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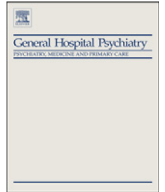

From impulse to action among military personnel hospitalized for suicide risk: alcohol consumption and the reported transition from suicidal thought to behavior

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ABSTRACT

Objective: Alcohol use is associated with unplanned or impulsive suicide attempts. Although unplanned suicide attempts assume a rapid transition for suicidal impulse to action, many studies do not quantify the time elapsed from suicidal impulse to action. The current study was designed to clarify how alcohol use facilitates the transition from suicidal impulse to action among U.S. Army personnel. We hypothesized that alcohol consumption during the 24 h preceding a suicide attempt would be associated with significantly faster transition from suicidal impulse to action but would be unrelated to medical lethality.

Method: A total of 119 active duty U.S. Army Soldiers who made a total of 175 suicide attempts during military service, 121 of which occurred during the preceding year, completed clinician-administered structured interviews focused on psychiatric diagnosis and the contextual characteristics of their suicide attempts.

Results: Alcohol use during the 24 h prior to a suicide attempt was associated with significantly faster transition from suicidal impulse to action. Among suicide attempts in the past year, lethality significantly increased as the length of time since the last alcoholic drink increased. Drug use during the 24 h prior to a suicide attempt was unrelated to speed of transition or attempt lethality.

Conclusions: Soldiers acted upon their suicidal impulses more quickly when they had been drinking on the day of their suicide attempts. This rapid transition may contribute to the selection of less lethal suicide methods during periods of active drinking as compared to methods selected after the discontinuation of alcohol consumption.
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1. Introduction

Although the suicide rate among members of the U.S. Armed Forces has traditionally been lower than that of the age- and gender-matched U.S. general population suicide rate, in 2008, the military suicide rate surpassed the general population rate and has remained elevated since [1]. The considerable difficulty in reliably predicting suicidal behavior has contributed to a widespread perspective of suicide as an "impulsive" behavior [2]. Supporting this perspective are findings indicating that the transition from suicide ideation to attempts typically occurs in less than 1 year among military personnel and veterans [3,4]. Furthermore, of those Soldiers who make a suicide attempt during military service, approximately 15% have been described as "unplanned," which refers to suicide attempts made by individuals who report a history of suicide attempt but deny ever making an explicit suicide plan [3,5]. This notion of the unplanned or "impulsive" suicide attempt has been similarly described and reported among non-military populations (e.g., Refs. [6–8]).

Because of the strong associations among trait impulsivity, initiation of substance use and the dysregulatory effects of substance use on impulse control [9], alcohol and drug use may play a particularly important role in unplanned suicide attempts. Indeed, the strong relationship of substance use and suicidal behavior is due in large part to its association with unplanned, as opposed to planned, suicide attempts [6]. Although the risk for suicide attempts is highest among those meeting diagnostic criteria for a substance use disorder [6,7], unplanned suicide attempts are also associated with amount of daily consumption of alcoholic beverages regardless of diagnosis [7] and are more likely to occur during heavy drinking episodes, especially among men [10]. In contrast to alcohol consumption, unplanned suicide attempts may be less likely to occur during periods of active drug use [11]. In light of these findings, alcohol use has been proposed to be a warning sign for near-term or imminent suicidal behavior [12,13]. Although alcohol use is associated with less advance planning, it is not associated with attempt lethality or attempt method [14], which suggests that risk for suicidal behavior is increased by alcohol use because alcohol use reduces the predictability (or, conversely, increases the suddenness) of the eventual suicidal act.

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Existing research is marked by several limitations, however, the most notable of which is how unplanned suicidal behavior is operationalized. As noted above, unplanned suicide attempts are defined in many studies as suicide attempts made by individuals who denied making a suicide plan in advance [3,5–8]. Such studies are based on several assumptions about the temporal sequencing of suicidal thoughts and behaviors: specifically, that suicide ideation precedes suicide planning and that suicide planning precedes suicide attempts. This hierarchy of risk is supported to some degree by findings indicating that suicidal planning is associated with greater risk for suicidal behavior as compared to suicidal thinking and ideation more generally [15,16]. Suicide planning can therefore be conceptualized as a particularly high-risk "subtype" of suicide ideation. Recent conceptual and empirical research suggests, however, that this linear model of progression from suicide ideation to plans to attempts may oversimplify the true nature of the emergence of suicidal behavior from suicidal thoughts [17].

According to the fluid vulnerability theory, for instance, suicide risk is a dynamic construct that is best characterized by fluctuations around stable set points [18]. Consistent with this perspective, individuals who attempt suicide are nearly three times more likely to describe the process leading up to their attempts as fluctuating and nonlinear in nature [17]. Wyder and De Leo further reported that more than two thirds of individuals who made unplanned or impulsive suicide attempts described a nonlinear, fluctuating process leading up to the attempt whereas only 7% of impulsive attempts were preceded by a linear progression from lower to higher levels of suicidal thinking (the highest being suicide planning). Because most studies do not take into account nonlinear change processes, suicidal behavior can appear to be unplanned even when it is actually preceded by a nonlinear temporal trajectory such as an oscillatory pattern marked by periodic and/or rhythmic fluctuations. Research on impulsive suicide attempts is further limited by findings that 27% of suicide attempters who described their attempts as "impulsive" also report having making a suicide plan at some point prior to their attempt and 29% of suicide attempters who described their attempts as "nonimpulsive" did not report making a suicide plan at any point prior to their attempt [17]. Alternative methods for examining how factors such as substance use are associated with the transition from suicidal thought to action are therefore needed.

