Tools to assess risk in people with personality disorder and or complex trauma

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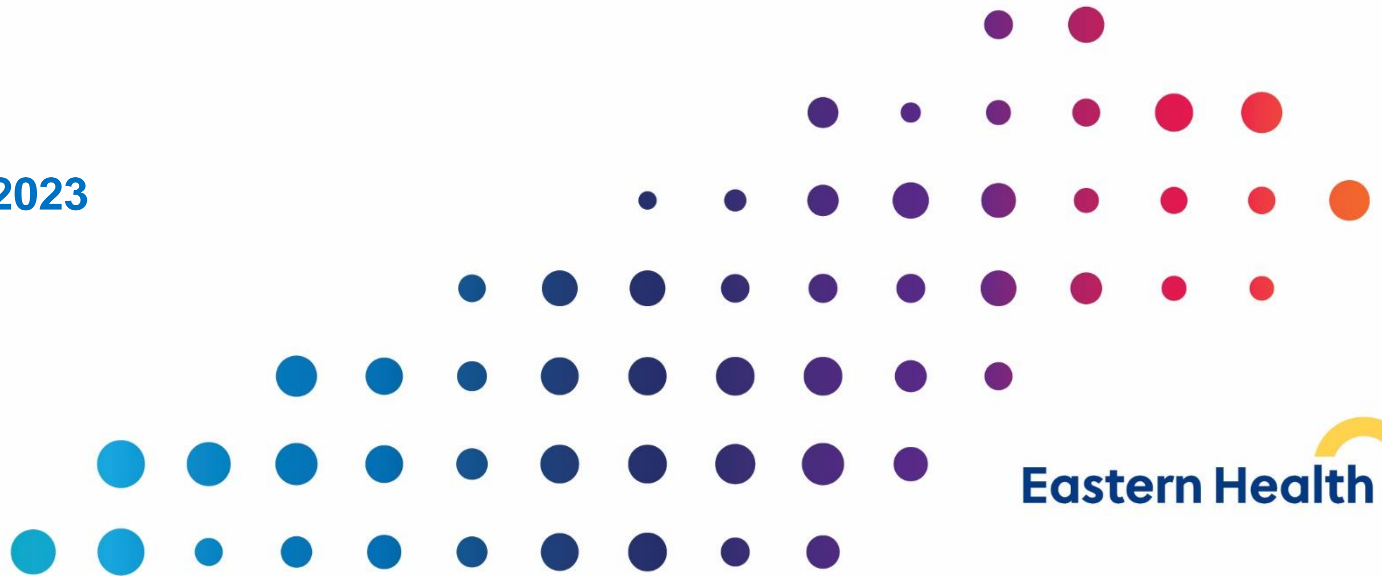
Project ECHO
8th November 2023



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There is no science to help us distinguish NSSI behaviours from suicidal behaviours

Spectrum Matrix Method of Risk Analysis

Most BPD patients seem to follow a pattern of self injury and chronic suicidal behaviours

(w.r.t. method, frequency and severity of self injury and chronic suicidal behaviours)

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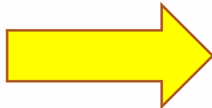
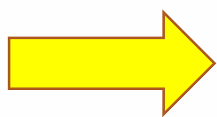
Pattern of chronic suicidal behaviours

Chronic pattern



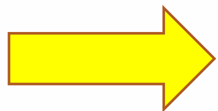
Change in the chronic pattern

Self Harm / Chronic Suicidality



High lethality acts (CO poisoning, hanging)

Low lethality acts (cutting, minor OD)



Chronic pattern

Change in chronic pattern

High Lethality Method

Chronic pattern

High Chronic Risk

Careful community treatment

Acute High Risk

Consider if admission is required

New pattern

Low Chronic Risk

Treat as usual

New emerging Risk

Assess why pattern has changed

Low Lethality Method

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Regular Article

AUSTRALASIAN PSYCHIATRY

Evaluation of a novel risk assessment method for self-harm associated with Borderline Personality Disorder

Australasian Psychiatry
1–6
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DOI: 10.1177/1039856217707390
journals.sagepub.com/home/apy

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Abstract

Objectives: Borderline personality disorder (BPD) is associated with frequent self-harm and suicidal behaviours. This study compared physician-assessed self-harm risk and intervention choice according to a (i) standard risk assessment and (ii) BPD-specific risk assessment methods.

