



Original article

Suicidality and hospitalisation in patients with borderline personality disorder who experience auditory verbal hallucinations



C.W. Slotema^{a,*}, M.B.A. Niemantsverdriet^a, J.D. Blom^{a,b,c}, M. van der Gaag^{a,d},
H.W. Hoek^{a,b,e}, I.E.C. Sommer^f

^aParnassia Psychiatric Institute, The Hague, The Netherlands

^bUniversity Medical Center Groningen, Department of Psychiatry, Groningen, The Netherlands

^cLeiden University, Faculty of Social Sciences, Leiden, The Netherlands

^dVU University, Department of Clinical Psychology, Amsterdam, The Netherlands

^eColumbia University, New York, NY, USA

^fUniversity Medical Center Utrecht, Department of Psychiatry, Utrecht, The Netherlands

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ABSTRACT

Background: In patients with borderline personality disorder (BPD), about 22–50% experience auditory verbal hallucinations (AVH). However, the impact of these hallucinations on suicidal ideation, suicide attempts, crisis-service interventions, and hospital admissions is unknown.

Methods: In a cross-sectional design, data were collected with the Psychotic Symptom Rating Scales (PSYRATS) and the MINI International Neuropsychiatric Interview Plus, as well as from the medical records of a convenience sample of outpatients fulfilling the DSM-IV criteria for BPD.

Results: Of the 89 included patients, 27 experienced AVH. In the latter group, the presence of AVH was associated with a significantly higher incidence of suicidal plans and attempts in the month prior to study participation, more hospitalisations, and a shorter interval until hospitalisation. All subscales of the PSYRATS correlated positively with suicide plans, while the phenomenological and emotional subscales also correlated positively with suicide attempts. Moreover, higher scores on the emotional subscale were associated with more hospital admissions.

Conclusions: AVH experienced by patients with BPD might constitute a risk factor for suicide plans and attempts, and hospitalisation. This finding emphasises that this population requires adequate clinical attention, as well as effective treatment for AVH.

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1. Introduction

Borderline personality disorder (BPD) is characterised by chronic emotional instability, identity disturbances, self-destructive behaviour, and generally low levels of functioning [1]. In non-hospitalised Western populations, the prevalence of BPD ranges from 1 to 1.5% [2]. Comorbidity with other psychiatric disorders is high, especially for depression, post-traumatic stress disorder, and substance abuse [3]. Auditory verbal hallucinations (AVH) do not feature on the list of diagnostic criteria for BPD. As a consequence, these phenomena might be underdiagnosed, and, as a consequence, undertreated. Textbooks often suggest that AVH in BPD patients are transient, mild and self-limiting, but evidence to the contrary is accumulating [4,5]. Five cross-sectional studies of

auditory hallucinations (i.e., verbal and non-verbal ones together) in BPD patients reported prevalence rates of 29–59% [4,6–9]. AVH are the most common type in this group, experienced by 22–50% of the patients [4,7–9]. In a cross-sectional study by our group [5], BPD patients were found to experience AVH for a mean duration of 18 years, with a mean frequency of at least once per day, and a mean duration of several minutes per episode. The phenomenological characteristics of these AVH, as well as the ensuing distress, are equal to those experienced by patients with schizophrenia [4,5]. In this respect, AVH in BPD patients are substantially different from those experienced by individuals without a psychiatric diagnosis (i.e., ‘healthy voice-hearers’) with regards to their phenomenological and emotional characteristics, as well as cognitive interpretations [5].

In patients diagnosed with schizophrenia, AVH and other psychotic symptoms may have severe consequences: 20–40% attempt to kill themselves at some point during their illness [10] and 5% actually commit suicide [11,12]. In these patients, a history

* Corresponding author. Parnassia Psychiatric Institute, Lijnbaan 4, 2512 VA The Hague, The Netherlands. Tel.: +31 883 573 107; fax: +31 883 584 220.

E-mail address: c.slotema@psyq.nl (C.W. Slotema).

of suicide attempts is considered a predictive factor for novel suicide attempts [13,14] and suicide [14]. However, the specific role of AVH in this process has not been fully elucidated. Nevertheless, in a study by Kjelby et al. [15] among psychotic patients, the presence of AVH and other hallucinations correlated positively with suicidal ideation and suicidal plans, while Fujita et al. [16] found that AVH increase the risk of suicide attempts in psychotic adolescents already familiar with suicidal ideations.

In the context of BPD, both AVH and suicide attempts are prevalent. As in schizophrenia, AVH experienced in the context of BPD often consist of personal commentaries, hateful remarks, and harmful commands. The lifetime prevalence of suicidal behaviour among BPD patients (with or without AVH) is approximately 70% [17], and the lifetime risk of suicide is 4–10% [18,19]. In a meta-analysis with 8 studies, the mean number of suicides in a year projected to a BPD population of 100,000 is estimated as 864 with a range from 165 to 1732 [20].

