The problem of suicidality, personality disorder, and treatment: an alternative psycho-social perspective

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ABSTRACT

Suicidal behaviour, including both attempted and completed suicides, has been increasing globally, particularly in industrialized nations, making suicidality a significant public health concern. Despite the allocation of increasing resources by US, EU, and UK governmental and mental health bodies, the effectiveness of current strategies for the treatment, management, and prevention of suicide remains in question. This paper reviews evidence from epidemiological studies and national prevention policies, alongside research data from a London-based specialist personality disorder treatment centre and clinical case studies from private psychiatric/psychotherapy practice, to explore an alternative psychosocial approach to addressing suicidality. The dominant psychiatric model, which relies heavily on medication, hospitalization, and often coercive methods of control, may have iatrogenic effects, potentially exacerbating the risk of suicide. In contrast, a psychodynamic and psychosocial approach, focused on understanding the underlying psychological dimensions of suicidality, fostering a trusting therapeutic alliance, addressing both internal and external factors contributing to suicidal behaviour, and promoting open dialogue around suicidal thoughts, has shown promise in reducing suicide risk. The findings presented in this paper argue for a rethinking of traditional psychiatric approaches, advocating for a shift toward more personalized, collaborative, and psychologically informed interventions that can more effectively reduce the risk of suicide.

Key words: suicidality, personality disorder, treatment, psychotherapy.

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Introduction

Suicide and suicidal behaviours have been on the increase throughout the Western world. In the US, the suicide rate increased by 35% from 1999 through 2018, becoming the 10th leading cause of death (Curtin *et al.*, 2016; Hedegaard *et al.*, 2018; Kochanek *et al.*, 2017). In England and Wales, 5,642 suicides were registered (10.7 deaths per 100,000 people) in 2022, compared to the 2020 rate of 10.0 deaths per 100,000 people (Office for National Statistics, 2023). Similarly, high rates of suicide (on average 12.8 deaths per 100.000 people) have occurred in Europe, the second highest suicide rate across all WHO regions.

The high rate of suicidality in the population has become a serious public health issue, and increasing funding has been provided by government agencies to address it. In December 2010, the US Department of Health and Human Services launched the Healthy People 2020 initiative. Amongst the four overarching targets, it aimed to reduce suicide rates to 10.2 per 100,000 by 2020, which it failed to achieve. From 2000 to 2016, the age-adjusted suicide rate increased by 30%, from 10.4 to 13.5 per 100,000 population (Hedegaard *et al.*, 2018). In Europe, a 10-year systematic review of suicide prevention strategies conducted by a specially commissioned task force has led to the publication of evidence-based national suicide prevention guidelines, outlined in a position paper authored by 29 suicide prevention experts (Zalsman *et al.*, 2017). In the UK, a number of initiatives have been launched by a number of governmental and mental health bodies to address, manage, prevent, and reduce suicide and self-harm. The Department of Health and Social Care has recently unveiled its ambitious policy paper entitled 'Suicide prevention strategy for England: 2023 to 2028', in

which its vision on how to prevent self-harm and suicide was outlined (Department of Health & Social Care, 2021).

The National Institute for Health and Clinical Excellence (NICE) published its quality standards guideline in 2019 with the aim of improving the quality of care as a means of reducing suicide rates and helping people bereaved or affected by suicide (National Institute for Health and Clinical Excellence (NICE), 2019). This strategy is based on a multi-agency suicide prevention partnership, with a clear 'governance and accountability structure,' which aims to reduce access to methods of suicide and to develop a media plan to encourage journalists and editors to follow best practices when reporting on suicide and suicidal behaviour. A greater involvement of family, carers, and friends is also encouraged as part of the service quality improvement. The Royal College of Psychiatrists joined the National Suicide Prevention Programme with a focus on reducing suicide for people who use mental health services (Royal College of Psychiatrists, 2021).

