Assessing Nocturnal Sleep/Wake Effects on Risk of Suicide (ANSWERS) Study

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Welcome to the ANSWERS Survey!

Thank you very much for your interest in our study. Our goal is to help determine how sleep and circadian rhythms affect an individual's risk for suicide and other negative mental health outcomes. Hopefully, your answers will help us identify factors that can reduce risk or prevent suicide.

Instructions

Thank you for agreeing to fill out this survey! This survey could take up to one hour to complete, so please make sure you have enough time to answer all the questions. Only complete surveys will be able to be used.

When you take the survey, you may notice that some of the items are repetitive. This is because the survey is made up of standard questionnaires often used in research. Thus, some questions may overlap, but to ensure the data is accurate we must include all the questions in the original questionnaire.

The purpose of this study is to explore how sleep and circadian rhythms affect mental health, particularly suicidal thoughts and behaviors. We believe that sleep is an important part of keeping people healthy and well, and your answers will help us determine exactly how sleep contribute to mental wellness.

Thank you for helping us with this project!

Are you interested in future suicide prevention research?

The ANSWERS survey is Phase I of an ongoing project to determine how sleep and sleeplessness increases risk for suicide. ANSWERS Phase II involves in-lab measurement of brain activity by electroencephalography (EEG) during the day and at night to see how brain activity changes over time. There is no compensation for completing Phase I.

Depending on your responses to the survey questions, you may be eligible to participate in Phase II. If you choose to participate in Phase II, you would be compensated $50 dollars for completing all Phase II study procedures.

If you are eligible, would you like to be contacted and provided further information about the ANSWERS Phase II study?

[ ] Yes, please contact me about the ANSWERS Phase II study

[ ] No, please do not contact me about the ANSWERS Phase II study

If you would like to be contacted, please enter your email here.

_____

Split week self-assessment of sleep survey (SASS-Y)

Please answer the following questions about your sleep **on WEEKDAYS during the previous week (Sunday night through Friday morning)**

1. What time did you get into bed, on average? _____ AM/PM
2. What time did you try to go to sleep, on average? _____ AM/PM
3. How long did it take you to fall asleep, on average? _____Hours and _____Min.
4. How many times did you wake up, not counting your final awakening, on average? _____
5. How long did these awakenings last (in total), on average? _____Hours and _____Min.
6. What time was your final awakening, on average? _____ AM/PM
7. On average, what time did you get out of bed for the day? _____AM/PM
8. How would you rate the average quality of your sleep? (Check one)

   □ Very Poor □ Poor □ Fair □ Good □ Very Good

9. How long have you slept this way? _____Year(s) _____Month(s)_____Week(s)

Please answer the following questions about your sleep **on the WEEKEND during the previous week (Friday Night through Sunday Morning)**

10. What time did you get into bed, on average? _____ AM/PM
11. What time did you try to go to sleep, on average? _____ AM/PM
12. How long did it take you to fall asleep, on average? _____Hours and _____Min.
13. How many times did you wake up, not counting your final awakening, on average? _____
14. How long did these awakenings last (in total), on average? _____Hours and _____Min.
15. What time was your final awakening, on average? _____ AM/PM
16. On average, what time did you get out of bed for the day? _____AM/PM
17. How would you rate the average quality of your sleep? (Check one)

    □ Very Poor □ Poor □ Fair □ Good □ Very Good

18. How long have you slept this way? _____Year(s) _____Month(s)_____Week(s)

Munich Chronotype Questionnaire

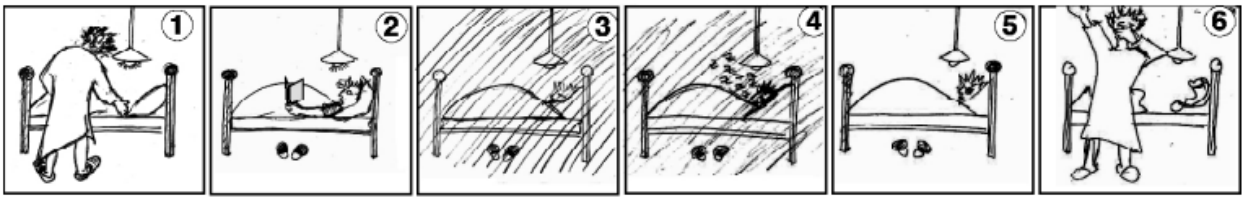
In this questionnaire, you will report on your typical sleep behavior over the past 2 weeks. We will ask about workdays and work-free days separately. Please respond to the questions according to your perception of a standard week that includes your usual workdays and work-free days.

1. I have a regular work schedule (this includes being, for example, a housewife or househusband):

[ ] Yes I work on [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 day(s) per week.

