



Predictors of daily life suicidal ideation in adults recently discharged after a serious suicide attempt: A pilot study



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ABSTRACT

The aims of the study are to examine the predictive role of fluctuations in daily life mood, social contexts, and behavior on subsequent suicidal ideation (SI); and to identify clinical and psychological factors associated with the general frequency of SI in a high-risk sample. The sample comprised 42 adults (73.8% female) hospitalized for a suicide attempt. Immediately following hospital discharge, they used Ecological Momentary Assessment for seven consecutive days, providing repeated measures of SI, environmental, contextual, and behavioral factors. Controlling for prior SI, a number of contextual variables were associated with subsequent SI. Being at home or at work were both associated with an increased probability of SI, while being in the home of close others, or in a festive or leisure environment decreased SI probability. Working, passive leisure and inactivity all increased the likelihood of SI. Being alone increased SI while being with close others significantly reduced this risk. Finally, no overall effect for stressful events was found but negative family events specifically were associated with increased likelihood of SI ($\gamma = 0.448$, $t = 2.255$, $df = 29$, $p < 0.05$). The findings provide preliminary results regarding proximal environmental and behavioral factors associated with the occurrence of suicidal ideation in a high-risk sample.

1. Introduction

It is widely believed that suicidal thoughts are a precondition for suicidal behavior; in other words, one must formulate the idea to engage in a suicidal act before taking such action (Kessler et al., 1999). Accordingly, proximal suicide contemplation preceding suicidal behavior (Bagge et al., 2013) may serve as a key target for prevention and intervention efforts. However, suicide contemplation is shown to fluctuate over time and to vary considerably within-person (Nock et al., 2009). Thus, from a prevention perspective, it is critical to understand what factors assessed in the minutes or hours before suicidal ideation may predict the occurrence of these thoughts and intentions. Suicidal ideation is a fleeting experience that may be better understood and treated by utilizing novel methods and intensive longitudinal data collection, so as to provide a clearer picture of the cognitive and emotional context in which suicidal thoughts arise.

The emergence of ambulatory monitoring techniques such as

Ecological Momentary Assessment (EMA) offer the opportunity to understand the immediate precursors of SI in daily life through the assessment of behaviors, experiences and mood states in real-time (Arney et al., 2015; Davidson et al., 2016a). EMA is based on ambulatory repeated self-reported brief electronic interviews for the assessment of variables in real time and in natural settings (Swendsen and Salamon, 2012). Typically persons are equipped with a smartphone and are prompted to complete a brief questionnaire several times a day over a period of one week or more, yielding a large number of in vivo observations per person. These techniques have been validated for use among persons with mental disorders who are at increased risk for suicide or self-harm (Barge-Schaapveld et al., 1999; Cooney et al., 2007; Granholm et al., 2007; Hilbert and Tuschen-Caffier, 2007; Husky et al., 2014, 2009; Johnson et al., 2009a; Kashdan and Steger, 2006; Myin-Germeys et al., 2003; Putnam and McSweeney, 2008; Santangelo et al., 2012; Serre et al., 2012a, 2012b; Smyth et al., 2007; Swendsen et al., 2011). Importantly, the use of EMA in patients at high risk for

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suicide has been shown to be feasible and reliable and to have no immediate deleterious effects, as the repeated ambulatory monitoring does not directly influence the frequency of suicidal ideation (Husky et al., 2014).

Investigations using ambulatory assessments to study SI and behavior remain limited in number, but their findings have generally underscored the important risk posed by fluctuations in negative mood. In a sample of inpatients with major depression, self-reports of sadness, tension, and boredom were found to predict subsequent SI later in the day, independently of SI status at the time of assessment of predictor variables (Ben-Zeev et al., 2012). A study of proximal predictors of thoughts of self-harm or the experience of negative mood among prison inmates reported that anger was associated with concurrent (but not subsequent) SI (Humber et al., 2013), and suicidal behavior among individuals with borderline personality disorder has also been shown to increase following periods of negative mood (Links et al., 2007). It is important to note, however, that these investigations have most often used paper-and-pencil diary techniques that may provide inaccurate information concerning the time at which assessments were completed (Broderick et al., 2003). The only investigation to date that has used electronic EMA to examine suicidal and non-suicidal self-injurious thoughts and behaviors did so among adolescents and young adults with a recent history of self-injury (Nock et al., 2009). This latter study confirmed the role of concurrent negative mood, but also revealed that self-injurious thoughts most often occurred when adolescents were alone or with peers, and less often when they were with family members or strangers.

