Comorbid Clinical and Personality Disorders: The Risk of Suicide

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Personality disorders are arguably the most challenging for psychiatrists because they are difficult to diagnose and frequently coexist with psychotic, affective, and anxiety disorders.

Clinical disorders (ie, Axis I disorders) often coexist with personality disorders. Patients with these comorbidities can be some of the most challenging for psychiatrists, because they pose a real and substantial risk for suicide and suicidal behavior. DSM-5 groups the 10 personality disorders into clusters A, B, and C. The prevalence of cluster A, B, and C personality disorders with Axis I comorbidity is 42.2%, 83%, and 50.3%, respectively (Table).¹

Comorbidity and its sequelae
Personality disorders frequently coexist with psychotic, affective, and anxiety disorders. Comorbid psychopathologies result in significantly greater functional impairment than do individual disorders. Comorbid psychopathologies are associated with poorer prognosis of mood disorders, higher rates of relapse and chronicity, poorer treatment response (possibly as a result of more severe negative cognition), poor treatment adherence, and an increased risk of suicidal behavior.

Comorbidity and suicidal behavior
Comorbid Axis I and personality disorders psychopathology is reported in 14% to 62% of all suicide decedents.³,⁴ In clinical samples of patients who had attempted suicide, as many as 84% had comorbid psychopathologies. More patients with comorbid Axis I and personality disorders psychopathologies had made multiple suicide attempts than those with other comorbid psychopathologies (65% vs 24%).⁵

Predictors of suicidal behavior in persons with personality disorders were examined to gauge the impact of comorbid psychopathology on the risk of suicide behavior. Comorbid Axis I and personality disorder psychopathology was associated with a 16-fold increase in suicide risk in men and a 20-fold increase in women.⁶ Comorbid personality psychopathology increased suicide risk more than additively for affective disorders and substance use disorders.⁷ Suicide attempters with comorbid MDD and personality disorder were 4 times more likely to have made at least one previous suicide attempt, 3 times more likely to have had higher frequency of alcohol use disorders, 10 times more likely to have a lifetime history of aggressive behavior, and 3 times more likely to have the onset of MDD at a younger age compared with patients who had MDD alone.⁸

The Collaborative Longitudinal Personality Disorder (CLPD) sample allowed for the study of predictive variables for risk of suicide behavior in patients seeking outpatient treatment within 4 personality disorders—schizotypal, borderline, avoidant, and obsessive compulsive—compared with MDD. Yen and colleagues⁹ examined the course of Axis I disorders as predictors of suicide attempts. Over the 2-year follow-up period, predictors of suicide attempts were the baseline diagnosis of drug use.
disorder and borderline personality disorder. Worsening of Axis I disorders was a significant proximal predictor of suicide attempts, and worsening of MDD, alcohol use, and drug use was a predictor of a suicide attempt in the subsequent month. A 7-year follow-up CLPD study examined whether negative affectivity and disinhibition predicted suicide attempts. In the final model, negative affectivity was a significant predictor over and above covariates of child sex abuse, substance use disorder course, and MDD course. Disinhibition did not remain as a significant predictor in the model.

The McLean Study of Adult Development followed a cohort of patients with borderline personality disorder and examined the predictive variables of suicide attempts over a 16-year follow-up period. The frequency of suicide attempts decreased over time from 79.3% (n = 230) at baseline to 8.2% between the 12-year and 14-year follow-up assessments (n = 19). The predictive variables for suicide attempts over the 16-year period were a diagnosis of MDD, substance use disorder, or PTSD; the presence of self-harm; adult sexual assault; having had a caretaker complete suicide; affective instability; and a higher score on the Dissociative Experiences Scale. Soloff and colleagues conducted one of the few prospective investigations of multiple risk factors for suicide attempts in borderline personality disorder. A suicide attempt in the first 12 months of their 5-year follow-up predicted subsequent attempts over the intervening 4 years. Comorbid MDD emerged as the best predictor of suicidal behavior in the first 12 months; however, it did not increase the risk of suicide attempt over the long term (eg, 2 to 5 years). Conversely, poor social adjustment at baseline conferred an elevated risk of suicide throughout the study’s 5-year follow-up period. Not all participants were receiving treatment during the study. Participants who received outpatient psychiatric treatment showed a reduced risk of suicide attempts in both the short- and long-term intervals. Factors that best predicted an elevated risk of suicide behavior over the 6-year interval were family history of suicide, no outpatient treatment before the attempt, a low socioeconomic status at baseline, and poor psychosocial functioning at baseline.

A higher Global Assessment of Functioning score at baseline was the only protective factor leading to a lower risk of suicide behavior. The 8-year follow-up of this cohort demonstrated that 20.3% of participants made an interval suicide attempt. These attempts were predicted by severity of illness, racial minority (related to social disadvantage), change of employment, and evidence of aggression at baseline; increased education predicted a lower increase in interval suicide attempts. Social functioning was a nonsignificant predictor in the univariate analysis at 8-year follow-up. Our group completed a study of risk factors for suicide attempts in a sample of patients with borderline personality disorder who received “indicated” interventions for the disorder. About a quarter (25.6%) of study participants had attempted suicide during the 1-year treatment phase, and 16.7% of participants attempted during the 2-year follow-up phase. The predictors of suicide attempts involved nonmodifiable risk factors such as a history of recent attempts, a history of childhood sexual abuse, and a history of recent frequent hospitalizations. The lethality of attempts during the 1-year treatment phase was predicted by the level of medical lethality at baseline. The number of suicide attempts in the 4 months before study entry predicted the lethality of suicide attempts over the 2-year follow-up period.