Compared with patients diagnosed with schizophrenia, the risk of ensuing suicide attempts might be enhanced by the absence of negative symptoms and by the impulsive behaviour often present in this patient group. In turn, such an increase in suicidal behaviour may result in a higher number of crisis-service contacts and hospital admissions, with their related economic consequences. The community costs for personality disorders in general are high. Soeteman et al. [21] calculated that patients receiving treatment for a personality disorder cost society (on average) 11,126 euros per person during the year prior to their enrolment in specialised treatment programmes, and that 33% of this sum is spent on psychiatric and general-hospital admissions.

Thus, there are diagnostic, therapeutic, humane, and socio-economic reasons to investigate the relation between AVH in BPD and suicidality. Therefore, the present study aimed to explore:

- whether suicidal ideation and suicide attempts occur more often among BPD patients who experience AVH than among those who do not;
- whether the severity of AVH (i.e., their phenomenological and emotional characteristics, as well as cognitive interpretations) is associated with suicidal ideation, suicide attempts, crisis interventions and hospital admissions;
- the predictive value of AVH for future hospitalisation of BPD patients.

2. Methods

2.1. Study population

Patients were recruited from May 2012 through March 2015 at the Outpatient Department of Personality Disorders of Parnassia Psychiatric Institute (The Hague). The study was approved by the medical ethical board of Parnassia (registration number 6237) and carried out in accordance with the Declaration of Helsinki. Criteria for inclusion were age ≥ 18 years, a diagnosis of BPD according to the Structured Clinical Interview for DSM-IV Axis II Personality Disorders [22], and written informed consent. Patients were excluded when they fulfilled the criteria of a schizophrenia spectrum disorder, as established with the aid of the DSM-IV-TR. Anticipating the new diagnostic criteria of the DSM-5 for schizophrenia spectrum disorders, we did not exclude patients whose hallucinations consisted of a voice keeping up a running commentary on the person's behaviour or thoughts, or two or more voices conversing with each other.

2.2. Design

The study was performed in a cross-sectional design.

2.3. Measures

To chart the severity of AVH, the participants were interviewed so as to cover the three categories of AVH-related items of the Psychotic Symptom Rating Scales (PSYRATS) [23], consisting of four items regarding phenomenological characteristics (i.e., frequency, duration, perceived location, and loudness), four items regarding emotional characteristics (i.e., distress due to the voices and the items 'amount and degree of negative content' and 'amount and intensity of distress'), and three items assessing cognitive interpretations (i.e., beliefs about origin, disruption of life, and controllability). Each item was rated on a five-point Likert Scale, ranging from 0 to 4. The presence of suicidal ideation and behaviour was assessed with the MINI PLUS (MINI International Neuropsychiatric Interview PLUS; items C3–C5, i.e., suicidal ideation, and suicide plans and attempts within the last month) [24]. In addition, the following data were derived from the patients' electronic medical records: the number of hospitalisations and the number of crisis-service interventions during two years after inclusion in the present study at Parnassia Psychiatric Institute. Finally, we collected the number of days until hospitalisation, i.e., from inclusion into the study up to a maximum of two years after participation. This maximum period was chosen because all these patients received treatment at our department for at least two years after participation, so data on hospital admission and crisis-service contacts were available for all included patients. The interviews were conducted by psychologists and residents in psychology and psychiatry who had been trained for these specific questionnaires. Monthly meetings were held to ensure interrater reliability.

2.4. Statistical analysis

Data analysis was performed with the Statistical Package for the Social Sciences, version 20. Patients were divided into two groups:

- one with AVH occurring at least weekly;
- one with less frequent AVH or no AVH at all.

This cut-off point was based on the distinction made in the item 'frequency' of the PSYRATS (i.e., 0 = voices not present or present less than once a week, and 1 = voices occur at least once per week). Group demographic data were compared by means of χ^2 analyses (Fisher's Exact test) and *t*-tests for independent samples. Furthermore, Fisher's Exact test was used to investigate differences in the presence of suicidal ideation and behaviour between the two groups with total number of BPD criteria and MINI PLUS diagnoses as covariates. As a normal distribution was lacking, a non-parametric test for independent samples (Mann–Whitney *U*-test) was conducted for the number of crisis-service interventions and hospitalisations in the two groups. To explore the association with severity of AVH, *t*-tests for independent samples were used to reveal associations between the three subscales of the PSYRATS, and suicidal ideation and behaviour. Correlation analyses for the number of hospital admissions and crisis-service interventions within two years after inclusion were performed with Spearman's rho as correlation coefficient, as they were not normally distributed. Other correlations were analysed using Pearson's correlation. The Benjamini–Hochberg correction was used to correct for multiple testing [25]. Logistic regression analyses were performed with dependent factors 'suicide plans' and 'suicide attempts in the month prior to inclusion', and independent factors the summed score of the AVH-related items of the PSYRATS, summed score of BPD criteria, and summed score of MINI PLUS diagnoses. To investigate whether the presence of AVH was associated with shorter intervals until hospital admission, the

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