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Persistent hallucinosis in borderline personality disorder

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Abstract

A case series of 10 patients with a diagnosis of borderline personality disorder (BPD) presenting with auditory hallucinosis is examined. In this series, the hallucinations were persistent, longstanding, and a significant source of distress and disability. Extrapolating from this series to our sample of 171 patients with BPD suggests that a form of auditory hallucinosis may occur in almost 30% of this population. The failure to emphasize this phenomenon in current systems of classification risks misdiagnosis or inappropriate treatment. Use of terms such as *pseudohallucination* or *quasi hallucination* dismisses the phenomenon as unimportant or as "not real." There is an emerging literature on the frequency of hallucinosis among nonpatients. A basis for understanding different forms of hallucination is discussed with reference to the concept of "normativity." We propose a nomenclature for hallucinosis that is expressed in positive terms, reflecting the clinical significance of the phenomenon in different contexts: (1) normative hallucinosis, (2) traumatic-intrusive hallucinosis (as in our series), (3) psychotic hallucinosis, and (4) organic hallucinosis.
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1. Introduction

This report concerns phenomena observed by those working with borderline personality disorder (BPD) but not widely recognized outside this field. A significant number of these patients experience persisting auditory hallucinosis. Information regarding this and related phenomena seems to be frequently withheld from medical attendants because of fears (or past experience) that disclosure may result in the diagnosis of schizophrenia.

Originally, the term *borderline personality disorder* was used by Stern [1] to describe patients who manifested both neurotic and psychotic symptoms. These original descriptions did not refer to persistent auditory hallucinosis. More recently, the diagnosis has become operationalized, with greater emphasis on affective instability, core emptiness or depression, disturbance of identity, and behavioral features [2,3]. While it is recognized that "psychotic" symptoms such as auditory hallucinations and other positive symptoms of psychosis may occur, they are said, in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*), to occur only for brief periods in situations of stress [2]. This follows the work of researchers such as Zanarini et al [4] who attempt to differentiate psychotic features in BPD from other psychotic disorders.

The research of Zanarini et al [4] has found the rate of quasi-psychotic experiences in borderline patients to be 40% and also that quasi hallucinations are more common than quasi delusions. This type of disturbance of thought is felt to be so characteristic as to be "virtually pathognomonic for the borderline patients. . .(it) successfully discriminated them from those in each of the other groups" (other personality disorder, schizophrenia, and normal controls) [4]. They are, however, critical of earlier studies for using terms such as *psychotic* or *psychotic-like* too generally, believing we can rely on the "clear-cut departure from consensual reality described in DSMIII" to distinguish psychosis from nonpsychosis [4].

The differentiation of Zanarini et al [4] of quasi from true psychotic symptoms relies on criteria of (*a*) transiency, (*b*) circumscription (only affecting 1 or 2 areas of the patients life), or (*c*) atypicality (possibly reality-based or totally fantastic in content). In a 6-year prospective study by the same group, many cases of "quasi-psychotic" symptoms of thought and perceptual disturbances are persistent [5]. Later works also emphasize distorted dysphoric cognitive abnor-

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malities as most specific for BPD [6,7]. Skodol et al [8] are critical of the current *DSM* classification for omitting regression-proneness and for only making indirect reference in criterion 9 to lapses in reality testing.

Other studies have demonstrated a significant incidence of such symptoms in general population samples [9,10,11]. Auditory and visual hallucinations are also commonly recognized in other, perhaps more controversial diagnostic entities, such as dissociative identity disorder (DID) or dissociative (hysterical) psychosis [12,13]. In this article, we identify a significant group of patients with a diagnosis of BPD who have ongoing symptoms including auditory hallucinations and other phenomena, such as thought insertion, that are more commonly associated with psychosis.

