



Psychotic symptoms, self-harm and violence in individuals with schizophrenia and substance misuse problems

Gillian Haddock*, Emily Eisner, Gabriel Davies, Nia Coupe, Christine Barrowclough

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ABSTRACT

When schizophrenia is combined with substance misuse, rates are consistently higher. However research findings on the relationship between violence, self-harm and schizophrenia are inconclusive. This study aimed to examine links between specific psychotic symptoms, substance misuse and violence in people dually diagnosed with schizophrenia and substance misuse.

Presence and frequency of violence to self and others were examined in relation to the type and severity of psychotic symptoms and level of substance use over a 24 month period in 327 people with schizophrenia and substance misuse problems.

32.3% had an incident of violence to others during the study period and 28.6% had a self-harm/suicide incident. 39 (11.9%) participants reported command hallucinations (CH) and 157 (48.0%) had threat control override symptoms (TCOS). Presence of TCOS and presence of CH were not associated with violence to others but were both associated with self-harm. Different command hallucination sub-types were associated with different types of violence. Delusional and hallucination severity and distress were mainly associated with self-harm.

These findings suggest that specific symptoms are related to different outcomes, particularly in relation to self-harm, and these effects remain even after substance use is controlled for. This has important implications for assessment and treatment of this group.

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1. Introduction

Research suggests that rates of violence and self-harm are higher in people with schizophrenia than in other diagnostic groups (Arsenault et al., 2000; Schanda et al., 2004; Walsh et al., 2004). Self-harm is common (Haw et al., 2005), although the prevalence of violence to others remains unclear (Walsh et al., 2004). The relationship between violence and schizophrenia is complex and a number of factors have been shown to increase the risk of violence, including specific positive symptoms and substance use, as well as social deprivation, male gender, and younger age (Bo et al., 2011; Witt et al., 2013).

In terms of specific positive symptoms, threat control override symptoms, command hallucinations and persecutory delusions/hallucinations (Bjorkly, 2002; Frasan et al., 2005; Erkiran et al., 2006; Swanson et al., 2006), have all been shown to increase the risk of violent behaviour towards others in individuals with schizophrenia. Research also suggests that feelings of distress in relation to positive symptoms may also predict violence (Bjorkly, 2002; Van Dongen et al., 2012). Although self-harm has been more strongly associated with depression than positive psychotic symptoms (Harvey et al., 2008; Pluck et al., 2012), there is some evidence to suggest that

positive symptoms may also influence self-harm and suicidal behaviour (Hodgins et al., 2003).

Substance misuse is common in schizophrenia, with prevalence estimates of 40–50%, compared to 16% in the general population (NICE, 2009). When substance use is linked with schizophrenia, rates of violence have been shown to be consistently higher (Wallace et al., 2004; Foley et al., 2005; Erkiran et al., 2006; Fazel et al., 2009), although not exclusively so (Modestin and Wuermler, 2005). Research suggests that substance use can exacerbate positive symptoms in individuals with schizophrenia (Margolese et al., 2004; Kerfoot et al., 2011), and both appear to predict violence, yet the interaction between these two variables and their effect on violent behaviour and self-harm remains unclear.

We therefore aimed to explore rates of violence and self-harm in a sample of people with schizophrenia dually diagnosed with substance misuse and to test the hypotheses that severity of specific psychotic symptoms (delusions and hallucinations) would not be associated with violence (to others or to self) once substance use was controlled for. In addition, we explored how psychotic symptom distress was related to violence and self-harm.

2. Methods

2.1. Subjects

The 327 study participants were recruited from 6 large Community Mental Health Teams in North West England and London regions, UK,

* Corresponding author at: School of Psychological Sciences, Zochonis Building, The University of Manchester, Brunswick Street, Manchester M13 9PL, UK. Tel.: +44 161 275 8485; fax: +44 161 275 8487.

E-mail address: Gillian.Haddock@Manchester.ac.uk (G. Haddock).

between October 2004 and April 2007, covering urban and rural areas in Greater Manchester, Lancashire and South London during the MIDAS trial (a Medical Research Council funded randomised controlled trial of motivational interviewing and cognitive behaviour therapy for people with schizophrenia and substance misuse problems) (Barrowclough et al., 2010). Inclusion criteria were: aged 16 or over; clinical diagnosis of non-affective psychotic disorder (ICD-10 and/or DSM-IV); no significant history of organic factors implicated in the aetiology of psychotic symptoms; meeting DSM-IV criteria for drug and/or alcohol dependence or abuse and also exceeded minimum levels of drug and/or alcohol use on at least 6 of the 12 weeks preceding baseline assessment (illicit drugs: use on at least two days per week; alcohol: 28 units per week for men, 21 units for women); English speaking; of fixed abode; had recorded contact with mental health services and were prescribed anti-psychotics at the point of recruitment.

2.2. Measures

Demographic information (age, gender, and ethnicity) was collected via self-report. See Fig. 1 for data collection and assessment timeline.

