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Suicidal ideation and risk factors in primary care patients with anxiety disorders

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A B S T R A C T

The presence of an anxiety disorder is associated with greater frequency of suicidal thoughts and behaviors. Given the high personal and societal costs of suicidal behaviors, suicide prevention is a priority. Understanding factors present within individuals with anxiety disorders that increase suicide risk may inform prevention efforts. The aims of the present study were to examine the prevalence of suicidal ideation and behaviors, as well as factors associated with suicide risk in patients with anxiety disorders in primary care. Data from a large scale randomized controlled study were analyzed to assess prevalence of suicidal thoughts and behaviors, as well as factors associated with suicide risk. Results revealed that suicidal ideation and behaviors were relatively common in this group. When examining mental and physical health factors jointly, presence of depression, mental health-related impairment, and social support each uniquely accounted for variance in suicide risk score. Methodological limitations include cross-sectional data collection and lack of information on comorbid personality disorders. Moreover, patients included were from a clinical trial with exclusion criteria that may limit generalizability. Results highlight the complex determinants of suicidal behavior and the need for more nuanced suicide assessment in this population, including evaluation of comorbidity and general functioning.

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1. Introduction

Global estimates suggest that each year there are 10–20 million suicide attempts and one million completed suicides (World Health Organization (WHO), 1999). Suicide attempts are costly in terms of occupational and interpersonal disruption (American Foundation for Suicide Prevention, 2009). Moreover, substantial financial costs are associated with the intensive psychiatric resources devoted to these patients (Rissmiller et al., 1994). Thus, understanding features and correlates of suicide is a critical public health matter.

One challenge in studying suicide is the relatively low base rate of attempted and completed suicides observed in most populations. Valuable information may instead be gained by studying factors that are associated with increased risk of suicide. Suicidal ideation and past suicide attempts are associated with risk for future suicide attempts and completions (Harris and Barraclough, 1997; Kessler et al., 1999; Kuo et al., 2001; Joiner et al., 2003; ten Have et al., 2009). Studying such thoughts and behaviors, therefore, may increase our understanding of who is likely to attempt or complete suicide, potentially informing suicide risk management and prevention efforts.

The presence of current or lifetime anxiety disorders, including panic disorder (PD), social phobia (SP), generalized anxiety disorder (GAD), and posttraumatic stress disorder (PTSD), is associated with increased suicide risk (Khan et al., 2002; Cougle et al., 2009a,b; Nepon et al., 2010; Nock et al., 2010; Lopez-Castroman et al., 2011). Individuals with anxiety disorders demonstrate increased suicidal ideation (Sareen et al., 2005a) and rates of self injury (Chartrand et al., 2012) and more frequent suicide attempts (Bolton et al., 2008; Sareen et al., 2005a,b) than those without mental health disorders. For these reasons, understanding factors associated with suicide risk within individuals with anxiety disorders is critical to managing this population.

In spite of the increased risk of suicide within anxiety disordered patients, the specific determinants of risk within this group are poorly understood. Studies of individuals with specific anxiety disorders including PD, SP, and PTSD indicate that the additional presence of depression and substance use disorders increases suicide risk (Noyes et al., 1991; Lepine et al., 1993; Warshaw et al., 1995, 2000). Severity and aspects of functional impairment are also related to suicide risk in patients with anxiety disorders. For example, anxiety symptom severity is associated with increased suicidal ideation and attempts in PD and PTSD patients (Noyes et al., 1991; Freeman and Moore, 2000; Huang et al., 2010). Associations between suicide risk and impairment in general functioning in PTSD (Tarrier and Gregg, 2004; Panagioti et al., 2011) and social functioning in both PTSD and PD (Noyes et al., 1991; Huang et al., 2010; Panagioti et al., 2011) are also documented. However, few studies in patients with anxiety disorders comprehensively account for mental *and* physical health conditions and impairment that may be associated with suicide risk (although see Freeman and Moore (2000) for an exception). The high comorbidity of anxiety disorders and physical health problems (Maier and Falkai, 1999; Levinson et al., 2008; Castro et al., 2009; Nicolson et al., 2009) suggests that the relationship between physical health and suicide in this population merits consideration. Physical health factors generally associated with suicide risk include pain (Braden and Sullivan, 2008; Ilgen et al., 2008), chronicity of medical conditions (Goodwin et al., 2003; Bartels et al., 2002; Robson et al., 2010), and functional limitation due to physical conditions (Kaplan et al., 2007; Park et al., 2010). Thus, our aim was to examine the potential contribution of these factors, along with other established predictors, to suicidality in individuals with anxiety disorders.

