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Thwarted interpersonal needs mediate the relation between facets of mindfulness and suicide ideation among psychiatric inpatients

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ABSTRACT

Previous research suggests a negative association between mindfulness and suicide ideation, yet limited research has examined the specific role of mindfulness on suicide ideation or attempted to link this construct with theory-driven risk factors for suicide among high-risk individuals. The current study examined the mediating role of thwarted interpersonal needs (i.e., thwarted belongingness and perceived burdensomeness) in the relation between facets of mindfulness and suicide ideation among psychiatric inpatients. Participants were 118 psychiatric inpatients who completed self-report assessments of mindfulness, thwarted belongingness, perceived burdensomeness, and suicide ideation. Results indicated that the additive effect of thwarted belongingness and perceived burdensomeness mediated the relation between the act with awareness, non-judging, and non-reactivity mindfulness facets, and suicide ideation. Facets of mindfulness appear to be differentially related to thwarted interpersonal needs and subsequent suicide ideation. Continued examination of specific facets of mindfulness, as they relate to suicide ideation, may highlight potentially important distinctions and better inform suicide risk assessment and treatment.

1. Introduction

Suicide is the 10th leading cause of death in the United States (Centers for Disease Control and Prevention, 2017) and one of the leading causes of death in psychiatric hospitals (Maris, 2002). Psychiatric inpatients are at high risk for suicide, as an estimated 100 to 400 psychiatric inpatients die by suicide per 100,000 admissions (Combs and Romm, 2007). Furthermore, 52.5% of psychiatric inpatients report suicide ideation at intake (Oiesvold et al., 2012). Although research among psychiatric inpatients has primarily focused on risk factors for suicide ideation (e.g., Combs and Romm, 2007), more research is needed to elucidate possible protective factors, such as mindfulness, within a theory of suicide.

Mindfulness, which refers to “paying attention in a particular way: on purpose, in the present moment, nonjudgmentally” (Kabat-Zinn, 1994, p. 4), has been found to be negatively associated with suicide ideation (e.g., Cheng et al., 2017; Zeng et al., 2017). Mindfulness requires one to intentionally allocate attention to the present moment, which may be impaired for individuals who are currently experiencing suicide ideation (McLaughlin and Nolen-Hoeksema, 2011). For example, negative or self-critical rumination is associated with suicide ideation (see Morrison and O’ Connor, 2008 for a review). Mindfulness is inconsistent with and disrupts ruminative processes (Jain et al., 2007), in which an individual loses awareness of the present moment and becomes entangled in maladaptive thought patterns. Although the rise in popularity of mindfulness has been criticized for potentially leading to a possible trend toward self-focus (Joiner, 2017), mindfulness may be protective against suicide ideation by increasing one's awareness of present moment experiences, which may interfere with or reduce a focus on maladaptive or ruminative thoughts that are characteristic of suicidal individuals (Luoma and Villatte, 2012).

Mindfulness is also a multifaceted construct comprised of several facets (Baer et al., 2006) and the widely used Five Facet Mindfulness Questionnaire (FFMQ; Baer et al., 2006) assesses the following mindfulness facets: observe (i.e., noticing or attending to one's experiences), describe (i.e., labeling internal experiences with words), act with awareness (i.e., attending to one's actions in the present moment), non-judging (i.e., being non-evaluative of thoughts and feelings), and non-reactivity (i.e., allowing thoughts and feelings to come and pass without becoming caught up in them; Baer et al., 2006). Among psychiatric inpatients, facets of mindfulness were found to be differentially associated with suicide ideation (Cheng et al., 2017). Specifically, significant negative associations were found between suicide ideation and the act with the awareness and non-judging facets, but non-significant associations were found between suicide ideation and the observe,

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describe, and non-reactivity facets. Despite this, limited research has attempted to link this construct with theory-driven risk factors among high-risk individuals (e.g., psychiatric inpatients).

The interpersonal theory of suicide (IPTS; Joiner, 2005; Van Orden et al., 2010) represents a useful way to conceptualize suicide risk among psychiatric inpatients. The IPTS suggests that thwarted belongingness (TB; indicated by a lack of reciprocal caring relationships and loneliness) and perceived burdensomeness (PB; indicated by feelings of liability and self-hate) act as *proximal* risk factors for suicidal desire. Specifically, the IPTS posits that TB and PB, independently, increase one's risk for passive suicide ideation (i.e., death ideation). However, when TB and PB (i.e., thwarted interpersonal needs) are experienced concurrently and an individual is hopeless about these states changing, suicidal desire (i.e., active suicide ideation) is theorized to occur. Support for the primary assertions of the IPTS involving the associations between thwarted interpersonal needs and suicide ideation has been demonstrated among psychiatric inpatients (e.g., Cero et al., 2015; Jahn et al., 2015; Mitchell et al., 2013,2017; Taylor et al., 2016); however, there is less evidence for how mindfulness may buffer against TB and PB, and in turn suicide ideation.

