### Reference

1. Harel TZ, Smith DW, Rowles JM: A comparison of psychiatrists' clinical-impression-based and social workers' computer-generated GAF scores. Psychiatric Services 53:340–342, 2002


***In Reply:*** Although Dr. Kopera's alternative explanations are based on an inaccurate belief that the training provided to the psychiatrists and social workers was very similar, we would like to thank him for his interesting comments and his contribution of three alternative explanations for our findings that further support the main conclusions of the study.

Our study demonstrated that after the hospital's psychologist provided adequate training to the hospital's social work staff in using a computer-based GAF report (1) to generate GAF scores for patients being discharged, those scores and GAF scores given to the same patients by psychiatrists on the basis of their clinical impressions did not differ significantly across diagnostic groups.

Furthermore, this high level of interrater reliability suggests that such training can increase the usefulness of GAF scores in improving interdisciplinary communication about the continuity of patient care in the community after discharge.


***Tamar Zohar Harel, Ph.D.***
***Donald W. Smith, Ph.D.***
***J. Mark Rowles, M.D., M.P.H.***



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1. First MB: GAF Report for the Global Assessment of Functioning Scale. Windows Version: User's Manual. Toronto, Multi Health Sustems, 1996


## Borderline Personality Disorder, Suicide, and Pharmacotherapy

***To the Editor:*** In a review article in the June 2002 issue, Dr. Paris (1) reported that suicide is relatively common among patients who have borderline personality disorder and made recommendations about the assessment of acute versus chronic suicidality, the role of hospitalization in the treatment of these patients, and the management of suicide risk among outpatients with this disorder (1). It is notable that the review made no mention of the role of psychiatric medications in preventing suicide among these patients.

The literature on the role of psychiatric medications in the management of borderline personality disorder is sparse compared with the literature on psychotherapeutic interventions (2). However, it is common for patients with this disorder to be taking several medications. Because these patients may experience chronic depression, mood instability, and symptoms of psychosis, clinicians use antidepressants, mood stabilizers, and antipsychotic agents, alone or in various combinations, to try to manage the symptoms of the disorder.

Antidepressants and lithium have been shown to reduce the risk of suicide among patients with depression and bipolar disorder (3). Recently, several studies have found that clozapine is effective in reducing psychosis, self-injurious behavior, and the length of hospital stays among patients with borderline personality disorder (4). These findings are intriguing, because clozapine has also been found to reduce the risk of suicide among patients with schizophrenia (5).

None of the studies cited here specifically state that a given medication or class of medication reduces the risk of suicide among patients with borderline personality disorder. However, I believe it is reasonable to extend the findings on pharmacotherapy for affective and psychotic disorders to borderline personality disorder because patients with this disorder often have comorbid axis I disorders. If these disorders are accurately diagnosed and appropriately treated, then the risk of suicide among patients who have borderline personality disorder should be reduced.

Although the literature on pharmacologic treatments for patients with borderline personality disorder is not technically strong, Dr. Paris would have done well to recognize the potential utility of psychiatric medications in managing the risk of suicide among patients with this disorder.


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*Dr. Parker is associate professor of clinical psychiatry at Indiana University School of Medicine in Indianapolis.*



### References

1. Paris J: Chronic suicidality among patients with borderline personality disorder. Psychiatric Services 53:738–742, 2002
2. Soloff PH: Psychopharmacology of borderline personality disorder. Psychiatric Clinics of North America 23:169–192, 2000
3. Angst F, Stassen HH, Clayton PJ, et al: Mortality of patients with mood disorders: follow-up over 34–38 years. Journal of Affective Disorders 68:167–181, 2002
4. Parker GF: Clozapine and borderline personality disorder. Psychiatric Services 53: 348–349, 2002
5. Walker AM, Lanza LL, Arellano F, et al: Mortality in current and former users of clozapine. Epidemiology 8:671–677, 1997


***In Reply:*** Dr. Parker is right to point out that my article did not substantively address the question of whether medication can reduce the risk of suicide in borderline personality disorder. I have commented briefly on this issue in a recent article (1) and will go into further depth in a forthcoming book (2).

At this point, we do not have enough data to determine how effective medications are for the symptoms of borderline personality disorder. As Dr. Parker acknowledges, their use is not well supported by solid evidence. Recent guidelines published by the American Psychiatric Association (3) argued for an algorithmic approach using a variety of agents to target specific symptoms. However, these recommendations are not based on the results of randomized controlled trials.

By and large, the medications used for borderline personality disorder, including selective serotonin reuptake inhibitors, neuroleptics, and mood stabilizers, reduce impulsivity to some degree but fail to reduce the affective instability that lies at the core of the disorder. It is possible that reducing impulsivity helps prevent suicide completion among borderline patients. However, we do not have data to support that conclusion.