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Anxiety sensitivity cognitive concerns predict suicide risk

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ABSTRACT

Anxiety sensitivity (AS) cognitive concerns, which reflects fears of mental incapacitation, have been previously associated with suicidal ideation and behavior. The first study aim was to replicate and extend upon previous research by investigating whether AS cognitive concerns can discriminate between those at low risk versus high risk for suicidal behavior. Secondly, we aimed to test the incremental predictive power of AS cognitive concerns above and beyond known suicide risk factors (i.e., thwarted belongingness and insomnia). The sample consisted of 106 individuals (75% meeting current criteria for an Axis I disorder) recruited from the community. Results revealed that AS cognitive concerns were a robust predictor of elevated suicide risk after covarying for negative affect, whereas AS social and physical concerns were not. Those with high, relative to low, AS cognitive scores were 3.67 times more likely to be in the high suicide risk group. Moreover, AS cognitive concerns significantly predicted elevated suicide risk above and beyond relevant suicide risk factors. Results of this study add to a growing body of the literature demonstrating a relationship between AS cognitive concerns and increased suicidality. Incorporating AS cognitive concerns amelioration protocols into existing interventions for suicidal behavior may be beneficial.

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1. Introduction

According to the Centers for Disease Control and Prevention, suicide is the 10th leading cause of death for Americans, with someone in the country dying by suicide every 13.7 min (CDC, 2010). Previous research has found that death by suicide is strongly predicted by both suicidal ideation and suicide attempt history (Weissman et al., 1989; Kessler et al., 1999). In addition, the National Comorbidity Survey found that approximately 70% of individuals with a lifetime history of suicide attempt met criteria for at least one anxiety disorder (Sareen et al., 2007). Recent research has indicated that anxiety disorders are significantly related to suicide, even after accounting for other relevant constructs such as depression. For example, Nepon et al. (2010) found anxiety disorders to be significantly associated with an increase in suicide attempts, even after covarying for Axis I and Axis II diagnoses.

Accurate categorization of suicide risk is clinically vital, helping to guide arguably the most important decisions a mental health care provider will have to make. Therefore, identifying risk factors that help to discriminate between individuals at low versus high risk for serious suicidal behavior is an important avenue for research. Previous research has proposed that there are distinct differences in suicide risk between individuals with passive thoughts about suicide and individuals with a plan to kill themselves and/or a prior attempt (Joiner et al., 1999; Wingate et al., 2004). Specifically, two factors are particularly important when considering suicide risk: (1) past attempt history and (2) the nature of suicidal symptoms (i.e., resolved plans versus ideation) (Joiner et al., 1999). Within this framework, individuals with a past history of suicide attempt and/or resolved plans and preparations are at higher risk for death by suicide, whereas individuals showing only suicidal ideation are considered at a low risk.

One factor that has received recent attention in regard to suicide risk is anxiety sensitivity (AS), which refers to an individual's fear of anxiety-related sensations (Reiss et al., 1986). Previous research has established AS as a multidimensional construct comprised of three separate dimensions referring to fears of the physical, cognitive and social domains of anxiety (Taylor et al., 2007a). The AS physical concerns subscale reflects a fear of physical disaster (e.g., "It scares me when my heart beats rapidly"), such as a heart attack. The AS social concerns subscale reflects adverse social consequences associated with anxiety (e.g., "I worry that other people will notice my anxiety"). AS cognitive concerns refer to an individual's fear of cognitive dyscontrol or mental incapacitation (e.g., When my thoughts seem to speed up, I worry that I might be going crazy") while feeling anxious or stressed.

AS is robustly associated with various forms of anxiety psychopathology (Taylor et al., 1992; Schmidt et al., 1997, 2006; Rodriguez et al., 2004). In addition, recent research has consistently suggested AS as an important risk factor involved in suicidal ideation and attempt history (Capron et al., 2012b, 2012c). AS cognitive concerns, in

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particular, appear to play an important role in suicide. Specifically, Capron et al. (2012c) found an association between AS cognitive concerns and suicidal ideation and suicide attempt in a sample of clinical outpatients. In addition, AS cognitive concerns were found to prospectively predict the initiation of suicidal ideation in a group of military cadets (Capron et al., 2012b). This association has been described within the depression–distress amplification model (Capron et al., 2012d), which suggests that AS cognitive concerns amplify the distress caused by uncomfortable feelings experienced when an individual is depressed. Specifically, the depression–distress amplification model proposes AS cognitive concerns as the mechanism that exacerbates the feelings of distress that accompany dysphoria. Suicidal ideation, a symptom of severe depression, manifests once the distress resulting from amplified depression reaches severe levels.