These initiatives are potentially useful, as they identify and focus their interventions on populations known to be at risk, such as people with affective disorders and personality disorders and people belonging to lower socio-economic status who are socially isolated and single. Moreover, they develop toolkits for mental health providers, which are based on '10 key elements, to evaluate current suicide prevention efforts against NCISH recommendations', and propose standardised risk assessment tools and structures of care that provide a team framework to work collaboratively with suicidal people in various settings. However, it remains an open question whether these very well-funded initiatives have, in fact, been effective in identifying people at risk and in reducing suicide rates (Ryan *et al.*, 2010). I contend that suicide prevention programs fail to address the many flaws present in the current mainstream psychiatric institutions and structures, which not only are inadequate to effectively manage and treat people at risk of suicide, but in fact, may increase suicide risk (Hjelmeland *et al.*, 2018).

In this contribution, I present evidence regarding the significant stepwise association between the level of psychiatric treatment and suicide, and I will outline an approach based on psychodynamic and psychosocial principles that was found to reduce suicidality.

Suicide risk and psychiatric treatment

Only a few studies have explored the association between levels of psychiatric treatment and risk of suicide. Intuitively, we would expect the risk of suicide to decrease as a result of psychiatric treatment and exposure. Although completed suicide and deliberate self-harm were found to increase during and soon after discharge from in-patient psychiatric treatment (Harris & Barraclough, 1997; Pirkis & Burgess, 1998), no comprehensive study at the population level had been carried out regarding the association between the level of psychiatric treatment and suicide. A Danish research group conducted an epidemiological study to assess the relative risk of suicide based on patients' levels of contact with psychiatric services. Using a case-control method, they matched 2,429 individuals who had died by suicide with 50,320 living controls, based on sex and date of birth, to explore the association between psychiatric treatment and suicide risk (Hjorthøj *et al.*, 2014). The level of psychiatric input, including medication, was graded for the whole sample using information from the Psychiatric Central Research Register and the Danish National Prescription Registry. The statistical analysis was based on a conditional logistic regression, stratified on the case-based risk sets, controlling for age, gender, and calendar year. The results showed that the relationship between suicide and psychiatric utilisation over the previous year was highly significant ($p<.001$). A significant increase in risk ratio for suicide was found for psychiatric medication use (RR=5.8), out-patient psychiatric treatment (RR=8.2), accident and emergency (A&E) treatment (RR=27.9), and inpatient psychiatric treatment (RR=44.3), compared to subjects with no corresponding psychiatric utilisation (Figure 1). Remarkably, of the subjects that attended A&E treatment and committed suicide, 28% died within two weeks from their visit, while of those who committed suicide and had psychiatric hospitalisation, 37% died within two weeks from discharge.

Higher risk ratios were also found for subjects who had ever been in contact with psychiatric services or received medication, including a higher risk for attempted suicide. Intriguingly, the association between psychiatric use and risk of suicide was higher for sub-groups regarded to be at lower risk of suicide (married, higher income and higher educational status), further underlying the significant contribution of psychiatric exposure to suicide as independent variable. Although selection bias – people with increasing levels of psychiatric contact may be more at risk of committing suicide – needs to be borne in mind when interpreting the results, the clear presence of a dose-response relationship between level of psychiatric utilisation and suicide found in this study, highlights the inadequacy of current psychiatric risk assessment and management in preventing and treating suicidality at a population level. These findings were rather startling, as they elevated by several fold previous psychiatric care contact, especially hospital-based care, as the greatest risk factor for suicide, compared to other traditionally held risk factors such as depression, hopelessness, prior suicide attempts, and marital status. Therefore, they raise the possibility of a causal relationship between traditional psychiatric care and suicide, and that dimensions present in the treatment setting may contribute to increase the risk of suicidality (Large & Ryan, 2014).

In a previous study by the same group, the authors found that the majority of suicides (7 out of 8) among 356,712 psychiatric admissions occurred in what was considered low-risk subjects, using the criterion of combining traditional risk factors for suicide (Madsen *et al.*, 2012). Other studies appear to confirm the disturbing association between hospital-based inpatient psychiatric care and increased risk of suicide. In a systematic review and meta-analysis, which comprised over 100 studies, Chung and colleagues found that the post-discharge suicide rate from psychiatric inpatient was 44 times the global suicide rate, 100 times in the first 3 months post-discharge (0.28% of all discharges), and 200 times for suicidal patients (Chung *et al.*, 2017). A number of in-

