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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.

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A letter to Jim Crabb *et al*

Congratulations on your article,[1] which I have been thinking about since reading it some weeks ago. I fully agree with your aims (attracting doctors into the specialty) and many of your arguments, but also have some reservations, which I would like to share. I am also wondering what kind of reactions you have had from others, and whether you have heard anything similar to the following observations.

In this age of internet 'click-bait', it seems, when advertisements are designed 'to create an anxiety relieved by a purchase', people are often naturally suspicious of advertising, branding and marketing. It is seldom fully truthful, misleading by presenting opinion as facts, by being selective of data, and by concealing flaws and inadequacies. This is the hype, spin or propaganda designed to sell products and maximise financial profit, and arguably therefore unsuitable for persuading medical students and young doctors to think about psychiatry as a long-term career path.

In the cold light of day, for example, particularly in today's evidence-based, politically governed, underfunded and overstretched National Health Service, people might wonder how truthful are the statements comprising the mantra you propose for 'brand psychiatry'. The experience of a patient, or family members, might not be exactly as you describe. The rational, materialist, left-brain dominated 'scientific' approach – which tends to search out symptoms and diagnoses, and then to provide physical treatments (medication) and brief impersonal psychotherapies (such as cognitive–behavioural therapy), rather than seeking healing for the whole person, body, mind and soul – still prevails over a more holistic, intuitive, poetic, right-brain dependent, person-oriented approach, do you not think?

I am sure, however, that you are on the right track. It is a genuine ideal to be pursued, 'To understand the connection between the mind, the body and the soul', and 'To have the rare ability to treat the person, not the problem'. But might not other doctors, particularly general practitioners, want to make similar claims?

An approach that might work well could be to stress the equal values of biological, psychological, social *and* spiritual aspects of mental healthcare (see for example, regarding the latter Culliford[2,3] and Cook *et al*[4]). In other words, giving the message that there is a welcome in the specialty for people with a wide range of knowledge, skills and experience, enabling each to grow – through training and practice – in those areas and attributes perhaps previously less well developed.

There is an important place for those whose abilities and preferences lie within the biological domain, still the 'comfort-zone' for many psychiatrists; but the aim, I suggest, is both to encourage such folk to broaden their horizons out of their familiar orbit, and to encourage new people to enter the specialty whose inclinations are more towards (to paraphrase the mantra) 'feeling with one's mind' and 'thinking with one's soul'. Arguably, this means fostering awareness and familiarity with the spiritual dimension of mental healthcare. Some may be surprised to know that this valuable – and hitherto neglected – aspect of our discipline can be taught.[5]

An axiom for this new psychiatry would be that everyone is on some kind of self-improvement pathway towards a maturity that involves personal integration, with continuing growth in terms of wisdom, compassion and love, derived from a sense of belonging not to any faction but to the entirety of humanity, similarly connected seamlessly to nature, to the dynamic structure and energy of the cosmos that underpin all the natural laws known to science. To become a psychiatrist would thus offer an unparalleled opportunity for making progress along this (I would call it 'spiritual') path.

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authors of Janse *et al*.[2] Looking at the Sickness Impact Profile 8 and Medical Outcomes Survey Short Form-36 physical functioning scores after the intervention at the group level (scores at the individual level are not reported), both iCBT groups would still be qualified as 'severely disabled'.

The effect of protocol-driven feedback iCBT and feedback-on-demand iCBT on objective measures are not reported, but other studies by the research group have shown that a CBT protocol has no effect on (low) physical activity levels, number of hours worked or cognitive test scores.[2]

The authors label their intervention CBT.[1] However, looking at the protocol, the intervention investigated not only incorporated CBT, aimed at 'behaviours and beliefs' perpetuating 'fatigue and impairment', but also included a graded activity programme, known as graded exercise therapy (GET). Several large-scale patient surveys and studies, for example Cheshire *et al*,[4] indicate that CBT, especially when combined with GET, can cause iatrogenic harm and is not safe.[5]

In conclusion, the study does not substantiate the claim that iCBT/GET for CFS is efficacious, while there are several indications CBT/GET is not a safe therapy.

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