Despite its importance, the focus of previous EMA investigations on negative mood alone may ignore a host of social, environmental and behavioral variables that may have important links with SI. Moreover, the assessment of only concurrent associations among variables prevents conclusions concerning their prospective, and potentially causal, role relative to SI onset. In response to these concerns, the current study examined the phenomenology of SI in daily life through electronic EMA administered to individuals recently discharged from the hospital following a suicide attempt. The objectives are: 1) to examine the predictive role of fluctuations in daily life mood, social contexts, and behavior on subsequent suicidal ideation; and 2) to identify clinical and psychological factors associated with the general frequency of suicidal ideation in this high-risk sample.

2. Methods

2.1. Participants

Participants were adults hospitalized in a specialized unit of a university hospital following a suicide attempt between July 2010 and October 2012 and who were scheduled for discharge. All patients approached for the present study were enrolled in a larger investigation of suicidal behavior that included a genetic component requiring individuals to be Caucasian of Western European descent. Pregnant or breastfeeding women, and persons who were not able to read were also excluded. Of the 48 participants who were offered participation in the EMA protocol, a total of 42 patients were enrolled.

2.2. Procedure

The study was approved by the local research ethics committee (CPP Montpellier Sud-Méditerranée IV, CHU Montpellier) and conducted according to the tenets of the Declaration of Helsinki. After providing written informed consent, participants were assessed concerning baseline depression levels, prior history of attempts, lifetime mental disorders as well as other psychological variables. Participants were then trained in how to use the mobile device (Tungsten E2 palm) for the EMA assessments. After completion of the training, each participant was given an EMA device to carry with them for the seven

consecutive days immediately following their discharge from the hospital. Each device was programmed to administer five electronic interviews per day with the timing of the interviews occurring within a sampling window ranging from 8:00 a.m. and 10:00 p.m. The sampling windows were adjusted to accommodate each participant's typical sleep and wake schedules so as not to modify usual daily life activities. One electronic interview was administered randomly within five time periods, with a minimum spacing of one hour between any two assessments. All participants were contacted by phone by a member of the research team on the second day of the study to answer any questions and resolve any technical issues, and again on the fifth day to remind participants to charge the device's battery. At the end of the seven-day assessment period, participants returned the device to the research staff and data were uploaded for analysis.

2.3. Measures

2.3.1. Clinical variables and psychiatric status

A suicide attempt was defined using the National Institute of Mental Health definition: "a potentially self-injurious behavior with a non-fatal outcome, for which there is evidence (either explicit or implicit) that the person intended at some (nonzero) level to kill himself/herself" (Brodsky et al., 2008; Silverman et al., 2007). The age of the first suicide attempt, the number of lifetime suicide attempts, as well as the severity (defined as requiring intensive care interventions) of the latest attempt were assessed as part of standard hospital procedures.

Lifetime psychiatric disorders were diagnosed by trained psychiatrists or psychologists from according to DSM IV criteria and using the French version of the Mini International Neuropsychiatric Interview (MINI 5.0.0) (Lecrubier et al., 1997; Sheehan et al., 1998).

The HAMD-17 (Hamilton, 1960) and the state STAI-Y (Spielberger, 1983) were used to assess the participants' current level of depression and anxiety, respectively.

Childhood traumatic events were also assessed using the Childhood Trauma Questionnaire (CTQ) (Bernstein et al., 2003). Finally, impulsivity was assessed by the tenth version of the Barratt Impulsiveness Scale (Barratt, 1985), and the State Trait Anger Expression Inventory (STAXI) was used to measure the expression of anger either directed inward or outward (Spielberger, 1999).

2.3.2. EMA measures

2.3.2.1. Behavior, environment, and social contexts. At each assessment, participants were asked to describe their current activity, location, and social company (if any). The response options provided to participants were based on those established through previous ambulatory monitoring investigations (Husky et al., 2007; Johnson et al., 2009b).

2.3.2.2. Daily life events. Using the inventory of small life events (Zautra et al., 1986) participants were asked to identify the most salient daily life event they experienced since the previous signal, to classify the event according to different categories including different types of social events (e.g. friends, partner, family) and then to rate the stressfulness of that event on a scale from 1 (not stressful at all) to 7 (extremely stressful). Specific events were then combined with the stressfulness scale to reflect the negativity of specific events.

2.3.2.3. Mood states. Participants were asked what degree of intensity would best describe their current feelings regarding sad, anxious, angry, impulsive, and happy mood states as well as optimism. Participants selected a number using Likert scales ranging from 1 'not at all' to 7 'extremely' for each variable assessed.

2.3.2.4. Suicidal ideation. In order to avoid unnecessary repetition of questions concerning suicidal ideation, a gate question was first administered at each assessment asking participants to rate the frequency of positive or negative thoughts since the previous

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