENGING CASE OF MULTIPLE SUICIDE ATTEMPTS IN A COMPLEX PATIENT WITH PSYCHIATRIC COMORBIDITIES

A case highlighting the challenges in assessing suicide risk and establishing the underlying diagnosis after a suicide attempt, the importance of managing relationships between psychiatric consultants and other physicians, and the role of appropriate pharmacotherapy and follow-up after the patient has medically recovered from a suicide attempt

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Case Details (1)

- A woman with a complex psychiatric history of bipolar disorder, borderline personality disorder, and generalized anxiety disorder was seen by medical providers on three occasions after expressing suicidal ideation.
- She was prescribed antidepressant medications at typical starting doses.
- The following month, the patient attempted to commit suicide by overdosing on her prescription antidepressants and pain medication.
- She was admitted to the critical care service of a hospital and received a low dose of lorazepam to relieve anxiety.

Case Details (2)

- A consulting psychiatrist at the hospital evaluated the patient, but she did not see her primary psychiatrist, as her primary psychiatrist did not provide inpatient consultations at this facility.
- The consulting psychiatrist was concerned about potential complications and side effects from starting mood-stabilizing medications, so they recommended continuation of lorazepam alone and did not recommend transfer to inpatient psychiatric care.
- The patient was discharged to her mother's care the same day that she was evaluated by the consulting psychiatrist, after her mother promised to monitor the patient and control her medications until she could be re-evaluated by a licensed clinical social worker in eight days.

Case Details (3)

- Two weeks later, before she could get appointed to see a psychiatrist, the patient attempted suicide by dousing herself in hairspray and setting herself on fire, resulting in third-degree burns over 42% of her body. The severity of the burns required four skin grafts and nearly two dozen laser surgeries.

CHALLENGING CASE OF MULTIPLE SUICIDE ATTEMPTS IN A COMPLEX PATIENT WITH PSYCHIATRIC COMORBIDITIES

THE COMMENTARY

By James A. Bourgeois, OD, MD, and Glen Xiong, MD

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BACKGROUND

Background (1)

- This case involves an adult woman with a history of suicidal ideation who was prescribed antidepressants but was later admitted to the hospital after overdosing on her prescribed medications.
- A consulting psychiatrist evaluated the patient but recommended sending her home on a benzodiazepine alone, under observation by her mother.
- This case raises important questions about assessing suicide risk, establishing the most likely underlying diagnoses immediately after a suicide attempt, managing relationships between psychiatric consultants and other physicians, and selecting appropriate pharmacotherapy and follow-up after the patient has medically recovered from a suicide attempt.

ASSESSING SUICIDE RISK

Assessing Suicide Risk (1)

- The risk of suicide is increased in people with syndromal major depressive disorder, anxiety,[1] schizophrenia, bipolar disorder, commingled substance use disorder, neurocognitive impairment, history of traumatic brain injury (TBI), borderline or narcissistic or antisocial personality disorder, neurologic illness, history of prior suicide attempts, and family history of suicide.
- Patients with several of these risk factors are at significantly increased risk of suicide attempts, so it is useful to tally these risk factors as part of suicidal ideation risk stratification.
- Behavior cannot be predicted with certitude, and suicide remains a rare event, even in high-risk patients. However, it is a common clinical rubric that most medically serious overdoses warrant psychiatric admission, even in the absence of other known suicide risk factors.

Assessing Suicide Risk (2)

- The consulting psychiatrist has the responsibility to develop a reasonable differential diagnosis based on available history and examination at the time of the encounter.[2]
- Many patients with overdose will initially present with delirium, which clouds the clinical picture and often affects the patient's memory for antecedent events, including the suicide attempt. Often the exact diagnosis is difficult to ascertain in the emergency department (ED) or critical care setting.
- The most important decision is whether psychiatric hospitalization is indicated, often on an involuntary basis for people with suicidal ideation and attempts.

DIAGNOSTIC CHALLENGES AFTER ATTEMPTED SUICIDE

Diagnostic challenges after attempted suicide (1)

- It is unclear based on this brief account whether this patient had both bipolar disorder and borderline personality disorder.
- While these illnesses are commonly comorbid, and the psychopharmacological approaches to them can overlap significantly, an important conceptual distinction is that borderline personality disorder is characterized by excess emotionality, irritable temperament, and brief emotion-driven crises driven by *relationship-based disruption*, such as actual or threatened abandonment.
- In contrast, bipolar disorder features *prolonged and sustained episodes* (i.e., at least several days) of hypomanic or manic elevated mood at some times, and two or more weeks of major depressive episodes at other times, not necessarily cued by social disruption.