**Potential causal mechanisms of suicidal behavior**

The causes of suicidal behavior are not fully understood; however, the behavior clearly results from complex interactions of different factors. The diathesis-stress model integrates neurobiology and psychopathology and suggests that the negative results of preexisting vulnerability factors are especially pronounced when activated by stress. The diathesis to suicide may be due to epigenetic effects and childhood adversity and is reflected in distinct biological, psychological, or clinical profiles (eg, personality traits of aggression and impulsivity). Psychosocial crises and psychiatric disorders constitute the stress factor in this model.

A shared characteristic of all personality disorder psychopathologies that is germane in the context of suicidal behavior is chronic, clinically significant distress or impairment in social, occupational, or other areas of functioning. Patients with personality psychopathology have difficulty responding flexibly and adaptively to the environment and to the changes and demands of life, and they lack resilience under stress. Their usual ways of responding tend to perpetuate and intensify their difficulties. Comorbid psychopathologies are associated with high levels of distress, impairment, and difficulties; life events during the past 3 months were found to be risk factors for suicide. In one study, psychopathology was related to cognitive vulnerability even after controlling for subsyndromal depressive symptoms in formally depressed patients. Personality psychopathology predisposes patients to the experience of negative life events. Concomitant chronic distress characteristics of personality psychopathology may continually be primed by the occurrence of...
Depressive cognitions in the presence of negative affect or negative events and intensify the distress.

Psychopathologies vary in the influence they wield along the trajectory leading from ideation to suicide attempts, according to Nock and colleagues. Their findings indicate that depression predicted the onset of suicidal ideation; however, it did not predict further progression to suicide plan or attempts among those with suicidal ideation. Conversely, disorders characterized by anxiety (e.g., PTSD) and poor impulse control (e.g., bipolar disorder, substance abuse disorders) were robust predictors that persons with suicidal ideation would form a suicide plan or attempt suicide. Some disorders may elevate suicide risk by intensifying the desire for death or suicide, whereas disorders characterized by impulsivity and poor conduct control may increase the risk of suicide by heightening the likelihood of individuals acting on their suicidal ideation.

**CASE VIGNETTE**

Agnes, a 22-year-old graduate student, presents to the university health clinic where she was being treated as an outpatient after receiving a diagnosis of borderline personality disorder. She had struggled with feelings of anger, emotional lability, self-harming behavior, eating disorders, stormy romantic relationships, and anxiety.

Agnes has recently been having “meltdowns,” and during the latest episode she swallowed all of the pills from a new prescription of escitalopram. She explains that she has been very emotional and anxious lately. She has shallow breathing and palpitations and feels shaky and nauseous during the meltdowns. The latest episode was precipitated by thoughts that her former boyfriend had been unfaithful, which had led to their breakup. Feeling overwhelmed by these thoughts, she tried to calm herself with controlled breathing. When this didn’t work, she took the pills. Shortly after, Agnes revealed her overdose to her roommate who took her to the hospital.

After careful questioning by the clinician, Agnes started to open up. She explained that with the academic year coming to an end, she was having more panic attacks and missing 1 or 2 classes every week after months of perfect attendance. As Agnes talked, she began to recognize the connection between her meltdowns and her anxiety; she finally felt more empowered to work on a safety plan.

Agnes’s case is in keeping with the diathesis-stress model. Her borderline personality disorder and relationship problems provided the diathesis and ongoing risk for suicidal behavior. Her more recent suicidal behaviors were exacerbated by the increasing panic episodes. This framework was helpful to both the clinician and the patient: Agnes’s feelings of self-efficacy increased as well as her ability to participate in creating a safety plan.

**Conclusion**

Recognition of comorbidity has significant clinical relevance, particularly for assessing and managing the risk of suicide. The findings on comorbid psychopathology and suicide risk are consistent with the diathesis-stress model of suicide. In patients with personality disorders, particularly borderline personality disorder, comorbid clinical disorders such as MDD and substance use disorders act as stressors and are proximal risk factors for suicide behavior. A patient in crisis must be carefully assessed for comorbid clinical disorders, and collateral history is often helpful. Comorbid disorders should be the primary management targets when their presence precludes active involvement in learning and/or motivation is lacking. A clinician can tap into diathesis risk factors by taking a careful history of previous suicidal behavior. Focusing on the times when the patient demonstrated attempts with the greatest subjective intent, objective planning, and medical lethality can determine the magnitude of the diathesis risk. The history may differentiate patients whose risk is driven by a desire to stop their anxiety and distress or by poor impulse control.

Sustainable reductions in the risk of suicide are more likely to be driven by engaging patients in evidence-based treatments and by attending to their social functioning. Clinicians should anticipate that the risk of suicide will decrease over time in patients with personality disorders who receive appropriate outpatient care. If this does not occur, consultation about the patient’s management would be appropriate.
TABLE. DSM-V personality disorders with frequently reported comorbid A...

Disclosures:
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References:


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