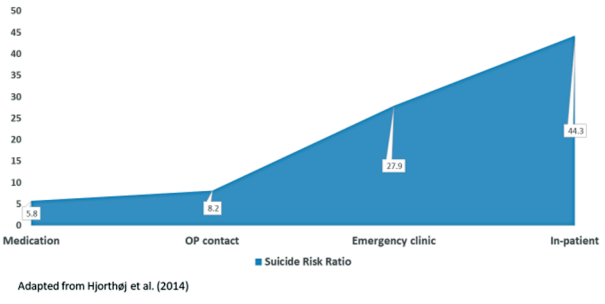

Figure 1. Suicide risk and level of psychiatric treatment.

dependent ecological studies encompassing dozens of countries reached a similar conclusion that the introduction of mental health national policies and greater funding in mental health provisions and systems may have a negative impact on reducing suicide rates (Burgess *et al.*, 2004; Rajkumar *et al.*, 2013; Shah *et al.*, 2010).

The current method of assessing suicidality is to stratify patients according to a combination of demographic and clinical risk factors, which leads to the identification of low-risk and high-risk sub-groups of patients (Wortzel *et al.*, 2014). The adequacy of this way of proceeding has been seriously questioned by results of studies carried out in inpatient psychiatric units and Accident & Emergency departments, which found that only a small proportion of patients judged to be high risk died by suicide, while suicide rates in low-risk category were significantly higher than expected in community settings (Large *et al.*, 2011; Steeg *et al.*, 2012). A large meta-analytic study regarding traditionally held longitudinal predictors of suicide and suicidal behaviours concluded that "Prediction was only slightly better than chance for all outcomes; no broad category or subcategory accurately predicted far above chance levels; predictive ability has not improved across 50 years of research; studies rarely examined the combined effect of multiple risk factors; risk factors have been homogenous over time, with five broad categories accounting for nearly 80% of all risk factor tests; and the average study was nearly 10 years long, but longer studies did not produce better prediction" (Franklin *et al.*, 2017).

When less is more

The Cassel Hospital, Richmond, Greater London, United Kingdom, is a specialist hospital-based mental health facility founded in 1919 to treat a variety of psychiatric disorders using psychodynamic and psycho-social principles and practices (Main, 1946). Since the late 70s, it has been focusing on the assessment, treatment and management of personality disorder (PD) in adults and adolescents (Hinshelwood & Skogstad, 1998; Levy *et al.*, 2022). Although, developed as an inpatient centre, in the early 90's the hospital diversified its approach to include a community-based out-patient service in the shape of a program to which patients could either step down after discharge from the hospital residential treatment or be admitted directly (Chiesa, 1997).

A comprehensive prospective research program was started to gather demographic, diagnostic, and outcome data from the adult PD population treated (Chiesa & Fonagy, 2000). We compared subjects who received long-term residential treatment (RT) with those who had shorter inpatient stays followed by community-based treatment (RT-CBP) or who were treated entirely in the community-based outpatient program (CBP). The latter two groups had significantly lower dropout rates (Figure 2) and better outcomes over four years, particularly in terms of reduced psychiatric symptoms, improved social adjustment, and better overall mental health (Chiesa *et al.*, 2017; Chiesa *et al.*, 2004). The odds ratio for dropout by 5 months for patients in RT was 5.4 (95% CI 1.9, 14.9) compared to CBP and 6.2 (95% CI 3.0, 13.1) compared to RT-CBP. CBP had the largest reduction in psychiatric symptoms severity, expressed as within-group effect size, from intake through to 48 months follow-up: a small effect (g=0.28) by 6 months, a moderate effect (g=0.55) by 12 months, and large effects at 24 months (g=0.80), 36 months (g=1.03) and 48 months (g=1.23). By comparison, RT-CBP showed small effect sizes at 6, 12, and 24 months (g=0.17, g=0.32 and g=0.47, respectively), and moderate effects at 36 and 48 months (g=0.58 and g=0.68). RT achieved small effects: g=0.07 at 6 months, g=0.14 at 12 months, g=0.20 at 24 months, g=0.26 at 36 months and g=0.30 at 48 months.