Diagnostic challenges after attempted suicide (2)

- Patients with borderline personality disorder who experience “mood swings” of emotional disruption and acting-out behavior for brief periods are often misdiagnosed as “bipolar disorder” without a rigorous examination for *discrete and prolonged* hypomanic/manic and major depressive episodes.
- In borderline personality disorder, extreme episodes of emotion-driven behavior (even if brief and precipitated by a social situation) may drive serious suicide attempts and are a common source of emergency psychiatry presentations.
- Borderline personality disorder is characterized by high risk of suicidal and other self-harm behaviors, interpersonal violence, multiple comorbid psychiatric illnesses (including substance abuse) and a tendency for crisis presentations.
  - Due to acute suicide risk, they often require psychiatric admission for clinical stabilization. They are prone to brief (<24 hour) episodes of psychotic decompensation when distressed.
  - While borderline personality disorder is fundamentally and ultimately an outpatient problem, acute borderline crisis often justifies psychiatric admission for initial management.

Diagnostic challenges after attempted suicide (3)

- Patients with borderline personality disorder have a high risk for comorbid major depressive disorder, which itself increases suicide risk.[3]
  - Patients with borderline personality may also have chronic suicidal ideation that does not warrant hospitalization.[4] However, acute suicidal ideation or behavior that differs from baseline suicidal ideation must be taken seriously and usually warrants hospitalization.[5]
  - Passive (i.e., a desire to be dead, or a lack of motivation to stay alive) versus active (i.e., has a desire and plan to kill oneself) suicidal thought should also be distinguished.[6]
- Borderline personality disorder, when comorbid with other psychiatric illnesses, increases the risk of suicidal behavior attributable to the other illness.[7-9]
  - As such, the presence of borderline personality disorder with other psychiatric illness in a crisis presentation should make psychiatric admission and evidence-based psychopharmacology more likely, not less likely.
  - Thoughtful application of depression rating scales (e.g., Hamilton Depression Inventory, PHQ-9) can help to attribute mood symptoms to depressive disorder, rather than to the associated borderline personality disorder.

Diagnostic challenges after attempted suicide (4)

- Both bipolar disorder and borderline personality disorder have fairly large evidence bases to support medication use including mood stabilizers, antidepressants, and antipsychotics.[10]
  - Benzodiazepine monotherapy does not treat personality disorders or depressive disorders directly and can lead to impulsive acting-out (including overdoses[11]) as well as disinhibition, so is typically avoided in borderline personality disorder.
- The clinical scenario described above would justify a brief psychiatric admission under a commitment order to initiate psychotropic medications and to establish psychiatric care, including close outpatient follow-up.
- Borderline personality disorder is common in patients with a history of substance abuse. As such, assessment for substance abuse should be routinely prioritized, as the substance use disorder often becomes the nidus of initial treatment.

APPROACHES TO IMPROVING PATIENT SAFETY

Approaches to Improving Patient Safety: The role of psychiatric consultants (1)

- The role of the psychiatric consultant and the relationship to the referring physician are important to review.
- In many healthcare systems, consultants only provide “advice” and do not write orders or otherwise provide care directly.
- The boundaries of this relationship need clarity as both parties need to know who is responsible for what.
- In this case, the inpatient physician may have been uncomfortable with the consulting psychiatrist’s recommendation to send the patient home in her mother’s care, without any pharmacologic treatment for her underlying psychiatric diagnoses.

Approaches to Improving Patient Safety: The role of psychiatric consultants (2)

- Since the primary treating physician and the consultant share responsibility for the patient's care, either must be able to challenge the other if they have safety-related concerns.
- In other words, the primary treating physician could have rejected the psychiatry consultant's opinion regarding the safety of discharge to home on a benzodiazepine alone, but such a decision would need to be followed by an attempt to obtain a second psychiatry consultant's opinion.
- At many facilities, even one psychiatry consultant has very limited availability, and a secondary psychiatry consultant is not available at all.