2.2.1. Violence and aggression

Data on acts of anger, aggression, violence and self-harm/suicide were collected by independent raters from mental health service case notes over 24 months, using relevant variables from the Ward Anger Rating Scale (WARS; Novaco, 1994) as a guideline. The WARS Part A consists of 18 items that relate to verbal and physical behaviours associated with anger and aggression. Eight of the Part A items were used to extract data on acts of verbal and physical aggression. Verbal items were: “verbally abused someone”, “verbally threatened to attack a staff member”, and “verbally threatened to attack a patient”. Physically aggressive items were: “physically attacked a staff member”, “physically attacked a patient”, “temper tantrums”, “shouting/yelling”, and “deliberate damage to property”. Given that participants in this study were in the community, items relating to staff and patients were applied to violence towards any other person. Recorded incidents in which participants attempted to harm themselves or end their own life, or discussed self-harm/suicidal ideation, were also extracted from the notes.

Frequency data for these items were collected by independent assessors who recorded that an event occurred if a description of an event was written in any part of the case notes or other clinical written material during the target period. Variables were computed to indicate whether or not an incident occurred and the number of incidents occurring for each of the following:

- verbally aggressive incidents
- acts of physical violence
- self-harm/suicide incidents/ideation.

Twelve research assistants across six sites assessed violent incidents (verbally aggressive incidents and acts of physical violence) and self-

harm/suicide incidents from participants' psychiatric case notes. There was good (84%) agreement across the 12 assessors when rating 6 randomly selected reliability cases (based on agreement of 151 items out of a possible 180 violent or self-harm incidents across cases).

2.2.2. Symptoms

The Positive and Negative Syndrome scale (PANSS; Kay et al., 1987) was used to elicit and collate data on the severity of positive, negative, and general symptoms and individual scores on hallucination and delusion severity at baseline.

The Psychotic Symptom Rating Scales (PSYRATS; Haddock et al., 1999) and symptom content recording sheets were used to record data on symptom content and distress from symptoms at baseline. Participants were categorised as having threat control override symptoms (TCOS) if one or more of the following were present: delusions of influence, delusions of threat, commanding hallucinations, and threatening content of auditory hallucinations. The method is described in more detail in Hartley et al. (2009, 2012).

2.2.3. Substance use

The Timeline Follow Back method (TLFB; Sobell and Sobell, 1992) was used to measure the frequency of substance use, in terms of days abstinent during the previous 3 months, at baseline, 6, 12, 18 and 24 months. Substance use severity was then calculated in terms of total days abstinent from all substances over the 24 month period. Baseline severity of substance use was assessed for the participant's main substance using the Drug Abuse Screening Test (Skinner, 1982) or the Alcohol Use Disorders Identification Test (AUDIT; Saunders et al., 1993). Information regarding primary drugs of use is provided in Table 1.

2.3. Statistical analysis

We examined the effect of specific psychotic symptoms on violence, with measures of verbal, physical and self-harm/suicide incidents analysed separately. Age and gender were entered as covariates in all analyses, as these have been shown to be associated with violence. Depression (PANSS depression item) was also entered as an additional covariate in the analyses of self-harm/suicide outcomes, as this has been shown to be associated with self-harm. Analyses were conducted both with and without controlling for severity of substance use, in terms of percentage days abstinent from all substances using the TLFB. Binary violence outcomes (whether or not a violent incident occurred) were examined using logistic regression. For those who had self-harmed or been violent towards others during the study period, we also examined the frequency of those incidents using linear regression. Stata version 9.2 was used for all analyses. Robust estimation procedures were used where appropriate.

In addition to the analyses outlined above, two other exploratory analyses were conducted. Firstly we investigated whether subtypes of command hallucinations (benign commands, commands to harm self,

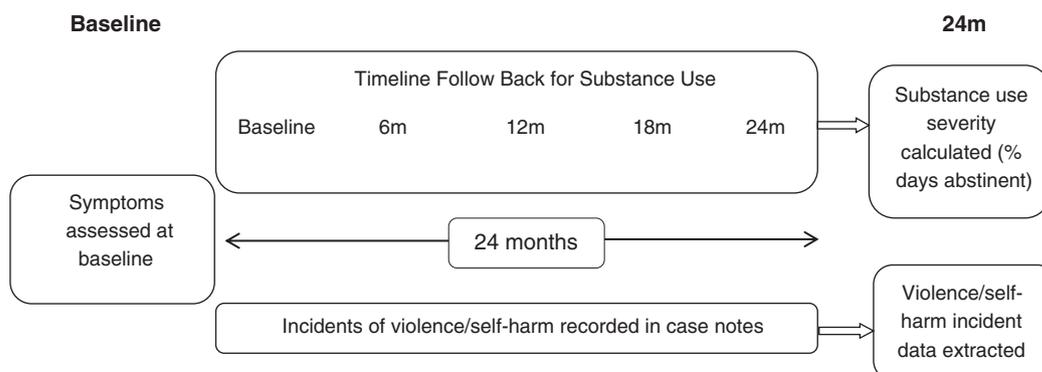


Fig. 1. Timeline for substance use and symptom assessments.

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