Research paper

Acute suicidal affective disturbance: Factorial structure and initial validation across psychiatric outpatient and inpatient samples

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ABSTRACT

Background: A new clinical entity, Acute Suicidal Affective Disturbance (ASAD), was recently proposed to characterize rapid-onset, acute suicidality including the cardinal symptom of behavioral intent. This study examines the proposed ASAD criteria factor-analytically and in relation to correlates of suicidal behavior and existing psychiatric disorders in samples of psychiatric outpatients and inpatients.

Methods: Two samples of psychiatric outpatients (N=343, aged 18–71 years, 60.6% female, 74.9% White) and inpatients (N=7,698, aged 15–99 years, 57.2% female, 87.8% White) completed measures of their ASAD symptoms and psychological functioning.

Results: Across both samples, results of a confirmatory factor analysis supported the unidimensional nature of the ASAD construct. Additionally, results provided evidence for the convergent and discriminant validity of ASAD, demonstrating its relation to, yet distinction from, other psychiatric disorders and correlates of suicide in expected ways. Importantly, ASAD symptoms differentiated multiple attempters, single attempters, and non-attempters, as well as attempters, ideators, and non-suicidal patients, and was an indicator of past suicide attempts above and beyond symptoms of depression and other psychiatric disorders.

Limitations: This study utilized cross-sectional data and did not use a standardized measure of ASAD.

Conclusions: ASAD criteria formed a unidimensional construct that was associated with suicide-related variables and other psychiatric disorders in expected ways. If supported by future research, ASAD may fill a gap in the current diagnostic classification system (DSM-5) by characterizing and predicting acute suicide risk.

1. Introduction

Each year, over 800,000 lives are lost to suicide (World Health Organization WHO, 2014), illustrating the dire need for better characterization and prediction of acute suicide risk. However, several issues limit the accurate assessment of acute suicide risk. First, the majority of suicide risk factors predict suicidal ideation, rather than suicide attempts or death by suicide, and poorly distinguish those who attempt suicide from those who only desire it (Klonsky and May, 2014; May and Klonsky, 2016). As prevalence rates of suicidal ideation are many times higher than rates of suicide attempts (Borges et al., 2012, 2008; Kessler et al., 1999), and suicidal ideation alone is a poor predictor of suicidal behavior (Borges et al., 2008; Fowler, 2012), the widespread use of suicidal ideation as an outcome variable limits the precision with which identified risk factors predict suicide attempts or deaths.

Further, significant diagnostic concerns exist regarding suicidal behavior, as the current classification system for mental disorders – the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (American Psychiatric Association, 2013) – does not fully capture the scope of individuals who experience suicidal thoughts, behaviors, and death by suicide (Aleman and Denys, 2014; Oquendo et al., 2008). Until the publication of the DSM-5, suicidality was conceptualized as a symptom of existing psychiatric disorders (e.g., borderline personality...
disorder [BPD], major depressive disorder [MDD]), rather than as a disorder of its own (Alemán and Denys, 2014). Given that the DSM is a primary framework through which clinicians assess psychiatric symptomatology, the lack of a parsimonious and precise suicide-specific entity may limit the ability of some clinicians to fully assess the entire continuum of suicide-related presentations (i.e., ideation, intention, plans/preparations, attempts, death), as recommended by leading suicide risk assessment protocols (Chu et al., 2015, p. 20; Joiner Jr. et al., 1999), particularly as it pertains to short-term suicide risk. To address this diagnostic void, Suicidal Behavior Disorder (SBD) was introduced to the DSM-5 as a Condition for Further Study (APA, 2013). However, SBD is limited in that it characterizes suicidal behavior as an outcome (i.e., past suicide attempts), without assessing acute danger of a lethal or near-lethal suicide attempt (APA, 2013). Although this information is clinically informative and reflected as such in suicide risk assessment frameworks (Chu et al., 2015), it provides little accurate insight as to whether and when an individual will attempt suicide in the future (Ribeiro et al., 2016). SBD also does not emphasize warning signs for suicide (Rudd, 2008), which may aid in short-term risk prediction. Critically, “clear and imminent danger to self” remains operationally and clinically elusive, precluding accurate assessment of acute suicide risk.

Despite relatively limited research on factors that specifically predict suicidal behavior, as opposed to suicidal ideation, and insufficient diagnostic characterization of suicidality, support exists for several constructs as acute risk factors and warning signs for suicide (Chu et al., 2015; Rudd et al., 2006), including agitation (Busch et al., 2003; Ribeiro et al., 2011), sleep disturbances (e.g., insomnia and nightmares; Bernert and Nadorff, 2015; Figeon et al., 2012), marked irritability (Trivedi et al., 2011), social withdrawal (Duberstein et al., 2004; Joiner, 2005; Van Orden et al., 2010), and severe affective states (Ihedin et al., 2010, 2007). These factors have been identified as having the potential to lead an individual with suicidal thoughts to engage in suicidal behaviors (Glenn and Nock, 2014; Klonsky and May, 2014). In light of the diagnostic gap in the DSM-5, and in an effort to extract meaningful information from these psychological states and theory-driven predictors of suicide into a parsimonious characterization of acute suicide risk, Joiner and colleagues (Joiner et al., In preparation; Tucker et al., 2016) proposed a new clinical entity, theorized to characterize acute, drastic spikes in suicidality: Acute Suicidal Affective Disturbance (ASAD). The proposed diagnostic criteria for ASAD were derived from a combination of clinical experience, legal cases, examination of near-term factors in suicide decedents, and modern theories of suicide (e.g., the interpersonal theory of suicide, three-step theory). They include:

(a) A geometric increase in suicidal intent over the course of hours or days, as opposed to weeks or months
(b) One or both of the following: marked social alienation (e.g., severe social withdrawal, disgust with others, perceptions that one is a burden on others) or marked self-alienation (e.g., self-disgust, perceptions that one’s psychological pain is a burden)
(c) Perceptions that the foregoing are hopelessly intractable
(d) Two or more manifestations of overarousal (i.e., agitation, insomnia, nightmares, irritability).

All four criteria must be present for a diagnosis of ASAD. Furthermore, ASAD must not be the direct result of an exacerbation of a mood disorder or substance use. Despite patients’ perceptions that the condition is intractable, ASAD is posited to be time-limited, such that symptoms will abate over time, especially if appropriately clinically monitored and managed.

ASAD is intended to characterize specific occurrences of suicide risk within individuals, a diagnosis of which would signal the possibility of recurrence to treating clinicians. It may also, however, reflect a syndrome in specific individuals that leads to recurrent spikes in suicidal intent and related symptoms. Importantly, this disturbance is theorized to be a unified construct, such that symptoms occur simultaneously alongside heightened behavioral intent with a rapid onset (criterion A). Much like the heterogeneity of MDD and BPD, of which there are 227 and 256 symptom combinations warranting each diagnosis, respectively (Biskin and Paris, 2012; Zimmerman et al., 2015), the heterogeneity of ASAD symptoms does not preclude its unification as a clinically useful construct. Importantly, unidimensionality among psychological constructs is paramount not only in construct validation and theory-testing, but also in the systematic development of a valid diagnostic classification that represents a single clinical entity formed from symptom clusters (see Smith et al., 2009, for a more thorough discussion of this issue).

Indeed, preliminary principal components analyses among university students and psychiatric patients suggest a one-factor model provides strong fit for constructs comprising ASAD (Joiner et al., In preparation; Tucker et al., 2016). Evidence also exists for convergent, discriminant, and predictive validity, as ASAD differentiated multiple attempters, single attempters, ideators, and non-attempters, and was an indicator of past suicide attempts above and beyond a variety of suicide-related constructs (Tucker et al., 2016). However, replication of these findings and further examination of the existence and clinical utility of ASAD is needed in diverse samples and settings in order to confirm and bolster the veracity of these findings.

There is also a need to examine ASAD in relation to other commonly-cited correlates of suicidal thoughts and behaviors, including symptoms of depression and anxiety (Bentley et al., 2016; Rogers et al., 2016a), anxiety sensitivity (Capron et al., 2012), rumination and other forms of emotion dysregulation (Law et al., 2015; Miranda and Nolen-Hoeksema, 2007; Rogers and Joiner, under review), certain types of impulsivity – particularly negative urgency (Anestis et al., 2014; Berg et al., 2015), capability for suicide (Klonsky and May, 2015; Van Orden et al., 2010), and a dynamic wish to live/die (Bryan et al., 2016; Kovacs and Beck, 1977). Specifically, ASAD should be positively related to each of these variables (negatively with wish to live), though likely with a small-to-moderate effect size, as the majority of these variables are related to suicidal ideation, rather than suicide attempts specifically (capability for suicide being the primary exception). In contrast, ASAD may occur in the hours or days preceding suicidal behavior.

2. The present study

The aims of the present study were to (1) replicate the unidimensional factor structure of the proposed ASAD criteria using the more statistically stringent confirmatory factor analyses (CFAs); (2) establish convergent and discriminant validity of ASAD with common correlates of suicidality and psychiatric diagnoses; (3) determine the ability of ASAD to differentiate by attempter and ideator status; and (4) examine whether ASAD is associated with past suicide attempts above and beyond depression and other psychiatric diagnoses. We examined these aims in samples of psychiatric outpatients (Study 1) and inpatients (Study 2), in whom suicide risk is known to be elevated (Qin and Nordenstfo, 2005) and for whom an ASAD diagnosis may be particularly clinically informative. We also included both samples in an effort to (1) demonstrate similar results in the model fit of ASAD within samples of varying severity (outpatient, inpatient) and in whom different proxy measures for ASAD were utilized; and (2) identify similarities and differences in ASAD across sample type.

3. Study 1: Methods

3.1. Participants and procedures

Participants were 343 outpatients (60.6% female) receiving psychological services at a university-affiliated clinic. Due to the clinic’s
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