Approaches to Improving Patient Safety: The role of psychiatric consultants (3)

- The attending physicians in the ED and the inpatient unit have shared responsibility with the consulting psychiatrist in caring for patients with acute mental health conditions.
- If the attending physician has concerns about the consultant's recommendations, he/she should have a "real time" discussion with the consulting psychiatrist.
- Due to the shortage of psychiatrists, many rural EDs rely on psychiatric consultants provided through telemedicine platforms.
  - This may create a barrier to in-person discussion, but it makes the case for "real time" interaction even more important.
- Just as for subspecialty surgery, if the attending physician believes that a patient needs inpatient psychiatric care, then further observation, diagnostic evaluations, and consultation should be initiated.

Approaches to Improving Patient Safety: Managing the suicidal patient (1)

- Following serious, especially repeated suicide attempts, it is often recommended to admit the patient to an acute inpatient psychiatric facility. This practice allows 24/7 supervision by health professionals skilled at managing psychiatric illness and suicide risk.
- Complex psychopharmacologic regimens for patients with psychiatric comorbidity often require several days or more to reach therapeutic levels.
- Admission to an inpatient unit allows daily monitoring to achieve therapeutic drug levels and assess tolerance before the patient is discharged to close follow-up outpatient care.
- At that point, the patient should no longer express active suicidal thought and should have fewer or milder psychiatric symptoms.

Approaches to Improving Patient Safety: Managing the suicidal patient (2)

- One factor that complicates management of medically stable suicidal patients in many communities is a shortage of inpatient psychiatric beds, compared to optimal numbers based on population-based studies.
  - A recent study of the availability of acute psychiatric beds in California in 2021 showed an estimated statewide inventory of 19.5 beds/100,000 adults (with considerable regional variation), where a desirable ratio to meet population needs is 26.0 beds/100,000 adults.[12]
  - This shortage leads to frequent delays in disposition of patients following suicide attempts, with psychopharmacologic treatment being started while the patient is still in the ED, often for several days.
  - Therefore, clinicians may face pressure due to non-clinical factors (e.g., lack of inpatient psychiatric beds, adverse effects on patient flow in the ED, appeals by family members) to discharge the patient despite high clinical acuity.
  - It is important for clinicians to set these factors aside in favor of a risk-based approach to suicide management.

Approaches to Improving Patient Safety: Post-acute care planning (1)

- Care planning can be separated into several tasks in the emergency and hospital setting.[13]
- The biopsychosocial approach addresses medications, psychotherapy, and social support. The management of suicidal ideation and suicide attempts is inherently complex and requires a comprehensive approach, yet even with an optimized approach, suicide risk assessment remains frustratingly imprecise.[13]
  - As illustrated in this case, the risks of inadequate treatment involve suicide, self-inflicted injury, danger to others, poor quality of life, and limited social-occupational functioning; the benefits of medication treatment almost always outweigh these risks.
  - Psychotherapies may include supportive, cognitive, and dialectical behavioral therapies, but their availability depends on community resources and health insurance status, and delays for referral or approval are common.
  - While family and social support are vital, they are not substitutes for inpatient and outpatient psychiatric treatments.[13]

Approaches to Improving Patient Safety: Family engagement (1)

- There is a paucity of research to support the use of family members as an appropriate disposition after a serious suicide attempt, even though patients who later deny suicidal ideation are often discharged to the care of family members.
- What is considered “good” social support is vaguely defined and a family member who is willing to provide housing for someone cannot necessarily provide “good” social support after a serious suicide attempt.
- This practice may be more common when inpatient placement is delayed, and sending the patient home with family may appear to be a reasonable alternative.
- Although recruitment of family members to “supervise” the patient may be a common improvisation, it is fraught with risk and should not be relied upon if hospitalization is otherwise the proper clinical decision.
  - Such arrangements are burdensome to the recruited family members, who may be torn between a sincere wish to assist an ill family member and their lack of clinical background and/or social support to serve this function.

CONCLUSION

Conclusion (1)

- In retrospect, given the acute presentation, this case could have been differently managed by a prompt psychiatric admission under a civil commitment order following the initial suicide attempt. If the initial attempt was “medically dangerous” (e.g., requiring resuscitation, intubation, ICU care), an acute psychiatric admission can be justified, even if the patient later claims to be “safe.”

TAKE HOME POINTS

Take-Home Points

- Physicians need to have a low threshold to initiate a psychiatric commitment for patients following medically serious suicide attempts.
- Borderline personality disorder is associated with a high risk of suicide on its own and is oft co-morbid with other psychiatric illnesses which themselves increase suicide risk.
- Psychopharmacology for borderline personality disorder involves several classes of psychotropic medication. Benzodiazepine monotherapy is not recommended due to minimal benefit, physical side effects, and risk for abuse.

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