Despite emerging evidence suggesting an important relationship between AS cognitive concerns and suicidality, there are still a number of gaps in the literature. First, prior research has not investigated the predictive power of AS cognitive concerns in discriminating between individuals at low versus high risk for suicide attempts. Given the clinical importance of suicide risk classification, it is vital to examine the relationship between AS cognitive concerns and suicide indicators (e.g., whether individuals have a plan to kill themselves or have made a prior attempt) that are central to predicting risk. Second, in previous research examining the relationship between AS cognitive concerns and suicide attempt history (Capron et al., 2012b, 2012c), the original ASI (Reiss et al., 1986) was used to measure AS cognitive concerns. Continuing to elucidate this relationship using the ASI-3 (Taylor et al., 2007a) is needed, as this newer scale was designed to more reliably measure the AS subfactors. Finally, prior research has primarily investigated this relationship in fairly homogenous samples, thus limiting the generalizability of these findings.

The aim of the current study was to address these current gaps in the AS cognitive concerns and suicide literature by: (1) utilizing a treatment-seeking sample with various anxiety and mood diagnoses; (2) using a more psychometrically refined measure of AS cognitive concerns (i.e., ASI-3); (3) examining the predictive power of AS cognitive concerns in discriminating between those at low versus high risk for serious suicidal behavior; (4) testing the specificity of this relationship within the AS subfactors and (5) examining the specific association between AS and serious suicidal behavior, above and beyond the influence of other relevant suicidal risk factors including thwarted belongingness and insomnia. Thwarted belongingness and insomnia were included as covariates in the present investigation given their strong association with both suicidal behavior and anxiety sensitivity (Joiner et al., 2009; Joiner, 2009; Fairholme et al., 2012; Nadorff et al., 2012). Based on previous findings (Schmidt et al., 2001; Capron et al., 2012a, 2012c), we hypothesized that AS cognitive concerns would significantly predict individuals at low versus high risk for serious suicidal behavior after accounting for negative affectivity, whereas AS physical and social concerns would not. In addition, we hypothesized that AS cognitive concerns would robustly discriminate between those at a low versus high risk for serious suicidal behavior after covarying for thwarted belongingness, insomnia and negative affectivity.

2. Methods

2.1. Participants

106 individuals were recruited from the community to participate in a randomized clinical trial investigating the effects of a computerized treatment targeting specific risk factors associated with suicidality and post-traumatic stress disorder (PTSD), namely AS. Data for the present report were collected as part of a larger study (Schmidt et al., 2014). To be included, individuals had to be 18 years of age or older, English speakers, and report elevated levels of AS cognitive concerns. Individuals were excluded if they were suffering from psychotic and/or bipolar-spectrum disorders or were not stabilized on medication. Ages of the participants ranged from 18 to 87 ($M=40.80$, S.D.$=17.45$) and gender was fairly evenly distributed (46.2% males). 50.9% were single, 17.9% married, 4.7% separated, 0.9% cohabitating, and 25.6% were divorced or widowed. The race/ethnicity was distributed as such: 67.9% White, 20.8% Black, 3.8% Hispanic, 0.9% Asian and 6.6% Other (e.g., bi-racial). With regard to the diagnostic makeup of the sample, participant's primary diagnoses were as follows: 36% anxiety disorders, 17% trauma and stressor-related disorders, 4% obsessive–compulsive and related disorders, 15% mood disorders, 3% substance-related diagnosis, 21% no diagnosis and 4% other (e.g., anorexia nervosa).

