A 31-Year-Old Female with Suicidal Intent

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A 31-year-old woman with a previous diagnosis of major depression and no previous suicide attempts or hospitalizations presented to her primary care clinic and reported planning on either jumping off a bridge or going to work and shooting herself in the head with her handgun. She was immediately referred to the Behavioral Emergency Center and recommended for inpatient admission. She worked as an imaging technician at a large hospital. She had no outpatient psychiatrist, but had been prescribed citalopram 40 mg by her primary care provider for treatment of mood symptoms, in addition to an oral contraceptive, asthma, and allergy medications.

She described a history of mood problems starting at an early age related to a history of physical and emotional abuse perpetrated by her mother, and sexual abuse by her uncle. This abuse had been reported to the authorities and parental custody was re-assigned to the patient’s father.

She reported that her long-term mood symptoms were managed with antidepressants and psychotherapy until 4 months prior, when her husband left the home to pursue a religious pilgrimage. He had been gone until a week before admission, at which point he asked for a divorce so he could become a priest. She had no children.

The patient had also been experiencing difficulty in the occupational setting. She had a feeling her colleagues did not respect her and she cited frequent disagreements. She had recently received an email from a co-worker telling her that the multiple conflicts in the work setting were “all your fault.” Based on these interactions, she disliked her occupational setting and had urges to avoid going to work. She also described feeling that her few close friends were “conspiring” against her.

She stated that she “never really liked” herself, had chronic feelings of “extreme worthlessness,” and often thought “I’d be better off dead.” The suicide plans had been present for the previous 2 weeks. She had never experienced homicidal ideation. She stated, “I love life and want to live, but when it hits bottom, I lose control.”

Associated psychiatric symptoms included decreased sleep, poor concentration, nervousness, worry, and low appetite. She denied a history of manic symptoms or behavior and history of psychotic symptoms. She reported occasional marijuana use as a teenager, but she had not used drugs or alcohol since that time.

She had a family history notable for a diagnosis of depression in her mother and a maternal uncle who committed suicide by overdosing on pills. Other maternal uncles had abused alcohol and methamphetamine, including the uncle that had perpetrated the sexual abuse.

During the hospital admission, her suicidal ideation and intent improved rapidly and completely. She discussed her frustration over frequently being angry with others and her lack of control over her emotions. These symptoms had been present for most of her life, but had reached the point of intolerability over the previous 2 months. She expressed a strong desire for help and a need for relief from her unbearable symptoms.

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The treating team administered the McLean Symptom Inventory for Borderline Personality Disorder (MSI-BPD) as a screening tool for borderline personality disorder (BPD). The patient strongly endorsed all items and reported that the symptom screen effectively captured the difficult symptoms she had been experiencing from an early age.

She expressed a strong sense of relief that this symptom profile better reflected most of her experiences compared with the criteria and symptoms of major depressive disorder (MDD). The patient had never heard of BPD despite having worked with many prior therapists.

The treatment team discussed the current medication treatments with early evidence showing effectiveness in treating BPD. After weighing the risks and benefits, the patient decided to start aripiprazole 2.5 mg to target the specific symptom domain of affective dysregulation and suspiciousness.

Laboratory testing was completed, including fasting lipids, fasting glucose, and weight. The patient’s handgun was removed from her home by her father. She was provided with educational resources and psychoeducation regarding BPD.

On day 3 of the hospitalization, she continued to deny suicidal ideation and expressed a sense of optimism and hopefulness for the future. She was discharged home with a psychiatric appointment and was referred to start dialectical behavioral therapy (DBT) in a BPD treatment program. The patient’s current individual DBT therapist notes she has been engaged willingly in the therapy. She continues to have some difficulty with colleagues, but has used DBT coaching to manage these situations. The patient has had a significant decrease in suicidal thoughts, and 6 months after her hospital admission has not engaged in suicide planning.

**DISCUSSION**

BPD is estimated to affect at least 10% of inpatient psychiatric populations. This case exemplifies much that is typical about BPD: a dysfunctional family; unstable interpersonal relationships; prior diagnoses of — and failed treatments for — MDD; and suicidality as the presenting problem that finally precipitates a BPD diagnosis. Suicidal thoughts and behaviors are present in about 83% of patients with BPD with childhood sexual abuse presenting as a significant risk factor.

Strong clinical and research evidence has identified the core problem of BPD as interpersonal hypersensitivity. In this model, the dysregulated emotions are secondary to exaggerated reactivity and/or mistaken perceptions of others. Borderline patients can convert even a small rejection into a crushing, “I’m terrible, unlovable, bad” or into, “I’m abandoned, alone, and forgotten.”

The emotions and suicidality stem from these misattributions. This formulation would, for example, help explain why childhood abuse that might be endured differently by others has more traumatic consequences for borderline patients. It would also help explain why this woman found relief in being hospitalized (“I’m held, adopted, accepted.”). This explanation transforms the shifting emotions the patient experienced in her office from a problem of failed regulation into
a phenomena intimately connected to whether she felt understood (depressed or anxious), rejected (angry, devalutative), or alone (dissociated).

Despite the prevalence and well-characterized nature of this disorder, the diagnosis is not often made or discussed with patients. A myth has persisted that it is detrimental for clinicians to diagnose BPD during an initial encounter or while a patient is experiencing psychiatric crisis on the inpatient setting.

While it is true one should refrain from using a brief clinical impression or “gut-based” diagnosis of BPD upon first meeting a patient, there is no reason to refrain from BPD symptom screening, with appropriate discussion of chronicity, precipitating events, and associated symptoms.

At times, clinicians screen for the disorder and identify the presence of sufficient criteria to make the diagnosis BPD and still hold back from discussing the diagnosis with the patient. Historically, this was somewhat justified, in that the disorder was viewed as a highly stigmatized, untreatable “character flaw.” Discussing the diagnosis with patients felt somewhat pejorative and cruel.

With the advent of several evidence-based treatments and long-term data suggesting a favorable prognosis for the disorder, clinicians no longer need to experience the pressure of avoiding the diagnosis. However, as with most medical patients, a therapeutic alliance is often necessary to hold diagnostic and treatment discussions.

Therefore, if a patient is being held involuntarily on the inpatient unit and has poor insight into the nature of her symptoms, diagnostic discussion related to the presence of any psychiatric disorder is made more challenging.

CONCLUSION

This case highlights the potential benefit of using a structured symptom screening tool, such as the MSI-BPD, in developing a therapeutic alliance with a distressed and care-seeking patient. For patients struggling with BPD symptoms, a screening tool and an associated discussion that accurately summarizes chronic and disabling symptoms can be a powerful bridge to treatment planning.

For this patient, the validation provided by this symptom screen helped secure an early therapeutic alliance with the treatment team. Psychoeducation alone has been shown to alleviate the severity of core features of BPD — impulsivity and unstable relationships. This patient readily engaged in discussion regarding recommended medication and psychotherapeutic treatment. However, in this case, making the diagnosis and providing psychoeducation about the disorder may have already had therapeutic effects.

Treatment advancements in the field have developed in part because of the presence of mental health professionals who specialize in BPD, such as those who have undertaken the necessarily extensive training required to achieve competence in DBT.

A multisite Canadian study showed that general psychiatric management (GPM) could be as effective as DBT.

The study found that properly trained psychiatrists with adequate experience should themselves feel comfortable taking on the aftercare of patients such as the woman described here.

Improved training and correction of misinformation about the disorder’s nature and prognosis will provide psychiatrists the necessary skills to treat patients with BPD in either office-based treatment or as part of a treatment team.

REFERENCES