[ ] No

If your answer “Yes, on 7 days” or “No”, please consider if your sleep times may nonetheless differ between regular ‘workdays’ and ‘weekend days’ and fill out the MCTQ in this respect.



Please use 24-hour time scale (e.g. 23:00 instead of 11:00 pm)!

2. Workdays

Image 1: I go to bed at _____ o’clock.

Image 2: Note that some people stay awake for some time when in bed!

Image 3: I actually get ready to fall asleep at _____ o’clock.

Image 4: I need _____ minutes to fall asleep.

Image 5: I wake up at _____ o’clock.

Image 6: After _____ minutes I get up.

I use an alarm clock on workdays: [ ] Yes [ ] No

If “Yes”: I regularly wake up BEFORE the alarm rings: Yes No

3. Free Days

Image 1: I go to bed at _____ o’clock.

Image 2: Note that some people stay awake for some time when in bed!

Image 3: I actually get ready to fall asleep at _____ o’clock.

Image 4: I need _____ minutes to fall asleep.

Image 5: I wake up at _____ o’clock.

Image 6: After _____ minutes I get up.

My wake-up time (Image 5) is due to the use of an alarm clock: [ ] Yes [ ] No

There are particular reasons why I cannot freely choose my sleep times on free days:

[ ] Yes If “Yes”: [ ] Child(ren)/pet(s) [ ] Hobbies [ ] Others _____

[ ] No

Work Details

4. In the last 3 months, I worked as a shift worker.

[ ] No [ ] Yes (please continue with “My work schedules are ...”).

My usual work schedule …

… starts at _____ o´clock.

… ends at _____ o´clock.

My work schedules are …

[ ] very flexible [ ] a little flexible [ ] rather inflexible [ ] very inflexible

I travel to work …

[ ] within an enclosed vehicle (e.g. car, bus, underground).

[ ] not within an enclosed vehicle (e.g. on foot, by bike).

[ ] I work at home.

For the commute to work, I need ___ hours and ___ minutes.

For the commute from work, I need ___ hours and ___ minutes.

Time Spent Outdoors

On average, I spend the following amount of time outdoors in daylight (without a roof above my head):

on workdays: _____ hours _____ minutes

on free days: _____ hours _____ minutes

Stimulants

Please give approximate/average amounts!

I smoke _____ cigarettes per	[ ] day	[ ] week	[ ] month
I drink _____ glasses of beer per	[ ] day	[ ] week	[ ] month
I drink _____ glasses of wine per	[ ] day	[ ] week	[ ] month
I drink _____ glasses of liquor per	[ ] day	[ ] week	[ ] month
I drink _____ cups of coffee per	[ ] day	[ ] week	[ ] month
I drink _____ cups of black tea per	[ ] day	[ ] week	[ ] month
I drink _____ cans of caffeinated soda per	[ ] day	[ ] week	[ ] month
I take sleep medication _____ times per	[ ] day	[ ] week	[ ] month

Pittsburgh Sleep Quality Index

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. **Please answer all questions.**

1. During the past month, what time have you usually gone to bed at night? _____
2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night? _____
3. During the past month, what time have you usually gotten up in the morning? _____
4. During the past month, how many hours of actual sleep did you get at night (this may be different than the number of hours you spend in bed)? _____

5. During the past month, how often have you had trouble sleeping because you …..	**Not during the past month**	**Less than once a week**	**Once or twice a week**	**Three or more times a week**
a. Cannot get to sleep within 30 mins				
b. Wake up in the middle of the night or early morning				
c. Have to get up to use the bathroom				
d. Cannot breathe comfortably				
e. Cough or snore loudly				
f. Feel too cold				
g. Feel too hot				
h. Have bad dreams				
i. Have pain				
j. Other reason(s), please describe:				
6. During the past month, how often have you take medicine to help you sleep (prescribed or over the counter)?				
7. During the past month, how often have you had trouble staying awake while driving, eating				

meals, or engaging in social activity?				
	No problem at all	**Only a very slight problem**	**Somewhat of a problem**	**A very big problem**
8. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?				
	Very good	**Fairly good**	**Fairly bad**	**Very bad**
9. During the past month, how would you rate your sleep quality overall?				
	No bed partner or room mate	**Partner/roommate in the other room**	**Partner in same room, but not same bed**	**Partner in same bed**
10. Do you have a bed partner or roommate?				
If you have a roommate or bed partner, ask him/her how often in the past month you have had:	**Not during the past month**	**Less than once a week**	**Once or twice a week**	**Three or more times a week**
a. Loud snoring				
b. Long pauses between breaths while asleep				
c. Legs twitching or jerking while you sleep				
d. Episodes of disorientation or confusion during sleep				
e. Other restlessness while you sleep, please describe:				

Brief Index of Sleep Control (BRISC)

Please answer the following questions for the past two (2) weeks.