Mindfulness may be particularly advantageous for psychiatric inpatients because of its ability to target multiple pathways to suicide ideation simultaneously (Hayes et al., 2008), which may include TB and PB. Initial support for the relation between mindfulness and thwarted interpersonal needs has been demonstrated. Buitron et al. (2016) found that among undergraduate students, the association between PB and suicide ideation was weaker for those who reported being more mindful relative to those who reported being less mindful; however, there was no change in the association between TB and suicide ideation due to mindfulness. Furthermore, in samples of undergraduate students, those who utilized a mindfulness strategy were more persistent through an activity that aimed to experimentally induce TB and PB (Collins et al., 2016, 2017). These findings suggest that mindfulness may increase one's ability to persist through interpersonally difficult states (e.g., TB and PB), which may then reduce suicide ideation. These studies provide preliminary support for the notion that mindfulness may decrease TB and PB, but it is important to understand these associations among high-risk populations, such as psychiatric inpatients who likely differ in risk for death by suicide and psychiatric symptom severity compared to undergraduate students. A better understanding of the relation between facets of mindfulness, thwarted interpersonal needs, and suicide ideation among psychiatric inpatients would help inform the development of suicide-specific, evidence-based psychological treatments.

To date, the associations between specific facets of mindfulness and suicide ideation have been examined but only a general mindfulness construct has been examined in the context of the interpersonal theory of suicide. Mindfulness has been found to be differentially related to suicide ideation (Cheng et al., 2017) and other psychological constructs (e.g., emotion regulation, thought suppression, psychological symptoms), and has demonstrated incremental validity in predicting psychological symptoms (Baer et al., 2006). Buitron et al. (2016) study used an undergraduate student sample and was limited by the use of a total mindfulness score derived from the FFMQ (Baer et al., 2006), which precludes the determination of the role of specific aspects of mindfulness in relation to TB, PB, and suicide ideation. Given previous findings on the associations between facets of mindfulness and suicide ideation among psychiatric inpatients (Cheng et al., 2017), it is possible that the act with awareness and non-judging facets of mindfulness may be significantly associated with thwarted interpersonal needs while the observe, describe, and non-reactivity facets may be non-significant. Clearly, conceptualizing mindfulness as a multifaceted construct may be particularly useful when exploring the relations between mindfulness and thwarted interpersonal needs, as this may provide a more nuanced understanding of the relation between facets of mindfulness and suicide ideation, and subsequently more effective suicide risk assessment and more targeted psychological treatment approaches.

1.1. *The current study*

Previous research has indicated a link between mindfulness, TB, PB, and suicide ideation (e.g., Buitron et al., 2016; Cheng et al., 2017); however, the relations between specific facets of mindfulness, TB, PB, and suicide ideation have yet to be examined. Research examining specific facets of mindfulness in relation to TB and PB would likely provide a more comprehensive understanding of suicide ideation among psychiatric inpatients. The current study aims to extend the literature by addressing these limitations and exploring the associations between facets of mindfulness, thwarted interpersonal needs, and suicide ideation. Further, each mindfulness facet was examined separately, as these may be differentially related to thwarted interpersonal needs and suicide ideation. Based on previous findings on the associations between facets of mindfulness and suicide ideation (Cheng et al., 2017), we hypothesized that the act with awareness and non-judging facets of mindfulness, but not the observe, describe, or non-reactivity facets, would be negatively associated with suicide ideation and that TB and PB, in parallel, would mediate these relations.

2. Method

2.1. *Participants*

The sample consisted of 118 adult psychiatric inpatients (M_{age} = 36.17, SD_{age} = 15.30) in the southwest United States, and included 63 males (53.4%) and 55 females (46.6%). The majority of the sample identified as non-Hispanic (*n* = 82, 69.5%) followed by Hispanic (*n* = 34, 28.8%), and 2 participants (1.7%) did not indicate an ethnicity. The majority of the sample also identified as White or Caucasian (*n* = 95, 80.5%), followed by "other" (*n* = 9; 7.6%), Black or African American (*n* = 6, 5.1%), American Indian or Native American (*n* = 4, 3.4%), and Asian or Asian American (*n* = 1, 0.8%). In terms of relationship status, the majority of the sample reported being single (never married; *n* = 55, 46.6%) followed by married (*n* = 28, 23.7%), divorced (*n* = 11, 9.3%), in a romantic relationship (*n* = 10, 8.5%), separated (*n* = 8, 6.8%), in a partnered/common law relationship (*n* = 4, 3.4%), and widowed (*n* = 2, 1.7%). The percentage of participants who reported not completing high school was 17.8% (*n* = 21), a high school diploma or equivalent was 22.2% (*n* = 26), some college, but no degree was 36.4% (*n* = 43), a college degree was 15.4% (*n* = 18), an advanced degree was 7.6% (*n* = 9), and not indicating level of education was 0.8% (*n* = 1). Participants were eligible to participate if they were at least 18 years of age and able to speak and read English. Exclusionary criteria included incapacity to consent to participation in the study. Data on reason for admission were not collected; however, 49.2% (*n* = 58) of participants reported at least one previous suicide attempt, 39.8% (*n* = 47) of participants reported previous non-suicidal self-injury, and 50.8% (*n* = 60) of participants reported at least one previous psychiatric hospitalization prior to their current admission.

2.2. *Measures*

2.2.1. *Demographic Questionnaire*

The Demographic Questionnaire assessed basic demographic information (e.g., age, gender, ethnicity) as well as questions regarding suicide risk, non-suicidal self-injury, and previous psychiatric hospitalization.

2.2.2. *Interpersonal Needs Questionnaire (INQ)*

The INQ (Van Orden et al., 2012) is a 15-item self-report questionnaire that assesses recent feelings of TB and PB. Participants rate each item on a 7-point ordinal response scale ranging from 1 (*Not at all true for me*) to 7 (*Very true for me*). The TB subscale consists of nine items with higher scores indicating greater feelings of TB and the PB

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