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Research report

Suicidal behaviours in adjustment disorder and depressive episode

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ABSTRACT

Background: Little is known about suicidal ideation and behaviours in adjustment disorder (AD). In this paper we sought to examine the variables independently associated with suicidal ideation and behaviour in patients diagnosed with AD or depressive (DE) episode among psychiatric outpatients and in liaison psychiatry.
Methods: 370 patients who were referred to the liaison psychiatry services (including those seen in the Emergency Department) at 3 Dublin hospitals, and were clinically diagnosed with either DE or AD, based on the ICD 10 diagnostic criteria, were recruited to the study. We examined their demographic and clinical characteristics, and the associations between these and suicidal ideation and behaviour on multivariate analysis.
Results: Younger age, single marital status, and greater severity of depressive symptoms were significantly associated with suicidality across both diagnoses. On multivariate analysis, greater severity of depressive symptoms was associated with suicidality in those with AD ($p=0.012$) and DE ($p=0.009$). Those with AD exhibited suicidality at lower symptom scores than did those with DE but in both groups it still occurred at the highest level of severity. There were differences in the objective circumstances measure of suicide intent.
Limitations: We used clinical diagnosis rather as the main diagnostic classification. The generalisability of this paper may be limited to consultation-liaison psychiatry settings, where suicidal ideation and behaviours are common.
Conclusions: Suicidality in AD and DE has broadly similar risk factors but differ in aspects of suicide intent. Different mechanisms may underpin suicidality in those with AD compared to DE.

1. Introduction

Adjustment disorder (AD) is defined by the World Health Organisation (WHO) as a state of "subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life change or to the consequences of a stressful life event" (WHO, 1992). The *International Classification of Diseases* (*Tenth Edition*) (ICD-10) (WHO, 1992) requires that onset of symptoms occurs within one month of the stressful event while the *Diagnostic and Statistical Manual of Mental Disorders* (*Fifth Edition*) (DSM-5) requires the onset of symptoms within three months (APA, 2013). Unlike major depressive disorder (MDD), where both classification systems list the symptoms which must be present in order for the diagnosis to be made, both systems are vague regarding the symptoms required for the diagnosis of AD. Regarding symptoms, ICD-10 states:

> "Symptoms or behaviour disturbance of types found in any of the affective disorders (except delusions and hallucinations), any disorders in F4 (neurotic, stress related and somatoform disorders) and conduct disorders, so long as the criteria of an individual disorder are not fulfilled. Symptoms may be variable in both form and severity." (WHO, 1992)

Suicidal ideation is common in MDD and depressive episode (DE), with a prevalence of between 10% and 48% (Greenberg et al., 1995; Nock et al., 2008). Suicidal ideation is more common in those admitted to psychiatric units with a diagnosis of AD than in other diagnoses, including DE (Nock et al., 2008). In community samples comparing AD and DE the prevalence of suicidal ideation is similar (Nock et al., 2008; Casey et al., 2006a).

Suicidal behaviour in AD (self-harm irrespective of motivation or intent) is common, varying between 25% and 60%, depending on age (Pelkonen et al., 2005; Kryzhananovskaya and Canterbury, 2001).

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Compared to those with DE, suicidal behaviour in AD is associated with lower levels of education, single marital status, lower socio-economic status, more familial instability, emotional deprivation in childhood and less planning of the attempt (Polyakova et al., 1998). The risk factors associated with suicidal behaviour in DE include younger age, major depression, dysthymia, PTSD and alcohol dependence (Bernal et al., 2007). Suicidal behaviours occur earlier in the course of AD than in DE (Runeson et al., 1996), as does suicide (Portzky et al., 2005; Schnyder and Valach, 1997).

All aspects of suicidality, including suicidal ideation, behaviour or death by suicide have been under researched in AD, instead focussing on DE and other mood disorders (Bernal et al., 2007). This neglect is surprising considering suicidality is commonly associated with AD in the emergency department (ED) (Schnyder and Valach, 1997), and among those admitted for in-patient psychiatric treatment (Greenberg et al., 1995).

The results presented here are part of a larger study examining AD and DE in liaison psychiatry. We examined the variables independently associated with suicidal ideation and behaviour in those diagnosed with AD or DE.

The aim of this study was to identify similarities and risk factors associated with suicidality in AD and DE respectively. We hypothesised that these would be similar in both diagnoses.

2. Methods

We recruited patients from the liaison psychiatry services (including those seen in the ED) at three Dublin hospitals who were diagnosed by the liaison psychiatrists with either DE or AD, based on ICD-10 diagnostic criteria (WHO, 1992).