2.2. Procedure

Individuals were recruited from the community via newspaper advertisements and flyers. Those deemed potentially eligible after an initial screening process were scheduled for a baseline appointment during which they completed a battery of self-report measures and a semi-structured diagnostic interview for the DSM-IV-TR Axis I disorders (First et al., 1996). Following the baseline assessment, eligible participants were randomly assigned to either a cognitive anxiety sensitivity treatment or a health information control condition. After the treatment phase, individuals were followed up at 1 month post-treatment. The current study utilizes data obtained during the baseline appointment, which took place prior to randomization and the onset of treatment. All procedures were approved by the university's institutional review board and data was collected after informed consent was obtained.

2.3. Measures

2.3.1. Clinician administered

2.3.1.1. Structured Clinical Interview for DSM-IV (SCID). All psychiatric diagnoses were determined using the SCID-NP (First et al., 1996). The SCID was administered by trained doctoral candidate therapists who completed extensive training in the administration and scoring of the SCID. Training included reviewing SCID training tapes, observing live SCID administrations, and conducting mock interviews with other trained therapists. Throughout the process of training, all trainees received feedback until they demonstrated high levels of reliability. In addition, all SCIDs were reviewed by a licensed clinical psychologist to ensure accurate diagnoses. Percent agreement between clinical interviewers for random sample of these SCID interviews resulted in high inter-rater agreement (e.g., over 80% with a kappa of 0.77).

2.3.2. Self-report measures

2.3.2.1. Anxiety Sensitivity Index-3 (ASI-3). The ASI-3 is an 18-item self-report questionnaire designed to measure fears of physiological arousal (Taylor et al., 2007b). The ASI-3 is a modification of the original ASI (Reiss et al., 1986). The multidimensional scale assesses three of the most commonly replicated subfactors of anxiety sensitivity (physical, cognitive, and social concerns). Respondents were asked to read a series of statements and rate the degree to which they agreed with each statement (e.g. "It scares me when my heart beats rapidly", "When I cannot keep my mind on a task, I worry that I might be going crazy" and "I worry that other people will notice my anxiety") using a five-point Likert type scale ranging from 0 (*Very little*) to 4 (*Very much*). Research has demonstrated that the ASI-3 is a reliable and valid measure of anxiety sensitivity (Taylor et al., 2007b). For the present analyses, internal consistency was good for the ASI-3 cognitive, physical, and social concerns subscales ($\alpha=0.94$, $\alpha=0.89$, $\alpha=0.88$).

2.3.2.2. Interpersonal Needs Questionnaire (INQ). The INQ is a 15-item self-report questionnaire designed to measure two constructs defined by the Interpersonal Theory of Suicide: thwarted belongingness and perceived burdensomeness (Van Orden et al., 2010). Individuals are asked to read a series of statements and rate how they have been feeling recently on a seven-point Likert type scale ranging from 1 (*Not at all true for me*) to 7 (*Very true for me*). Previous research has demonstrated high internal consistency and construct validity for both subscales (Van Orden et al., 2008, 2012). In the present investigation, only five items from thwarted belongingness subscale were administered, as they were part of a larger ongoing study. In the current sample, internal consistency for this subscale was excellent ($\alpha=0.94$).

2.3.2.3. Insomnia Severity Index (ISI). The ISI is a brief five-item self-report questionnaire assessing current sleep difficulties, satisfaction with current sleep pattern, and interference with everyday functioning due to sleep difficulties (Bastien et al., 2001). Items are rated on a five-point Likert type scale. The ISI has been demonstrated to be both a valid and reliable measure of insomnia (Bastien et al., 2001). Only a subset of items were included in the questionnaire battery (i.e., items one through three), as they were part of a larger ongoing investigation. The questionnaire demonstrated good reliability ($\alpha=0.86$) in the current sample.

2.3.2.4. Positive and Negative Affect Schedule-Expanded Form (PANAS-X). The PANAS-X is a 60-item self-report measure consisting of 13 subscales including negative affect (Watson and Clark, 1999). Items are rated on a five-point Likert type scale ranging from 1 (*Very slightly or none*) to 5 (*Extremely*). Previous research has indicated that the PANAS-X has acceptable internal consistency, temporal

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