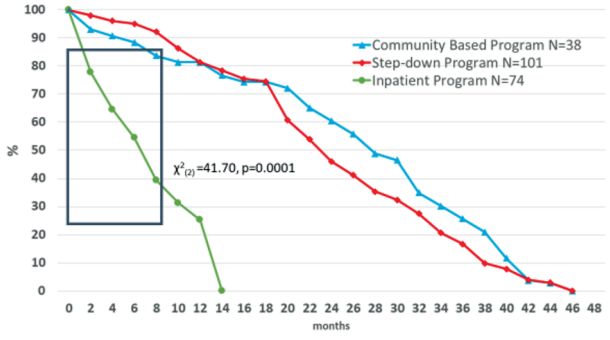

Figure 2. Percentage of patients in active treatment over the study period.

Patients with a diagnosis of personality disorder are at high risk of suicidal behaviour (McClelland *et al.*, 2023), and affective disorders with a comorbid personality disorder are at increased risk of suicidality compared to affective disorder without a PD diagnosis (Williams *et al.*, 2023). In our study, we found that the number of suicides over the study period in the RT group (long-term inpatient) group was 5 compared to 1 in the RT-CBP group (step-down) and 0 in the CBP group (community-based)[1]. The percentage of patients who attempted suicide was found to have gradually, but significantly, decreased in the CBP group from 33% to 7% over the course of 4 years and from 48% to 7% in the RT-CBP group, while it remained high in the RT group during the period of hospitalisation (from 44% to 40%), although it decreased to 24% at 4-year follow-up. Moreover, the percentage of patients who self-harmed at least once in the RT group increased during the year of hospitalisation (from 51% to 67%), and it remained stable between 38%-49% over the course of four years; in contrast, a gradual reduction was found in the CBP (from 33% to 23%) and RT-CBP groups (from 63% to 30%). Unsurprisingly, logistic regression analyses controlling for intake values revealed that treatment group was a significant predictor for both attempted suicide and deliberate self-harm. Re-admission rates to psychiatric units were found to be significantly lower in the CBP patients (an average of 11 days (SD=47.2)) compared to the RT patients (an average of 34 days (SD=57.7)) over the previous year, at 2-year follow-up, probably as a result of the significant improvement in impulsive behaviour (Chiesa *et al.*, 2009)..

The inpatient setting has four times the number of mental health staff and far greater resources compared to the community-based program, and each patient has an average of 18 therapeutic inputs a week (twice-weekly individual and group psychotherapy, 4-times week community meetings, a structured daily program of psychosocial activities in the therapeutic community, one-to-one psychosocial nursing, dance, and movement therapy, etc.), compared to 3-weekly offered by the community-based program (group psychotherapy, small psychosocial nursing groups, psychiatric reviews). Correspondingly, treatment costs are much

[1] If we include patients who had refused to give informed consent for the research projects, the overall number of suicides was 8 in the long-term IP group (Healy & Chamberlain, 2005).

higher for the inpatient program compared to the community-based program. Although the residential program adopts an 'open door' policy with no locked room facilities, patients are monitored 24 hours a day by highly trained staff (Griffiths & Leach, 1998). By contrast, patients in the community-based program live in their independent accommodations and have an average of 6 hours a week interface with mental health staff, although telephone contact is available if needed. However, the way in which the program is structured with regard to patient discipline and safety is very different from the RT program. The residential treatment setting enforces several rules, such as prohibiting alcohol, drugs, self-harm, sexual activity, and violence. Violations of these rules may result in sanctions, including discharge from the program. When a patient becomes suicidal, they are placed under 24-hour observation by staff and other patients. If the risk is deemed too high or an attempt is made, the patient may be temporarily transferred to an acute care unit.