The tendency when confronted with positive psychotic phenomena is for the clinician to either make a diagnosis of schizophrenia or other major psychotic disorder or to dismiss the phenomenon in question by resorting to a concept such as "pseudohallucination." This term was coined initially by Hagen in 1868 to describe hallucinations that were not "real" hallucinations, although the debate about what had constituted genuine hallucinations had been going on considerably longer [14]. Berrios and Dening point out that this amounts to casting the concept into "the unpleasant role of being a 'joker' in the diagnostic game: by taking different clinical values it allows clinicians to call into question the genuineness of some true hallucinatory experiences that do not fit into a preconceived psychiatric diagnosis" [14]. In fact, it is difficult for clinicians to distinguish between "true" hallucination and "pseudohallucination," and empirical efforts to assess the validity and reliability of this distinction have failed [15,16]. From a clinical point of view, if the distinction cannot be made in a reliable way, then it amounts to either a concept that lacks utility or a "nonconcept."

The case series presented in this article arose out of the clinical experience of one of the authors (LY) who was treating patients who presented with distress and concern in relation to auditory experiences. These were described as "voices" that had been present for long periods and persisted consistently during therapy. The subjects came from a treatment program for BPD in which diagnoses are made by experienced psychiatrists using updated versions of *DSM* (*DSM-IV* at the time of this study) criteria for the disorder [17]. Having become interested in the phenomenon, LY sought to evaluate a larger group of patients from this program.

2. Methods

2.1. Subjects

Three patients were treated by LY, a psychotherapist affiliated with the Westmead Hospital's BPD treatment program, with an additional 7 patients randomly selected from a larger group enrolled in the BPD research (and treatment) program. The 3 patients of LY were selected on the basis of their self-report during therapy of auditory hallucinosis as part of their experience. The other 7 patients were selected after they had indicated, on completion of the Symptom Checklist 90 (SCL-90) [18], that auditory hallucinations were part of their ongoing experience.

All subjects met *DSM-IV* criteria for BPD at the time of referral. Further diagnostic confirmation was made using the Diagnostic Interview for Borderlines (DIB-R) [19] and by a psychiatrist experienced in management of personality disorder.

The resulting 10 subjects had a mean age of 33 years (range, 23-48). Nine subjects were female and 1 was male; 8 had at least some secondary education and 2 had some tertiary education; 7 were unemployed, 2 had part-time work, and 1 has full-time work; 9 were single and 1 was married. All patients were re-interviewed for the study.

2.2. Interview method

All patients were informed that the interview would focus on the experience of auditory hallucinations. Informed consent was obtained from all participants. Three assessment instruments were used in a semistructured format: (1) Dissociative Experiences Scale (DES) [20], (2) Steinberg's Structured Clinical Interview for *DSM-IV* Dissociative Disorders (SCID-D) [21], and (3) McGuffin's Opcrit Questionnaire [22].

The DES was chosen to see how closely the symptoms corresponded to dissociative phenomena. Total scores and scores on subscales (amnesia, depersonalization, and absorption) were analyzed. The SCID-D was used, selecting only questions relevant to the experience of auditory hallucinations (questions 134-157 and questions 202-210). The semistructured interview format of the SCID-D lent itself to a more free-flowing format with elaboration of any answers as the interview proceeded. The Opcrit questionnaire was developed for research into psychotic illness [22]. Questions 38 to 45 were used, focusing on symptoms of thought insertion, thought broadcast, thought withdrawal and blocking, auditory, visual, and olfactory hallucinations, and delusions of external control or passivity. It was anticipated that this group, not having a diagnosis of schizophrenia, would not score highly on this questionnaire and that this might provide a means of differentiating borderline phenomena from those of schizophrenia.

To gain an estimate of the proportion of patients with BPD from this research program who have features of auditory hallucinosis, the percentage of the overall sample that indicated that auditory hallucinations were present on the SCL-90 at the time of initial assessment was calculated.

3. Case series

1. R was a 30-year-old single woman with full-time work. She reported hearing "voices" 20% of the time and that these had been "present since high

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