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Suicide schemas in non-affective psychosis: An empirical investigation

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ABSTRACT

Suicide is the leading cause of premature death among individuals experiencing psychosis. The risk of suicide is proposed to increase with a greater potential for activation of suicide related schemas. Empirical representations of suicide schemas were compared between individuals experiencing non-affective psychosis, with and without a history of suicidal behaviour. Employing a cross-sectional between-groups comparison design, 84 participants, previously diagnosed with a non-affective psychotic disorder, were recruited from community mental health services. Participants completed a demographic questionnaire and clinical measures of psychopathology. To assess participants' suicide schemas, a series of direct and indirect cognitive tasks were designed and administered. Pathfinder analysis enabled the construction of empirically derived representations of the groups' suicide schemas based on responses to the cognitive tasks. The suicide group achieved significantly greater scores on measures of anxiety, depression, hopelessness and suicidality than the non-suicide group, but not on measures indicative of the severity of psychosis. The suicide schema for the suicide group was more elaborate and extensive than for the non-suicide group, even when clinical measures were taken into account. Clinical and theoretical implications are discussed.

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Introduction

Suicide is the leading cause of premature death among individuals experiencing psychosis with the rate of suicide ranging from 147 to 750 per 100,000 persons per year (Heila et al., 1997; Palmer, Pankratz, & Bostwick, 2005). Approximately 40% of patients diagnosed with schizophrenia report suicidal ideation (Tarrier, Barrowclough, Andrews, & Gregg, 2004), 20–40% make at least one suicide attempt during the illness phase and 5–13% end their lives by suicide (Barraclough, Bunch, Nelson, & Sainsbury, 1974; Harris & Barraclough, 1997). The lifetime risk of completing suicide is estimated to be 20–50 times higher than in the general population (Caldwell & Gottesman, 1992).

An established literature now exists describing factors reliably shown to be associated with an increased risk of suicide among people experiencing psychosis, including previous suicide attempts and comorbid mental health problems (Hawton, Sutton, Haw, Sinclair, & Deeks, 2005; Hu et al., 1991; Roy & Draper, 1995). The identification of such risk factors is a major strategy for predicting and preventing suicide (Tatarelli, Pompili, & Girardi, 2006). However, it remains a much more difficult task to prospectively evaluate which individual will eventually complete suicide (Bolton, Gooding, Kapur, Barrowclough, & Tarrier, 2007). In order to develop viable psychological interventions for suicide in psychosis, a better understanding is required of the underlying mechanisms. However, there are few well-articulated, theoretically driven and empirically tested models to explain suicidal behaviour in general (O'Connor & Sheehy, 2000) and in psychosis, in particular (Bolton et al., 2007).

One theoretical model that attempts to explain suicidal behaviour is the Cry of Pain model (Williams, 1997). In brief, events, either directly or indirectly related to psychosis, can present as the necessary stressors for suicide risk. Specifically, situations of social rejections, failure to achieve valued roles or negative self-evaluation may be appraised in terms of defeat. Information processing biases, a negative schema and problem-solving deficits may influence appraisals such that inflexible negative perceptions of the self or negative responses to others become more likely. Positive, constructive exits or escape routes subsequently become limited. This process then elevates a felt sense of pessimism, worthlessness, and helplessness resulting in intractable feelings of entrapment. A real or perceived absence of rescue factors, in the form of social support resources that are available and important, accentuate the effects of this process. Finally, the 'Cry of Pain' can only be acted upon in the presence of imitation models and access to available means.

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Williams' (1997) Cry of Pain model supports a common multi-factor mechanism approach and, as such, should be equally applicable to a range of mental disorders. In recognition of the strengths and limitations of this model, we have developed the Schematic Appraisal Model of Suicide (SAMS; Johnson, Gooding, & Tarrier, 2008). The SAMS model extends the focus upon concepts of defeat, entrapment and 'no rescue' by specifying the key underlying cognitive and behavioural processes associated with suicidal behaviour. Negative information processing biases are thought to feed into a semantic memory system or 'suicide schema' and a multi-stage appraisal system (current, historical, future, self, agency). These latter two systems interact and determine goal directed escape behaviour towards suicide. Our empirical research so far has supported the SAMS model (Johnson, Tarrier, & Gooding, 2008; Tarrier, Gooding, Gregg, Johnson, & Drake, 2007; Taylor, Wood, Gooding, Johnson, & Tarrier, 2009).