How much control do you have over…	None at all	A little control	Some control	A lot of control	Complete control
When you go to sleep?					
When you wake up?					
How much you sleep?					
How well you sleep?					

Insomnia Severity Index

Please rate the following symptoms for the past two (2) weeks.

	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How **SATISFIED/DISSATISFIED** are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How **NOTICEABLE** to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all noticeable	A little	Somewhat	Much	Very much noticeable
0	1	2	3	4

6. How **WORRIED/DISTRESSED** are you about your current sleep problem?

Not at all worried	A little	Somewhat	Much	Very much worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning CURRENTLY?

Not at all interfering	A little	Somewhat	Much	Very much interfering
0	1	2	3	4

Short UPPS-P

Below are a number of statements that describe ways in which people act and think. For each statement, please indicate how much you agree or disagree with the statement. If you Agree Strongly circle 1, if you Agree Somewhat circle 2, if you Disagree somewhat circle 3, and if you Disagree Strongly circle 4. Be sure to indicate your agreement or disagreement for every statement below.

	Agree Strongly	**Agree Some**	**Disagree Some**	**Disagree Strongly**
1. I generally like to see things through to the end.	1	2	3	4
2. My thinking is usually careful and purposeful.	1	2	3	4
3. When I am in a great mood, I tend to get into situations that could cause me problems.	1	2	3	4
4. Unfinished tasks really bother me.	1	2	3	4
5. I like to stop and think things over before I do them.	1	2	3	4
6. When I feel bad, I will often do things I later regret in order to make myself feel better now.	1	2	3	4
7. Once I get going on something I hate to stop.	1	2	3	4
8. Sometimes when I feel bad, I can’t seem to stop what I am doing even though it is making me feel worse.	1	2	3	4
9. I quite enjoy taking risks.	1	2	3	4
10. I tend to lose control when I am in a great mood.	1	2	3	4
11. I finish what I start.	1	2	3	4
12. I tend to value and follow a rational, “sensible” approach to things.	1	2	3	4

13. When I am upset I often act without thinking.	1	2	3	4
14. I welcome new and exciting experiences and sensations, even if they are a little frightening and unconventional.	1	2	3	4
15. When I feel rejected, I will often say things that I later regret.	1	2	3	4
16. I would like to learn to fly an airplane.	1	2	3	4
17. Others are shocked or worried about the things I do when I am feeling very excited.	1	2	3	4
18. I would enjoy the sensation of skiing very fast down a high mountain slope.	1	2	3	4
19. I usually think carefully before doing anything.	1	2	3	4
20. I tend to act without thinking when I am really excited.	1	2	3	4

Center for Epidemiologic Studies Depression Scale (CESD)

Please rate the following symptoms for the past two (2) weeks.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4. I felt I was just as good as other people.	0	1	2	3
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	0	1	2	3
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	0	1	2	3
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	0	1	2	3

17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people dislike me.	0	1	2	3
20. I could not get “going”.	0	1	2	3

Generalized Anxiety Disorder – 7 Questionnaire

Please rate the following symptoms for the past two (2) weeks.

	Not at all	Several Days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3

Sleep Disorders Symptoms – Check List – 25

Please rate the following symptoms for the past three (3) months.

	NEVER	ONCE A MONTH	1-3 TIMES / WEEK	3-5 TIMES / WEEK	>5 TIMES / WEEK
1. My work or other activities prevent me from getting at least 7hrs of sleep	0	1	2	3	4
2. My bedtime or waketime varies by more than 3 hours	0	1	2	3	4
3. It takes me 30 minutes or more to fall asleep	0	1	2	3	4
4. I am awake for 30 minutes or more during the night	0	1	2	3	4
5. I wake up 30 or more minutes before I have to and can't fall back asleep	0	1	2	3	4
6. I am tired, fatigued, or sleepy during the day	0	1	2	3	4
7. I sleep better if I go to bed before 9PM and wake up before 4:30AM	0	1	2	3	4
8. I sleep better if I go to after 1am and wakeup after 9am	0	1	2	3	4
9. I am prone to fall asleep at inappropriate times or places	0	1	2	3	4
10. I snore	0	1	2	3	4
11. I wake up with a dry mouth in the morning (cotton mouth)	0	1	2	3	4
12. My snoring is so loud, that my bed partner complains	0	1	2	3	4
13. I have been told that I stop breathing in my sleep	0	1	2	3	4
14. I wake up choking or gasping for air	0	1	2	3	4