Primary care is an important setting to examine correlates of suicide risk in patients with anxiety disorders for a number of reasons. Anxiety and comorbid physical health conditions often present in primary care settings (Serrano-Blanco et al., 2010), and patients with anxiety disorders are often diagnosed and treated in primary care settings (Bijl and Ravelli, 2000; Price et al., 2000; Shear and Schulberg, 1995; Weisberg et al., 2007). Moreover, many individuals who eventually commit suicide present to primary care within weeks or days of making a suicide attempt (Luoma et al., 2002). Knowledge of potential risk factors could improve risk management in this setting by alerting providers to critical features of patients who may be likely to attempt suicide.

Given the great social and economic burden associated with suicide and its relatively high prevalence in primary care, examination of the features of suicide risk behaviors in this setting is warranted. The present study examined suicide risk variables in a sample of individuals with one or more anxiety disorders referred from primary care as part of the Coordinated Anxiety Learning and Management (CALM) study (Roy-Byrne et al., 2010). The first aim of the present study was to first examine the prevalence of suicidal ideation and behaviors in a large group of individuals recruited from the primary care setting. Second, we sought to examine which clinical factors were associated with suicide risk in these patients. To do so, we examined correlational and regression analyses of factors previously documented to be associated with suicide (including mental and physical health variables, as well as social support), and suicide risk score.

2. Methods

2.1. Participants

Participants were 1620 individuals who completed an initial eligibility assessment in a randomized controlled effectiveness trial comparing the CALM intervention to usual care conducted between June 2006 and August 2008 (UC; Roy-Byrne et al., 2010; clinicaltrials.gov Identifier NCT00347269). Study procedures were reviewed and approved by the institutional review boards at all study sites. Eligible participants were between the ages of 18 and 75, met DSM-IV criteria for at least one anxiety disorder (SP, GAD, PTSD or PD), and indicated a score of eight or greater (moderate anxiety symptoms on a scale ranging from 0 to 20) on the Overall Anxiety Severity and Impairment Scale (OASIS; Campbell-Sills et al., 2009). All participants who completed the eligibility screening are reported for analyses of prevalence of suicide risk variables. Because excluded participants did not complete a comprehensive assessment battery, only those meeting inclusion criteria ($N=1002$) were considered for regression analyses of suicide risk. Including the larger initial sample of individuals who conducted the screening allowed for examination of baseline rates *before* individuals who met exclusion criteria (including suicidality) were removed from the trial. Information on both the full sample and the screened sample are reported in the prevalence data for suicide risk variables. Exclusion criteria included the presence of life-threatening medical conditions, marked cognitive impairment, active suicidal or homicidal intent or plan, Bipolar I disorder, current substance dependence (except alcohol and marijuana), ongoing treatment in a cognitive behavioral intervention program, and inability to speak either English or Spanish. A total of 10 individuals were removed from the study for suicide or homicide-related reasons. Potential participants were referred from primary care physicians in 17 primary care clinics from four U.S. regions. Table 1 presents demographic data for the sample.

2.2. Assessments

2.2.1. Diagnostic status and suicide risk score

A trained study clinician administered the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) to participants to determine diagnostic status (including presence of current SUDs and MDD) and assess for study eligibility. As part of this assessment, individuals completed a suicide risk module in which they were asked about the presence and severity of risk factors for future suicidal action. Specifically, participants were asked about a history of accidents with intention of self harm, passive suicidal ideation (“thinking you were better off dead”), desire for self harm, thoughts of suicide including frequency and intensity, and history of suicide attempts. Participants endorsing suicidal ideation were also asked about suicide plan and/or action upon plan, self injury, current intention for

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