One possible alternative is the assessment of elapsed time from the decision to act upon a suicidal impulse (e.g., "I'm going to do it") to the suicide attempt itself. Assessing elapsed time in terms of seconds, minutes, hours or days provides a more objective metric for quantifying the transition from impulsive to reflective action [19] while also aligning with more traditional conceptualizations of unplanned versus planned suicidal behavior. For example, shorter periods of time (e.g., seconds or minutes) from suicidal impulse to action might correspond to "unplanned" or "impulsive" suicide attempts whereas longer periods of time (e.g., hours or days) might correspond to more "planned" or "reflective" attempts. Such an approach may provide a more nuanced understanding of the role of substance use in the emergence of suicidal behavior, especially among high-risk populations such as the military, a group for whom little is known about substance use immediately prior to suicidal behavior.

The primary aim of the present study was to examine the associations of alcohol and drug use with suicidal behavior in a sample of active duty military personnel who attempted suicide during military service. Consistent with prior research, we hypothesized that alcohol consumption, but not drug use, during the 24 h preceding Soldiers' suicide attempts would be associated with significantly faster transition from suicidal thought to action. We also hypothesized that neither alcohol nor drug use would be associated with the medical lethality of the suicide attempt. In addition to these a priori hypotheses, we conducted exploratory analyses to examine how different dimensions of substance use on the day of suicidal behavior (i.e., amount used, duration of acute substance use, length of time of continued or discontinued use relative to a suicide attempt) might be correlated with speed of transition from suicidal to action and suicide attempt lethality.

2. Method

2.1. Participants and procedures

Participants included 119 active duty Soldiers (106 men, 13 women) ranging in age from 19 to 44 years ($M = 27.03$, $SD = 6.16$) who had made at least one suicide attempt during military service. Self-identified racial distribution was 81 (68.1%) Caucasian, 15 (12.6%) African-American, 6 (5.0%) Native American, 3 (2.5%) Pacific Islanders, 3 (2.5%) Asian and 11 (9.2%) other. Hispanic/Latino ethnicity was assessed separately and was endorsed by 29 (24.4%). Rank distribution was 85 (71.4%) E1-E4, 29 (24.4%) E5-E6 and 5 (4.2%) E7-E8. The majority of participants (83.2%) had deployed at least one time ($M = 1.63$, $SD = 1.40$, range: 0–8). Approximately half (49.6%) of the participants had made two or more lifetime suicide attempts.

Soldiers were referred for an intake evaluation following discharge from inpatient psychiatric hospitalization to determine eligibility for enrollment in a randomized clinical trial [20]. Soldiers interested in enrolling completed the informed consent process, after which they completed structured clinical interviews and self-report measures. Inclusion criteria for the parent study included active duty military service, age 18 years or older and a lifetime history of suicide attempt. The only exclusion criterion was the presence of a medical or psychiatric condition that precluded informed consent (e.g., acute intoxication, impaired consciousness, mania, psychosis). The present study was reviewed and approved by the institutional review board at Madigan Army Medical Center.

2.2. Instruments

2.2.1. Suicide attempt self-injury interview (SASII)

The SASII [21] is a structured clinician-administered interview designed to assess the characteristics of intentional self-injurious behaviors (e.g., intent, method, medical lethality) in order to accurately differentiate between suicide attempt and nonsuicidal self-injury. Participants were asked to describe the circumstances leading up to their suicide attempt, to include the amount of time spent planning in advance. Time elapsed from suicidal impulse to suicide attempt was scored by the evaluator on the following 7-point scale that includes scoring options that take into account both respondent appraisal of impulsivity and quantified periods of time:

1 = Commitment to act, followed by very careful or elaborate plan carried out over many days;
2 = Actively planned and/or got implements; had impulse, resisted for multiple days, then acted;
3 = Actively planned and/or got implements; had impulse, resisted for less than 24 h;
4 = No active planning; had impulse, resisted for multiple days, then acted;
5 = No active planning; had impulse, resisted for less than 24 h, then acted;
6 = No active planning; occurred impulsively, with no forethought and without very strong emotion (i.e., seconds to hours); and
7 = No active planning; occurred impulsively, with no forethought and with very strong emotion (i.e., seconds to hours).

Prior research indicates that higher scores on this scale (i.e., faster transition) are associated with less ambivalence when making a suicide attempt, decreased likelihood of writing a suicide note, lower suicidal intent, taking fewer steps to prevent discovery and greater likelihood of rescue (Linehan et al., 2006). In the present study, these scores were collapsed into the four categories corresponding to different durations of time: multiple days, less than 2 days, less than 1 day or hours or less. Response option one was categorized as "multiple days." Response options 2 and 4 were both categorized as "less than 2 days" because both of these response options indicate the passage of at least 24 h

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