



Prevalence of suicide attempts in pathological gamblers in a nationwide Austrian treatment sample



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ABSTRACT

Background: For pathological gambling (PG), a 12-month prevalence rate of up to 0.66% has been reported. Multiple financial, occupational and relationship problems and losses, humiliation of the person and the environment are possible side effects and may lead to hopelessness, suicidal ideation and suicidal behavior. Suicide attempt rates among pathological gamblers of between 4% and 40% and suicidal ideation of between 12% and 92% have been reported.

Aim: This study aims at assessing the prevalence of suicide attempts in PG and at elucidating differences between the patients with and without suicide attempt history (SAH) in a large nationwide Austrian sample. **Methods:** Between 2002 and 2011, the Austrian Society for the Research of Non-Substance Related Addiction collected 862 questionnaires of pathological gamblers undergoing outpatient and inpatient treatment for PG in Austria.

Results: (a) Of all pathological gamblers, 9.7% had an SAH. (b) The SAH group suffered significantly more from a comorbid disorder and was more often in previous inpatient treatments. (c) The SAH patients had a longer time of an abstinence period in their PG career.

Discussion: One in 10 pathological gamblers has an SAH, demonstrating the relevance of suicidality in this population. Significant differences for several parameters were found for PG with and without SAH. However, a regression analysis only explained 15% of the variance. This suggests that suicidality must be considered in pathological gamblers in general.

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1. Introduction

Pathological gambling (PG), characterized by persistent and recurrent maladaptive patterns of gambling behavior, is associated with impaired functioning, reduced quality of life, high rates of bankruptcy, social difficulties, employment problems and divorce [1]. Estimated prevalence rates for PG vary worldwide [2]. In the United States, reported rates range from 0.4% to 1.1% [2,3], and

approximately 20% to 40% of individuals with PG are women [4,5]. Recent representative studies found a 12-month prevalence rate of PG of 0.35% in Germany [6,7] and 0.66% in Austria [8], respectively, and a lifetime prevalence of 1% [7]. Rates of comorbidity up to 95.5% have been reported for PG [7,9]. Especially depression and substance use disorders were found to be the most common comorbid disorders [9–14]. Furthermore, several studies described an elevated risk for suicidal ideation, suicide attempts and suicides among patients with PG [15]. Rates of suicidal ideations among PG range between 12% and 92% [16–22], and rates for suicide attempts range between 4% and 40%. In a 12-month follow-up study of 79 PG subjects [23], 81.4% reported suicidal ideation, and 30.2% reported one or more suicide attempts in the preceding 12 months. The link between PG, suicidal ideation, suicide attempts and suicide, however, has not been fully understood.

A study assessing factors specific for distinguishing between suicidal from nonsuicidal behavior in pathological gamblers showed

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that those who had experienced suicidal ideation or suicide attempts reported gambling at an earlier age, engaging in treatment earlier, having higher rates of divorce or separation, being more likely to engage in theft to support gambling and having a greater number of addicted children and alcoholic relatives [18]. There were no differences found between gamblers who experienced suicidal ideation versus those who made attempts. A link to younger age and a history of depression was also described by McCormick et al. [24]. Another study with 342 pathological gamblers in treatment showed that patients with more psychiatric symptoms, poor living conditions, marital conflicts, gambling severity and craving were more likely to suffer from suicidal behavior [25].

A subsequent study of MacCallum and Blaszczynski [26], however, reported that suicidal ideation was associated with depression, self-control and urge, whereas depression, marital difficulties and illegal activities, but not gambling severity, were predictors for suicidal behavior.

A retrospective chart review of inpatients ($n=114$, 91% male) found that suicide attempters were more likely to report lifetime history of drug dependence (but not alcohol dependence) and to suffer from a current psychiatric disorder. Impulsivity was related to suicide attempts but only among those with a history of drug or alcohol dependence [22].

Limitations of these previous studies were the absence of a classification of suicidal ideation and behavior and the assessment of the level of risk and lethality. The latter may facilitate the identification of specific types of predictors of subsequent suicidal ideation, attempts and completed suicides. To address this issue in gamblers, MacCallum et al. [27] used the four levels of suicidal risk developed by Rudd and Joiner [28]. They found that 38% of 50 treatment-seeking gamblers reported suicidal ideation, 8% were in the extreme range of risk and 4% reported a past attempt. Another limitation of the reported studies is the time period and the missing assessment of the suicidality – as an overall term including the spectrum from suicide-related ideations to completed suicide according to Silverman et al. [34,35] – being related to gambling or not. Hodgins and colleagues [15] reported that “gambling-related” suicide attempts were relatively rare. The subjects with a history of suicidal ideations and/or behaviors had a significantly increased risk of depression and substance use disorders [15]. In contrast, Petry and Kiluk [25] showed that, of 342 US patients undergoing treatment, 17% had attempted suicide, almost all following gambling problems. McCallum and Blaszczynski [26] supported in their study the high rate of gambling-related suicide, showing that, of the 7% of suicide attempters, only 3% were due to nongambling reasons.