We excluded those whose primary diagnosis was a substance use disorder, with cognitive impairment, who were incapable of giving informed consent, who were under 18, who had psychotic symptoms and who were not competent in the English language.

Patients were interviewed at two points by a researcher blind to the clinical diagnosis, at recruitment and at 6 months using validated instruments. This paper will focus on the cross-sectional data obtained from the first interview. The instruments used included:

1. SCAN – Schedules for Clinical Assessment in Neuropsychiatry, a clinician-administered structured interview schedule providing diagnoses based on ICD-10; it includes AD in a section entitled 'Inferences and Attributions', only used if caseness for another diagnosis is not reached (Wing et al., 1990).
2. BDI-II – Beck Depression Inventory, second edition is a 21-item self-report schedule of depressive symptoms (range 0–63), with higher scores indicating more severe symptomatology (Beck et al., 1961, 1996). For analysis, we used the total score on BDI-II minus question 9 measuring suicidality to avoid collinearity.
3. IDS-C30 – Inventory of Depressive Symptoms – Clinician Rated is a 30-item clinician administered schedule of depressive symptoms (range 0–90), where higher scores indicate greater symptom severity (Trivedi et al., 2004). We excluded question 18, measuring suicidality, to avoid collinearity.
4. The List of Threatening Experiences is a measure of life events in the preceding 6 months, comprising 12 questions for 12 different traumatic life events (range 0–12) (Brugha et al., 1985).
5. SAPAS Standardised Assessment of Personality- Abbreviated Scale is an 8-item self-rated personality disorder screen (range 0–8), where a score of >3 indicates a probable personality disorder (Moran et al., 2003).
6. Oslo Social Support Scale is a self-rated instrument which assesses perceived social support, comprising three subscales. The total score ranges from 3 to 14, with a higher score indicating greater perceived support (Nosikov, 2003).
7. SFS – Social Functioning Schedule was used to assess social dysfunction by rating functioning over a number of domains on an analogue scale. A higher score indicates greater levels of social dysfunction (Remington and Tyrer, 1979).
8. SIS – Suicide Intent Scale is a 15-item self-report questionnaire with subjective and objective measures of severity of intent in patients presenting with suicidal behaviour. Each question is rated 0–2, with a higher score indicating a greater degree of suicidal intent (A. Beck et al., 1974).
9. SSI – Scale of Suicidal Ideation is a 19-item self-report schedule assessing suicidal ideation in individuals who did not present following suicidal behaviour. Each question is rated 0–2, with a higher score indicating a greater degree of suicidal ideation (R. W. Beck et al., 1974).
10. DUREL – Duke University Religion Scale is a 5-item scale measuring aspects of religiousness. For this study subscale 1, examining participation in organised religion, was used (Koenig et al., 1997).

3. Measures of suicidality

To assess suicidality we used three different measures:

a. All participants completed the IDS-C30: Question 18 (Q18) allows evaluation of suicidality spanning passive death wishes, suicidal ideation and self-harm (Trivedi et al., 2004).
b. Participants who presented following an act of suicidal behaviour completed the SIS (A. Beck et al., 1974).
c. Participants who presented with features other than suicidal behaviour completed the SSI (R.W. Beck et al., 1974).

4. Definitions

Suicidality was defined as any symptom relating to suicide, including suicidal ideation or suicidal behaviour.

Passive death wishes were coded as an absence of suicidal ideation.

Suicidal behaviour refers to self-harm irrespective of method used or its lethality, motivation or level of suicide intent.

5. Diagnostic gold standard and measures of AD

Structured interviews for AD are poorly developed. In those that include AD, the diagnosis is only made if the threshold for another disorder is not met. This approach, ignoring context, has been criticised by many researchers in the area of stress-related disorders (Strain and Diefenbacher, 2008; Baumeister et al., 2009). Accordingly, we chose clinical diagnosis as the diagnostic gold standard for this study, although we also used a structured interview (SCAN) for the purpose of other analyses (Wing et al., 1990).

6. Power calculation and statistics

Power calculations were based on methodology of Smith and Morrow (1996). For 95% confidence of detecting a difference in depressive symptomatology of similar magnitude to that detected in Casey et al.: at a significance level of $p<0.05$, we required 180 individuals with AD and 180 with DE (Casey et al., 2006b).

Statistics analysis was conducted using SPSS (v20) and STATA. Univariate analysis included independent samples *t*-test, Mann–Whitney *U* test and Chi-Square test examining the differences in suicidality for various demographic and clinical variables. Binary multivariate