The 'suicide schema' can be seen as an example of a semantic network of interconnecting stimulus, response and emotional stored information pertaining to suicide. When activated, this schema will trigger thoughts of suicidal behaviour as an escape strategy from an intolerable emotional or situational state (Bower, 1981). According to spreading activation theories, each time the suicide schema is activated, it becomes strengthened and embellished as it incorporates further cognitive, emotional or stimulus elements, such as experiential psychotic symptoms and associated emotional, cognitive states or consequences (Teasdale, 1988). The more extensive and elaborate the suicide schema becomes, the greater its potential to be re-activated and subsequently even more refined, persistently adding to the individual's risk of eventual suicide. Repeated activation of the schema will lead to associations with a wider range of mood states and contexts; thus increasing the risk of suicidal behaviour in the future (Williams, Crane, Barnhofer, & Duggan, 2005).

It is expected that suicide schemas will vary from individual to individual, since the differential activation model suggests that people differ in the ease with which small changes in mood can reactivate particular networks of self-referent, negative thoughts (Williams et al., 2005). However, Rudd, Joiner, and Rajab (2001) hypothesised consistency across individuals in terms of categories or themes comprising the suicide schemas. Whilst the conceptual notion of schemas has been intuitively appealing since it was introduced into clinical applications by Beck (1967), empirical descriptions of individuals' actual schemas are rare in the literature.

The main aim of the current study was to construct an empirical representation of a suicide schema typical of individuals with psychosis and a history of suicidal behaviour (suicide group) and to compare that suicide schema with a suicide schema typical of individuals with psychosis but with no previous suicidal behaviour (non-suicide group). People with a history of suicidal behaviour are predicted to have activated their suicide schema more often than people without such a history (Lau, Segal, & Williams, 2004). Therefore, the suicide schema generated by the suicide group was hypothesised to be more extensive and elaborate, compared to the non-suicide group.

Since the current study was exploratory in nature, two additional investigations were conducted to examine potential alternative explanations to any differences found between the suicide and non-suicide groups. To investigate the potential influence of psychopathology on suicide schemas (Hawton et al., 2005), the current study examined whether differences in the groups' suicide schemas could be explained by measures of psychopathology. A second exploratory hypothesis suggested the suicide schema generated for individuals with histories of multiple suicide attempts would be more extensive and elaborate than the suicide schema for individuals with one or no previous suicide attempts (Hu et al., 1991; Roy & Draper, 1995).

Method

Design

The study employed a cross-sectional between-groups design with a suicide group, comprising of individuals with a self-reported history of suicidal behaviour, compared with a non-suicide group, with no such history. All participants had previously received a diagnosis of a non-affective psychotic disorder.

Participants and recruitment

Participants were recruited via contact with the adult community mental health, early intervention and assertive outreach services within an NHS trust in the North West of England. Local voluntary sector mental health organisations also supported recruitment. Recruitment was conducted between October 2008 and April 2009. Eligible participants referred to the study by their care team were interviewed by a research psychologist (DP, JJ, PT) at a mutually convenient time and place. Following written consent, clinical measures and cognitive tasks were completed.

The inclusion criteria for participants were (i) aged over 18 years; (ii) a chart diagnosis (ICD-10 criteria) of a non-affective psychosis (schizophrenia, schizophreniform disorder, schizo-affective psychosis, delusional disorder or psychosis not otherwise specified); (iii) under the care of an appropriate clinical team; and (iv) a sufficient grasp of the English language or English as first language to enable the completion of the measures. Participants were excluded from the study if (i) substance misuse or organic disorder was a primary diagnosis or judged to be the major cause of their psychotic experiences, (ii) they were currently acutely suicidal or considered a danger to themselves or others by the clinical team, or (iii) unable to give informed consent (e.g. displaying severe thought disorder). A self-reported history of at least one previous suicide attempt informed group allocation.

Assessments and measures

Anxiety

The Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) was used to assess the severity of participants' anxiety. The BAI is a 21-question multiple-choice self-report inventory that asks participants how much they have been "troubled by each symptom during the past week including today" (such as numbness, hot and cold sweats, or feelings of dread). Items are scored on a 0–3 point scale. The BAI total score ranges from 0 to 63, with higher scores indicating greater severity of anxiety. The BAI has previously been used in psychotic populations (Kuipers et al., 1997; Startup, Freeman, & Garety, 2007).

Depression

The revised version of the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996) is a 21-item multiple-choice self-report inventory. Participants rate how they were feeling for the past fortnight on a four point scale (0–3). The items relate to depressive symptoms, cognitions, and physical symptoms. Responses are summed to provide an overall score ranging from 0 to 63, with higher scores indicating greater severity. The BDI-II is one of the most widely used instruments for measuring the severity of depression and has been used in samples of participants with psychosis (Birchwood, Iqbal, Chadwick, & Trower, 2000; Smith et al., 2006).

Hopelessness

The Beck Hopelessness Scale (BHS) is a 20-item, self-report inventory for measuring three major aspects of hopelessness;

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