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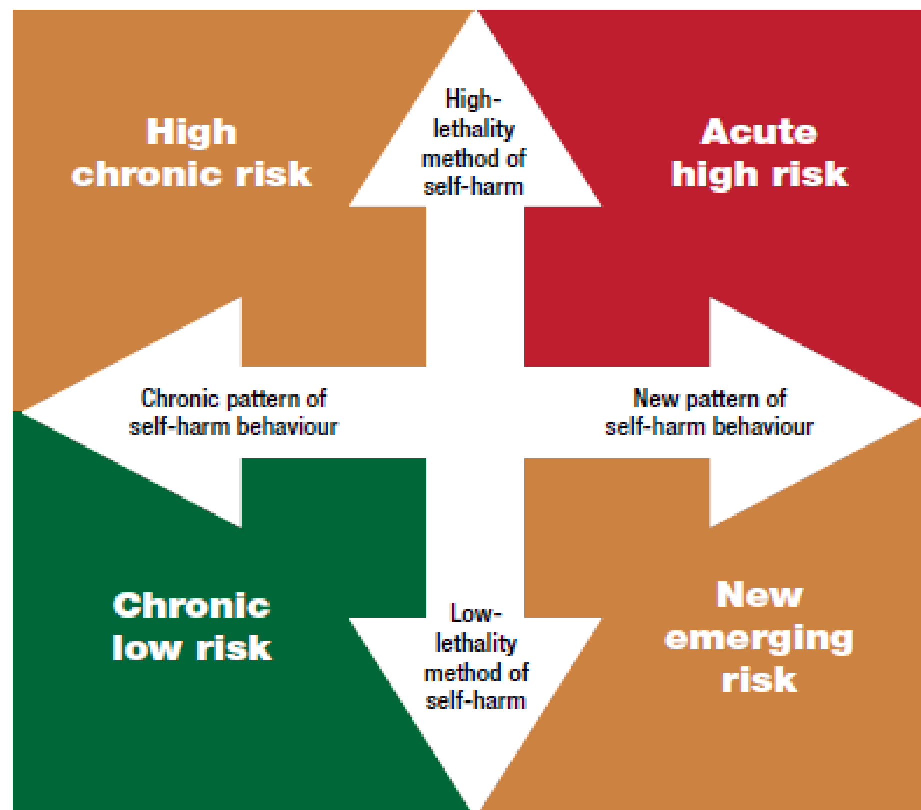
NHMRC guidelines for BPD - 2012

Figure 8.1 Estimating probable level of suicide risk based on self-harm behaviour



Adapted from Spectrum (personality disorder service for Victoria: www.spectrumbpd.com.au)

Figure 8.1 is a guide to estimating the probable level of risk in a person with BPD who self-harms, by considering the pattern and lethal potential of self-harm. However, risk may change suddenly or be difficult to predict based solely on the signs and symptoms available to the clinician. Frequent review, a trusting therapeutic relationship and helping the person to build a strong support network are necessary to help keep the person safe.

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BPD-specific risk factors

- Sexual abuse
- Changes in the usual **pattern** or type of self-harm
- Co-occurring mental illness, depression, ASPD, SUD
- Repeated high lethal attempts in a short period of time
- Severe abandonment emotional dynamics
- Emergence of psychotic states
- Severe regression
- High levels of impulsivity (Soloff et al 2005, Soloff et al 2000, Livesley 2003, Brodsky 1997)
- Chronic severe emptiness- ***identitylessness***
- Severe self-loathing
- Chronic and high levels of hopelessness (Soloff et al 2000)
- Prolonged dissociation
- Access to medications
- Age: 25 - 64 years
- Gender: ? male

Risk management

Treatment of BPD with evidence based psychotherapies is perhaps the best risk management we can offer to manage suicidality and self-harm.

Summary of risk management

- Look for **changes in patterns** of risk behaviours- Spectrum Matrix method
- Understand **reasons for recent escalation** of risk
- Help the patient understand the **emotional dynamics** that has resulted in recent escalation
- Problem solve
- Teach **emotion regulation** skills
- **If therapists cannot tolerate suicidality, patients get more frightened**.
- Discuss with patient what may help them? - Collaboration
- **Validate** the emotional pain/ hopelessness of the situation from her point of view
- **Express your hope and optimism-** don't become a cheer leader.
- **Beware of "empathy fatigue"**
- Do not get in to a debate where patient is for death and you are for living
- Explore reasons for living

Summary of risk management

- *Consider admission. Sometimes it is life saving. However avoid routine hospitalizations*
- Time is your friend if the patient is suicidal… holding on till the urge passes
- Identify reasons for living
- Hope is necessary for normal life
- Be aware of *overreaction* versus *under reaction* on your part.
- Involve family, friends, partners where possible.
- Document your treatment plans carefully
- Consult colleagues
- Seek supervision.
- Follow up closely

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Management of chronic suicidality

Research tells us that most chronically suicidal patients get better.

We can therefore remain optimistic and positive, even in the face of frightening suicidal expressions.

(Paris 2007).

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Collaborative Longitudinal Personality Disorders Study- 10 year F/U

- Most patients eventually get a life
- They find a place in the world
- Stop wanting to kill themselves

Remission of BPD symptoms

Self-injury, suicide attempts

(Gunderson 2011)

Time to remission	% of BPD with Self Injury, suicidal attempts
Index	70%
2 years	25%
6 Years	8%
10 Years	5%

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Thank You