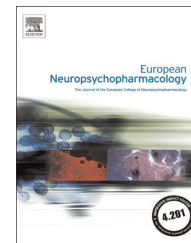




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Suicidal behaviour in first-episode non-affective psychosis: Specific risk periods and stage-related factors

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Abstract

Suicide is a major cause of premature death in psychosis. Earlier stages have been associated with higher risk. However, such risk periods have not been specifically determined and risk factors for suicidal behaviour may change over those periods, which may have crucial implications for suicide prevention. The aim of this study was to determine and characterize the highest risk period for suicide in a representative sample of first-episode psychosis (FEP) patients. Suicidal behaviour prior to first presentation of psychosis and during a 3-year follow-up was examined in a sample of 397 individuals. Risk factors for suicidal behaviour during specific time periods were investigated and compared. The greatest suicide risk was found during the month before and 2 months after first contact with psychiatric services (i.e., 'early' attempts). Severity of depressive symptoms and cannabis use emerged as predominant risk factors across time. 'Early' attempters were characterized as being male, living in urban areas, having poor premorbid adjustment, requiring hospitalization, scoring higher on anxiety measures and unusual thought content than non-attempters. Greater suspiciousness and more severe depressive symptoms distinguished the 'late' attempters. In conclusion, there is a specific high risk period for suicide in FEP around the time of the first presentation. Early intervention programmes targeting phase-specific risk factors, particularly psychotic symptoms

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management and secondary depression prevention strategies may be useful for suicide prevention in psychosis.

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1. Introduction

The lifetime risk of suicide following first-episode psychosis (FEP) is approximately 5% (Dutta et al., 2010; Hor and Taylor, 2010; Palmer et al., 2005). Between 15% and 26% of FEP patients have made at least one suicide attempt by their first treatment contact, and 2-11% attempt to end their lives over the first year after treatment onset (Melle et al., 2006).

A history of previous suicide attempts and severity of depressive symptoms have been repeatedly associated with a higher suicide risk (Bakst et al., 2010a; Large et al., 2011; Pompili et al., 2011). Other potential contributors include being young and male (Hor and Taylor, 2010); possessing a high IQ and better neurocognitive functioning, in particular higher executive function (Lara et al., 2015; Nangle et al., 2006); a high level of education and high socio-economic status, poor premorbid adjustment, living alone, the severity of psychotic symptoms, a longer duration of untreated psychosis, types of insight, a family history of suicide and a higher rate of substance abuse (Drake et al., 2004; Harvey et al., 2008; Hor and Taylor, 2010; Lopez-Morinigo et al., 2012; Serafini et al., 2012). Compliance with treatment has been demonstrated to reduce suicide risk (Qin et al., 2006).

Some studies show that the periods of the greatest risk of suicide in FEP patients are shortly before and after hospitalization (Harvey et al., 2008; Melle et al., 2006). Flanagan and Compton, 2012 found nearly one-quarter of patients endorsed a history of suicidal ideation in the two weeks prior to first admission and should be carefully monitored among initiating treatment and during the early course of illness. It should be pointed out that such a history may influence clinicians in the decision to admit and hence this is observation is somewhat circular. To our knowledge, little is known about this period of extreme risk because studies that specifically investigated suicidality surrounding admission are limited (Fedyszyn et al., 2010; Melle et al., 2006). The highest suicide risk period in FEP patients remains unclear, as do possible changes to the contributors to suicide risk over the early stages of the psychotic illness. To address this further, there is a need for studies on large FEP samples and longitudinal designs.

1.1. Aims of the study

The aim of this study was to determine and characterize the highest risk period for suicide in a representative sample of FEP patients. We focused on examining premorbid, demographic, clinical, insight and neurocognitive characteristics that are potentially related to suicide risk before the first presentation to psychiatric services and over the follow-up period. We hypothesized that 1) suicide attempts will be more likely to occur in the period around the first contact

with psychiatric services and related to psychotic symptoms and neurocognitive function and 2) suicide attempts later in the follow-up period will be linked to insight, depressive symptoms and certain specific premorbid and demographic characteristics.

2. Experimental procedures

2.1. Study design and setting

Data for the present study came from a large epidemiological and 3-year longitudinal study of first-episode psychosis (PAFIP) conducted at the outpatient clinic and the inpatient unit at the University Hospital Marques de Valdecilla, Santander, Spain. This study was approved by the local institutional review board and informed consent from participants was obtained. A more detailed description of our programme has been previously reported (Pelayo-Teran et al., 2008).

All referrals to PAFIP over 2001-2010 were screened with the following inclusion criteria: age 15-60 years; living in the catchment area; experiencing their first episode of psychosis; no prior treatment with antipsychotic medication or, if previously treated, a total life time of adequate antipsychotic treatment of less than 6 weeks; meeting DSM-IV criteria for brief psychotic disorder, schizophreniform disorder, schizophrenia, or schizoaffective disorder. DSM-IV criteria for drug dependence and mental retardation and having a history of neurological disease or head injury were exclusion criteria.

Three hundred and ninety seven patients who met inclusion criteria were included in the PAFIP program during this time interval. Diagnoses were made using the Structured Clinical Interview for DSM-IV (SCID-I) (First et al., 1996), which was carried out by an experienced psychiatrist (BC-F) 6 months after the baseline visit. In particular, the baseline diagnoses of our FEP patients (i.e. six months after first contact) were as follows: schizophrenia ($N=224$), schizophreniform disorder ($N=96$), schizoaffective disorder ($N=5$), brief psychotic disorder ($N=41$), psychosis NOS ($N=29$) and delusional disorder ($N=2$). At three years, diagnoses were: schizophrenia ($N=274$), schizophreniform disorder ($N=60$), schizoaffective disorder ($N=17$), brief psychotic disorder ($N=22$), psychosis NOS ($N=22$), and delusional disorder ($N=1$).

2.2. Measures

2.2.1. Premorbid and sociodemographic variables

Information was obtained from patients, relatives and medical records. This included sex, age at admission, age at onset and duration of untreated psychosis (DUP). Other sociodemographic variables collected were: years of education, relationship status ("married/cohabiting" vs. "single/divorced/separate or widowed"), living status ("alone" vs. "other"), socio-economic status derived from the parents' occupation ("low" vs. "other"), employment status ("employed" vs. "unemployed"), living area ("urban" vs. "rural", which included those living in areas with less than 10,000 inhabitants), cannabis and alcohol use (self-reported as yes/no) and first degree family history of psychosis (yes/no). Premorbid social adjustment (PAS) (Cannon-Spoor et al., 1982) was split around the

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