In contrast, the community-based team does not place emphasis on rules for a number of reasons. Firstly, the presence of strict rules may become very tempting for patients with borderline personality disorder to challenge and test; secondly, rigid rules concerning behaviours may be applied inconsistently, creating a sense of uncertainty and discrimination in patients; thirdly, the threat of sanctions can be counterproductive, creating a compliant adherence to protocol, driving disturbed behaviour underground and conveying the message that undesirable conduct is out of bounds and cannot be understood in psychological terms. The RT setup increases the likelihood of acting-out, since disturbed emotions and states of mind do not find verbal expression and, above all, tends to undermine the psychological containment inherent in the mentalising interaction with mental health staff (Fonagy & Allison, 2014). The increase in self-harming episodes, the lack of reduction in attempted suicide, the alarming finding of eight completed suicides, and the high dropout rates found in our research, point to the regressive and iatrogenic nature of the structural arrangements of the inpatient setting and to the futility of strict rules to govern patients' behaviour.

In clinical practice, we know that patients who end up committing suicide do not verbalise or share their intent before acting. In the CBP, we were very alert to this occurrence, and whenever we suspected that a patient may become suicidal, staff were trained to raise concerns with the patients and actively engage with them by naming what may be brewing inside them and encouraging them to be open about it. With patients at risk, staff was very sensitive to sudden changes in mood, particularly following rejections, disappointment or events that may trigger in patients a sense of failure or self-hatred, which, in many instances, succeeded in averting likely suicidal acting-outs. Since the association between economic deprivation, low socio-economic status, and social isolation with suicide is clearly established (Näher *et al.*, 2019), an important component in the CBP psychosocial approach to reduce suicidality has been to have a clear focus on improving the patient's external reality, with particular emphasis on living conditions, education, employment, physical well-being, and increased re-socialisation (Chiesa & Fonagy, 2002).

Too sick for inpatient treatment

Lucy was 22 when she was referred to my private practice. At the time, Lucy was being treated as an inpatient at a London private psychiatric clinic. This was the latest of a number of hospitalisations over the previous six years, both in the state and private sectors, on account of repeated and serious episodes of deliberate self-harm and suicide attempts. I learned that, on at least two occasions, she came very close to death, following overdoses of psychiatric medication and alcohol. When I saw her for the initial consultation, Lucy immediately told me that she was determined to die, that life had become unbearable, and that she had no reason to continue living. She spoke in a soft voice, on the surface betraying little emotions, but I could sense the deep sadness, hopelessness, and desperation inside her. Despite her arms being covered by a shirt, I could see the tail-end of large scars. Previous psychiatrists had given her diagnoses of affective disorder, schizoaffective disorder, and borderline personality disorder. She was taking a cocktail of psychiatric medication that included Olanzapine, Lamotrigine, Lofepramine, Lorazepam, and Zopiclone, with substantial side effects such as weight gain, dry mouth, sedation, a degree of cognitive impairment, bluntness of affect, digestive issues, and psychomotor retardation.

Lucy came escorted by her father for the second consultation and they told me that the private clinic had discharged her because she was too much of a suicidal risk for the clinic to take responsibility for, as she had taken another serious overdose and had absconded from the inpatient ward. The clinic black-listed her and suggested that she should return to be managed by NHS mental health services. I started to see Lucy three times a week and I became both her psychiatrist and psychotherapist, regularly liaising with her primary care doctor. My priority was to establish an emotional connection with Lucy and to convey my genuine interest in her as a person and as a patient. She had a history of childhood emotional neglect and a degree of physical abuse. Her mother suffered from depression, which worsened after her husband started a new relationship and left her. Lucy's father worked long hours and had a short temper, at times verbally and physically punishing Lucy and her younger sister. Lucy developed a belief that she was bad, that she deserved to be punished, as she felt responsible for her mother's depression and for her father's leaving the family. She started to self-harm and attempted suicide aged 14.

I had the impression that she had no real experience of a genuinely caring and supportive environment and carried a deep sense of unworthiness and badness inside her, which made her feel dispensable and that life was not worth living. I shared my understanding and appreciation of her need to commit suicide and of the misery that she had been carrying inside for many years. I said that I would be here for her to help her as much as I could to make sense of her suicidality and other problems that afflicted her life, but I clearly conveyed that I could not and would not stop her if she was really determined to die. It would be futile for me to act outside of the sessions, as she would always find a way and the means to try to kill herself, as her history demonstrated. I began to establish a setting in which mutual trust would become possible and foster an interpersonal climate that may allow hope to emerge. To her surprise and relief, I suggested a regime of slow discontinuation of her psychiatric medication over a six-to-eight-month period to minimise the occurrence of withdrawal and rebound effects, while monitoring her mental state. It was clear that several years of various medications had done very little to improve the clinical picture, while Lucy had developed a biological state of dependence and suffered from their adverse effects.

