

Command hallucinations and clinical characteristics of suicidality in patients with psychotic spectrum disorders

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Abstract

Background: Suicide is a leading cause of death among patients with psychotic illnesses. Several researchers have suggested that specific illness symptoms may better predict suicide risk. An ability to identify high-risk patients would aid clinicians in instituting risk-reduction measures to decrease suicidal behavior in this population.

Methods: We examined the association between psychotic symptoms and suicidal behavior among 148 inpatients with psychosis using the *Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV), the Scale for the Assessment of Positive Symptoms, and the Positive and Negative Syndrome Scale. Measures of suicidality were obtained from risk assessment clinical data routinely collected during intake.

Results: For individuals with a DSM-IV diagnosed psychotic spectrum disorder, 40% (n=57) endorsed suicidal ideation on admission and 23% (n=33) endorsed a recent suicide attempt. The presence of command auditory hallucinations was significantly associated with active suicidal ideation across diagnostic categories. Similarly, a greater percentage of patients endorsed a recent suicide attempt in the presence of command hallucinations. These correlations with CAH are noteworthy, as we found no significant difference in the prevalence of SI among those with and without general auditory hallucinations (42.5% and 37.7%).

Conclusions: The presence of command auditory hallucinations, in particular, but not auditory hallucinations, in general, was associated with suicidal behavior. These results indicate that command auditory hallucinations may identify or even place psychotic individuals at greater risk for acute, suicidal behavior — these symptoms should be the target of immediate and aggressive characterization and treatment.

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1. Introduction

The evaluation of suicide risk is a critical clinical issue, but past research has been unable to answer many key questions regarding assessment and prediction. Psychotic patients are at an increased risk for suicide [1–6]. Prior studies have focused on schizophrenia, yet suicide is a leading cause of death among all patients with psychosis, including those with bipolar and other psychotic disorders [1,7–10]. Multiple studies demonstrate a link between suicidality and demographic factors such as age, sex, ethnicity, marital status, and education [6,8]. However,

these fixed characteristics are less robust predictors of suicidal behavior as compared to clinical variables [11].

Some of the most salient features of psychosis, such as hallucinations, are present in several psychiatric disorders. While these features may be most common in schizophrenia, they are by no means pathognomonic [12]. A growing body of genetic and epidemiologic evidence suggests that, contrary to the dichotomous separation of schizophrenia and affective psychoses, these conditions may lay on the same disease spectrum [13–16]. Given these challenges to the existing nosologic framework and research suggesting that specific illness symptoms may better predict suicide risk, we focused on dimensional features of psychopathology and their relationship to suicide without regard to traditional diagnostic categories [17,18].

Several clinical features in psychotic spectrum disorders are associated with suicidal ideation, including

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suspiciousness and paranoid delusions [19,20], thought disorders [21], mental disintegration and agitation [22,23], increased insight [24], depression [23,25], and hallucinations [26]. Command auditory hallucinations (CAH), in particular, are thought to increase suicidality. However, the few studies examining its predictive capacity have produced conflicting results [27–31]. Recent studies show that while CAH may increase suicide attempts in already at-risk patients, the presence of CAH alone does not directly predict suicide attempts [29,30]. Conversely, Rogers et al. [31] indicated that individuals endorsing CAH often respond to those commands, resulting in self-injurious behavior, if not directly causing their death.

Many associated risk factors for suicidal ideation and attempts have been identified. Still, the prediction of suicide is difficult due to the low frequency of completed suicides and the lack of specificity and sensitivity of current predictive measures. The clinical evaluation of suicidality is especially difficult in this population given their reluctance or inability to communicate their distress [32]. An ability to identify high-risk patients by recognizing a range of associated factors would aid clinicians in instituting risk-reduction measures to decrease suicidal behavior. The aim of this study was to examine the relationship between specific psychotic symptoms, particularly hallucinations, and suicidal ideation and attempts among patients recently admitted and diagnosed with a psychotic spectrum disorder. We hypothesized that specific symptoms, especially command hallucinations, would be highly associated with suicidal behavior in our acutely ill patients.

2. Method

2.1. Participants

Subjects were initially recruited for a genetic association study of psychotic and affective disorders [33,45]. More than 1000 consecutive admissions to the McLean Hospital Psychotic Disorders inpatient units and 40 stable outpatients were screened. Individuals were included if they were 18 to 89 years old, legally competent to provide informed consent, and carried a DSM-IV diagnosis of schizophrenia, bipolar disorder, or other psychotic spectrum disorder. Patients were excluded if their symptoms could be attributed to a general medical condition, if they had a history of significant head trauma, or if they carried a diagnosis of a developmental disorder or mental retardation. Study personnel reviewed inpatient medical records daily to identify and approach subjects meeting criteria. The study was approved by the McLean Hospital (Belmont, MA) institutional review board. Subjects provided informed consent, including permission for data collected to be used for future research studies. Additional data were obtained at a later date from subjects' hospital admissions assessment information via chart review.

From this database, we focused on inpatients recruited from 2008 to 2010. This yielded 199 subjects on which a

formal, comprehensive diagnostic assessment based on the *Structured Clinical Interview* for DSM-IV-TR (SCID) [34] had been completed. Fifty-one subjects without psychotic symptoms were excluded from the analysis. The final sample included a total of 148 patients carrying diagnoses of schizophrenia (N=35), schizoaffective disorder (N=37), schizophreniform disorder (N=4), bipolar disorder with psychotic features (N=59), MDD with psychotic features (N=8), psychosis NOS (N=4), and delusional disorder (N=1).

2.2. Measures

The SCID evaluation utilized all available information from hospital records, family members, and outside providers, with patient consent, to diagnose primary and psychotic mood disorders. Individuals also participated in formal diagnostic measures, including the Scale for the Assessment of Positive Symptoms (SAPS) [35], to gather information about auditory, somatic, olfactory, and visual hallucinations. The Positive and Negative Syndrome Scale (PANSS) [36] was used to assess severity of anxiety, depression, and hostility measured on a 7-point scale. The SCID does not methodically evaluate measures of suicidality, nor does the SAPS ask specifically about content of auditory hallucinations. Given our interest in suicidal ideation and command hallucinations, we looked to the risk assessment form completed by clinicians during intake for assessment of suicidality.

The risk assessment form contains 20 items evaluating current suicidal ideation, recent suicide attempts, history of suicidal behavior, and notes additional factors such as chronic pain or lack of family and social support. Items are coded in severity from none, low, moderate, to severe. Subjects marked as low, moderate, or severe under "current suicidal ideation" were considered to be endorsing suicidal ideation, whereas subjects marked as none were considered to be denying suicidal ideation. A suicide attempt was defined as any behavior done with the intent to cause death, excluding self-harm without intent. Subjects were similarly scored, where those marked as low, moderate, or severe under "recent suicide attempt" were noted as having made a recent attempt, while subjects marked as none were noted as having no recent attempts.

Information regarding command auditory hallucinations (CAH) was also taken from the risk assessment form. Patients were scored similarly (none, low, moderate, severe) in regards to experiencing "command auditory hallucinations concerning self-harm or aggression." They were noted as having a presence of CAH if marked low, moderate, or severe on the form and an absence of CAH if marked none.

Patients were evaluated by psychiatrists and research staff trained in administering the SCID, SAPS, and PANSS. Monthly diagnostic reliability exercises, where study subjects were interviewed in the presence of the research team, were performed to maximize consistency. Each rater

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