Personality disorder and suicide

The discussion about the association between personality disorder and suicide is important.1 First, I want to present some information on the risk of suicide in patients with personality disorder with special reference to the subtype of personality disorder.

Coleman et al. conducted a cross-sectional study to understand the relationship between narcissistic personality disorder (NPD) and suicidal behaviour in 657 patients with mood disorders.2 The adjusted odds ratio for suicide attempt in the participants with NPD was 0.41 (95% CI 0.19–0.88). In addition, being male, substance use disorder, aggression and hostility also presented a significant increase in odds ratio for suicide attempt. In contrast, the adjusted odds ratio for suicide attempt in those participants with borderline personality disorder (BPD) was 4.96 (95% CI 3.25–7.58). NPD in patients with mood disorders showed a protective effect for suicidal behaviour, which was different from that in participants with BPD. Sher reports that patients with NPD have a risk of suicide behaviour,3 and I recommend stratified analysis by subtype of personality disorder for risk assessment of suicide.

Second, there is a difference between suicidal ideation and attempt.4 In addition, mood disorder is a risk factor for suicidal behaviour.5 Wang et al. conducted a prospective study to investigate the effect of stressful life events on subsequent suicidal behaviour in patients with major depressive disorder.6 They clarified that financial stress was a strong predictor for suicide attempts after adjusting for sociodemographic variables, anxiety, substance use and personality disorder. As Liu also pointed out, comprehensive analysis is recommended for risk assessment of suicide.

As you have hinted, personal sacrifices are necessary. It is a tough, and occasionally dangerous profession. It is not too hard academically, but it is challenging at a deeply personal level. Compassion – ‘suffering with’ one’s patients and their carers, also one’s colleagues – means feeling and sharing the emotional pain and distress of others. As I have written about extensively elsewhere, it is this very suffering, acting as a kind of medicine, which affords the best opportunity to initiate healing from life’s inevitable psychological traumas, threats and losses, resulting in the deepest satisfaction that human experience can offer, inherent in personal growth. To become wiser, kinder, humbler, more truthful and tolerant, enjoying lower levels of anxiety, anger, sorrow, doubt, confusion, and greater levels of equanimity and self-esteem, accompanied most often by the heartfelt esteem of others, are among the inestimable rewards to be garnered. This is undoubtedly what I have gained from becoming and working as a psychiatrist.

Arguably, acknowledged or not, psychiatry is a brand of sorts. Doctors making career decisions may be accustomed to thinking of themselves as consumers and consider their options in a transactional way. In this case the explicit branding of psychiatry makes some sense, and in recognising this possibility Crabb et al provide a valuable insight. But promoting psychiatry as a brand may mean that other ways of understanding how our specialty might appeal are overlooked. What I hope is not lost is the notion of the new recruits to psychiatry’s ranks as engaged citizens, drawn to this specialty as an expression of deeply held values and as a demonstration of commitment to their community and to wider society.


Rethinking rebranding

Recruiting sufficient psychiatrists in the UK apparently resists straightforward remedy. Crabb et al’s recent editorial Shrink rethink: rebranding psychiatry is a welcome contribution on this subject. Innovative and provocative in turn, it urges that the psychiatric profession draw on expertise from the fields of advertising and public relations. We should engage with potential recruits by thinking of psychiatry as a ‘brand’.

But brands are ethereal things. Their existence is championed by some, whereas others have written about the negative impact of brand-oriented corporate activity. Marketing psychiatry as a brand certainly has an attractive simplicity. Yet doing so situates the practice of psychiatry in the realm of things that are bought and sold, where it sits only uncomfortably.

The ubiquity of some brands is a marketing triumph, but emulating their tactics is not necessarily desirable. The advertising of brands seeks to sow discontent; to demonstrate to customers a drop-off rate of 15% when deciding on sample size and other studies by the same group have reported even higher drop-out rates. They state ‘a substantial number of patients did not fully adhere to the interventions’. One could also question whether accessing treatment modules and email contact are ‘strict criteria’ to guarantee adherence to the graded activity protocol. Although the authors state that ‘the treatment is tailored to a patient’s current activity pattern as assessed with actigraphy’, increased activity levels was not included in the adherence criteria.

According to the authors, both iCBT conditions are efficacious, since 29/80 (36%) in the protocol-driven feedback iCBT group and 34/80 (43%) in the feedback-on-demand iCBT achieved the ‘normal range’ for Checklist Individual Strength fatigue severity, compared with 12/80 (15%) in the waiting list group. However, the treatment effects of the protocol-driven feedback iCBT and feedback-on-demand iCBT in the study are by far insufficient to achieve ‘normal levels of fatigue’ (Checklist Individual Strength fatigue severity ≤27) as defined in another study by two of the

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Cognitive-behavioural therapy for chronic fatigue syndrome: neither efficacious nor safe

Janse et al investigated the effect of two variants of internet-based cognitive–behavioural therapy (iCBT) for chronic fatigue syndrome (CFS): iCBT with protocol-driven feedback and iCBT with feedback on demand.

First, it should be acknowledged that CBT trials for participants with CFS have a high preselection bias, i.e. self-selection, since, according to another study by two of the authors of Janse et al, patients seem to be sceptical about psychological interventions.

Janse et al’s study reported ‘clinically relevant depressive symptoms’ in both iCBT groups (protocol-driven feedback iCBT group 31%, feedback-on-demand iCBT group 29%), while depression and other psychological conditions that could explain ‘chronic fatigue’ exclude the diagnosis CFS. It is feasible that many patients who improved had depression, not CFS.

Comparing the number of patients working full-time in this study with other studies, for example Sunnquist et al, the CFS (?) patients can be classified as ‘mild cases’. Since CFS is a heterogeneous condition, the results of this study cannot be generalised to CFS.

Drop-out rates are not reported but the authors assumed a drop-out rate of 15% when deciding on sample size and other studies by the same group have reported even higher drop-out rates. They state ‘a substantial number of patients did not fully adhere to the interventions’. One could also question whether accessing treatment modules and email contact are ‘strict criteria’ to guarantee adherence to the graded activity protocol. Although the authors state that ‘the treatment is tailored to a patient’s current activity pattern as assessed with actigraphy’, increased activity levels was not included in the adherence criteria.

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2 The Economist. The case for brands. The Economist 2001; 8 September.