The process of deprescribing was complemented by psychotherapeutic work on her past and present suicidality. Two months into treatment, Lucy showed me the deep and widespread scars that covered her arms and told me that she used to cut herself regularly on her breasts, abdomen, and the inside of her legs. We discussed very openly the way she carried out these acts, and I

enquired about the ways in which she was planning to kill herself, be it *via* overdose, jumping from a bridge, or in front of a train.

It was the first time that she experienced a professional talking without fear about her suicidal acts and intent, without taking any action, like admitting her to the hospital or changing or increasing her medication. As the emotional blunting effect of medication started to lift and her trust in me increased, Lucy became more available and open to the psychotherapy process, which enabled us to make significant strides in addressing her low self-image and self-esteem, her deep sense of shame and guilt that was associated with her wish to harm herself and to die. Lucy expressed her belief that she should never have been born, and her aim was to return to a state of non-existence, a place where there was no pain, no torturing thoughts and emotions. The wish not to exist was very deep-seated and represented the foundation for her suicidality. At times, I felt very anxious that she might give in once again to her wish to die, and I was relieved when I saw her again for her next session.

As treatment unfolded, Lucy's mental and physical state improved; she went out for walks and started a relationship with a former classmate, who appeared to be serious and devoted to her. Her suicidality decreased in intensity, she stopped self-harming, and she was accepted at a London university to study Spanish. After a year from the start of treatment, Lucy was on no psychiatric medication, had not attempted suicide, and became one of the brightest students in her intake. The frequency of sessions was reduced to twice weekly, although the within-session intensity remained high with regard to exploring Lucy's internal dynamics and the nature of the transference to me. Her perception of me as a person who genuinely cared for her and offered her a safe space within which she could be open about her inner turmoil and demons was subject to fluctuations, and at times she became suspicious of my motives and feared I could become unreliable, untrustworthy and rejecting like she had experienced her parents and previous professionals. The exploration of this persecutory ideation and emotions within the therapeutic relationship was very important in strengthening her attachment to me and establishing, through introjective identification, a more solid and benign internal parental figure. This process of internalisation was borne out by her admission that at times of low mood and desperation, she drew strength from thinking about our sessions, which prevented her from acting-out and helped to shorten and reduce the intensity of her internal terror.

As part of her final year at university, Lucy had to spend six months in Madrid and join the local University as an associate. Although Lucy looked forward to this experience, as the date approached, she became very anxious, and a degree of suicidality emerged again. Despite her awareness that her anxiety was linked to the prospect of having to discontinue our sessions, she took an overdose for which she needed medical attention at her local Accident & Emergency department, an indication that our work was not yet terminated. She got married before her Madrid trip, which went very well, and eventually graduated with honours. Lucy won a scholarship for a master's degree at a London University and continued treatment with me on a once-weekly basis for a further year, during which time no suicide attempt and self-harm took place.

Discussion

The increase in suicide rates and self-harm in the US, UK and European population is testament to the ineffectiveness of traditional approaches to identify, treat and prevent suicide and suicidal behaviour. The complex and expensive programs implemented by governmental agencies for tackling this serious public health issue have shown severe limitations. The recent epidemiological and descriptive studies, outlined in this contribution, have identified increasing levels of contact with traditional psychiatric institutions and practices as the highest risk factor that predict suicide and suicidal actions. According to these studies, psychiatric inpatient treatment and management is by far the setting most associated with suicide. A number of authors have argued that inherent factors present in inpatient psychiatry are responsible for increasing the risk of suicide (Large *et al.*, 2014). The trauma and stigma associated with psychiatric hospitalisation, often experienced by patients as highly restrictive and a punishment, contribute to suicidality in vulnerable subjects (Large *et al.*, 2014; Schomerus *et al.*, 2015). The coercive culture and set-up often present in inpatient settings, particularly in forced involuntary admissions and coercive attitudes to ensure medication compliance, are also contributing factors in traumatising and stigmatising patients, who may find in suicide the only escape. In addition, the modest discriminating power of currently used suicide risk assessment procedures exposed in a number of cited studies, seriously limits their translation into clinical decisions and other interventions to treat and prevent suicide and suicidal behaviour (Large & Ryan, 2014). Despite available evidence of their poor longitudinal predictive ability, currently held risk factors are still used to identify and stratify risk in psychiatric patients, hence persisting in a flawed strategy to prevent suicide (Chang *et al.*, 2016; Franklin *et al.*, 2017; Ribeiro *et al.*, 2016).