The combined effect of multiple financial, occupational and relationship losses, and the humiliation of criminal charges for some lead to hopelessness, suicidal ideation and suicidal behavior.

This study aims at assessing the prevalence of suicide attempts in PG and at elucidating differences between the patients with and without suicide attempt history (SAH) in a large nationwide sample.

2. Method

Between 2002 and 2011, the Austrian Society for the research of non-substance-related addiction collected 862 questionnaires of pathological gamblers undergoing outpatient and inpatient treatment of PG in Austria. The questionnaire consisted of demographic information, years of PG, longest abstinent period ever, abstinent period before treatment, debt, comorbid disorders, quantity of treatments and specific stress factors. All patients were diagnosed according to the *International Classification of Diseases, 10th Revision*, F63.0 criteria by clinical investigation. Suicide-related behavior and ideations are understood according to the definition proposed by Silverman et al. [34,35].

2.1. Statistics

For statistical analysis, SPSS 18 (SPSS Inc., Chicago, IL, USA) was used. All continuous data were tested for normal distribution using the Kolmogorov–Smirnov nonparametric test. For the calculation of the differences between the groups (SAH vs. not), nonparametric tests (Mann–Whitney U test, Kruskal–Wallis test) were used. A two-tailed α -significance level of $P=.05$ was defined to be statistically significant.

Logistic regression was employed to evaluate how risk factors influenced suicide attempts history in the context of all relevant variables which differed significantly between groups in the univariate analyses. All variables were entered simultaneously into the equation together with age and gender, while history of suicide attempts served as dependent variable.

3. Results

One questionnaire was incomplete. Therefore, a total of 861 questionnaires were included in the calculations.

3.1. Sample characteristics

Of the sample, 709 (82.3%) were male and 148 (17.2%) female patients. An SAH was reported by 83 (9.6%; 59 men, 27 women). Sample characteristics are summarized in Table 1.

3.2. Characteristics related to SAH

Significant differences were found for age ($P=.001$), gender ($P=.007$), retirement ($P=.006$) and unemployment ($P=.008$). Patients with an SAH were more likely to be older (median, 43.5 vs. 38 years), retired (24.1% vs. 12.7%) and unemployed (43.4% vs. 28.4%). The proportion of females was significantly higher in the SAH group (27.7% vs. 16.1%). Furthermore, there was a significant difference between both groups with regard to comorbidity ($P<.01$). The SAH group was more likely to have a diagnosis of a comorbid disorder (88.9% vs. 63.5%). More details are given in Table 2.

As presented in Table 2, SAH subjects reported significantly more often a longer time of abstinence in their PG career ($P=.015$) and previous inpatient treatments ($P=.00$; 20.5% vs. 7.1%). The SAH

Table 1
Descriptive data of PG subjects with and without history of suicide attempts

	Total N= 861	PG with SAH n= 83 (9.7%)	PG without SAH n= 778 (%)	Significance
Age	Median 39	43.5	38	$P=.005$
Gender				
Male	708 (82.2)	59 (71.1)	649 (83.4)	$P=.007$
Female	148 (17.2)	23 (27.7)	125 (16.1)	
MD	5 (0.6)	1 (1.2)	4 (0.5)	
Marital status				
Married/partnership	380 (44.1)	34 (41)	346 (44.5)	NS
Separated/divorced	128 (14.8)	19 (22.9)	109 (14)	$P=.040$
Single	265 (30.7)	22 (26.5)	243 (31.2)	NS
Widowed	8 (0.9)	3 (3.6)	5 (0.6)	$P=.032$
MD	80 (9.3)	5 (6)	75 (9.6)	
Employment status				
Employed	423 (49.1)	22 (26.5)	401 (51.5)	$P=.000$
Unemployed	258 (30)	36 (43.4)	222 (28.5)	$P=.008$
In training	31 (3.6)	3 (3.6)	28 (3.6)	NS
Housewife/-man	11 (1.3)	2 (2.4)	9 (1.2)	NS
Retired	119 (13.8)	20 (24.1)	99 (12.7)	$P=.006$
MD	19 (2.1)	0	19 (2.4)	
Comorbidity	562 (65.9)	72 (88.9)	490 (63.5)	$P=.000$
MD	8 (0.9)	2 (2.4)	6 (0.8)	

MD, missing data; NS: not significant.

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