The findings of our research at the Cassel Hospital, which included a higher rate of suicide and an increase in self-harming behaviour for patients treated in the long-term IP program, compared to patients treated in a psycho-social community-based program, add evidence as to the presence of inherent factors that increase the risk of suicidality in hospitalised patients. The iatrogenic effects of residential treatment for a sizeable subgroup of patients, contribute to increase suicidal behaviours and other acting out in patients with borderline personality disorder (Chiesa *et al.*, 2017; Paris, 2004). The high intensity and frequency of therapeutic inputs present in the inpatient setting may not suit patients with borderline personality disorder, as the 'high pressure cooker' environment, coupled with high staff expectations, may engender acute anxiety and claustrophobic reactions, and the sudden re-emergence of dysfunctional, pathological and conflict-laden early attachment patterns. These, in turn, aggravate the patients' emotional dysregulation, which is acted out in highly disturbed interpersonal interactions, and through suicidal behaviour (Chiesa *et al.*, 2011). The poor results found in the inpatient BPD sample further suggest that too much emphasis on control, rules compliance and sanctioning of disturbed behaviour is not conducive to foster a therapeutic alliance, and the establishment of trusting connections with mental health professionals, where mutual respect and a recognition of suffering and understanding can take place (Hagen *et al.*, 2018).

An important component of the CBP approach was the regular review of the medication regime, slowly tapering medication from polypharmacy usage to monotherapy and complete deprescribing. Polypharmacy, which was common in most patients referred to our service, is known to be an unsafe practice that increases overall mortality, and it significantly increases the risk of serious adverse effects (metabolic syndrome, akathisia, parkinsonism, sexual dysfunctions, cognitive impairment, gastrointestinal symptoms, etc.) due to drug interactions (Keller *et*

al., 2024). Although the use of psychiatric medication, often in combination, is put forward as an essential component in suicide prevention strategies (Zalsman *et al.*, 2016), a recent systematic review and meta-analysis of observational studies have found that SSRIs do not decrease the relative risk of suicide, while new-generation antidepressants significantly increase the risk of suicide (Hengartner *et al.*, 2021). Other meta-analytic studies of RCTs have found that antidepressants, including SSRIs, significantly increase suicide risk relative to placebo (Barbui *et al.*, 2008; D. Healy & Whitaker, 2003). Our experience with a high-risk population of patients with PD indicates that a gradual deprescribing of psychiatric medication within the context of a supportive and containing psycho-social treatment program reduces the risk of suicidality.

In light of the significant reduction in self-harming behaviours and absence of completed suicide over the course of a 22-year period, the CBP provides the blue-print for a suicide effective treatment and prevention approach. As also exemplified in the clinical case presented, the building of a mutually trusting relationship, the strengthening of the therapeutic alliance, the transmission of genuine empathy and understanding, an openness in addressing suicidality, a reduction of stigmatising attitudes, taking care of not repeating traumatic events in the relationship with the patient, and a best-practice based approach in monitoring, rationalising and gradual deprescribing of unnecessary and adverse-effects laden polypharmacy, are the main ingredients of a strategy that aims to reduce suicidality in a clinical population (Farina *et al.*, 2023). A number of recent contributions have also underscored the centrality of establishing a strong therapeutic alliance with suicidal patients and exploring the meaning of suicidal ideation and behaviour. These new developments have reshaped the psychoanalytically-informed approach to suicidality, which emphasise the therapist's active engagement, facilitating in a non-judgemental and empathic exploration of the patient's personal meaning of suicidality (Schechter *et al.*, 2016; Schechter *et al.*, 2019).

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