15. I feel uncomfortable sensations in my legs, especially when sitting or lying down, that are relieved by moving them	0	1	2	3	4
16. I have an urge to move my legs that is worse in the evenings and nights	0	1	2	3	4
17. I wake up frequently during the night for no reason	0	1	2	3	4
18. When angered, humored, frightened, I experience sudden muscle weakness	0	1	2	3	4
19. When falling asleep or waking up, I experience scary dream like images	0	1	2	3	4
20. When I am first awakening, I feel like I can't move	0	1	2	3	4
21. I have nightmares	0	1	2	3	4
22. For no reason, I awaken suddenly, startled, and feeling afraid	0	1	2	3	4
23. I have been told that I walk, talk, eat, act strangely or violently when I sleep	0	1	2	3	4
24. I grind my teeth or clench your jaw during your sleep	0	1	2	3	4
25. My sleep difficulties interfere with my daily activities	0	1	2	3	4

Columbia Suicide Severity Ratings Scale – Modified

Please answer the following questions.

Suicidal Ideation	**Lifetime**		**Past 3 Months**	
1. Have you wished you were dead or wished you could go to sleep and not wake up?	Yes	No	Yes	No
2. Have you had any thoughts of killing yourself?	Yes	No	Yes	No
3. Have you been thinking about how you might kill yourself?	Yes	No	Yes	No
4. Have you had these thoughts and had some intention of acting on them?	Yes	No	Yes	No
5. Have you worked out the details of how to kill yourself? Do you intend to carry out this plan?	Yes	No	Yes	No
Suicidal Behavior	**Lifetime**		**Past 3 Months**	
6. Have you taken steps toward making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away, or writing a suicide note)?	Yes	No	Yes	No
7. Have you hurt yourself for reasons other than to die or without any intention of killing yourself (like to relieve stress, feel better, or get something else to happen)?	Yes	No	Yes	No
8. Have you made a suicide attempt?	Yes	No	Yes	No

Disturbing Dream and Nightmare Severity Index (DDNSI)

Please rate the following symptoms for the past two (2) weeks.

1. How many nights in a week do you have nightmares?

0 1 2 3 4 5 6 7

2. How many nightmares do you have per week?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

3. How many times do the nightmares wake you up?

0 (Never) 1 2 3 4 (Always)

4. How severe is your nightmare problem?

0 (No problem) 1 2 3 4 5 6 (Extremely severe)

5. How intense are your nightmares?

0 (Not intense) 1 2 3 4 5 6 (Extremely intense)

The Interpersonal Needs Questionnaire

The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently. Use the rating scale to find the number that best matches how you feel and circle that number. There are no right or wrong answers: we are interested in what you think and feel.

	Not at all true for me			Somewhat true for me			Very true for me
1. These days, the people in my life would be better off if I were gone	1	2	3	4	5	6	7
2. These days, the people in my life would be happier without me	1	2	3	4	5	6	7
3. These days, I think I am a burden on society	1	2	3	4	5	6	7
4. These days, I think my death would be a relief to the people in my life	1	2	3	4	5	6	7
5. These days, I think the people in my life wish they could be rid of me	1	2	3	4	5	6	7
6. These days, I think I make things worse for the people in my life	1	2	3	4	5	6	7
7. These days, other people care about me	1	2	3	4	5	6	7
8. These days, I feel like I belong	1	2	3	4	5	6	7
9. These days, I rarely interact with people who care about me	1	2	3	4	5	6	7
10. These days, I am fortunate to have many caring and supportive friends	1	2	3	4	5	6	7
11. These days, I feel disconnected from other people	1	2	3	4	5	6	7
12. These days, I often feel like an outside in social gatherings	1	2	3	4	5	6	7
13. These days, I feel that there are people I can turn to in times of need	1	2	3	4	5	6	7

14. These days, I am close to other people	1	2	3	4	5	6	7
15. These days, I have at least one satisfying interaction every day	1	2	3	4	5	6	7

Medical History

1. How would you rate your overall health?

Excellent Very Good Good Fair Poor

2. Do you have depression?

Yes, diagnosed by a clinician Yes, but undiagnosed No Not sure

3. Do you have bipolar disorder?

Yes, diagnosed by a clinician Yes, but undiagnosed No Not sure

4. Do you have an anxiety disorder?

Yes, diagnosed by a clinician Yes, but undiagnosed No Not sure

5. Do you have schizophrenia, schizoaffective disorder, or another psychotic disorder?

Yes, diagnosed by a clinician Yes, but undiagnosed No Not sure

6. Do you have post-traumatic stress disorder (PTSD)?

Yes, diagnosed by a clinician Yes, but undiagnosed No Not sure

7. Do you have a seizure disorders, or have had seizures?

Yes, diagnosed by a clinician Yes, but undiagnosed No Not sure

8. What medications are you currently taking? (Please include prescription and over-the-counter medications).

Name of medication	Dose/How much?	When do you take it	Why do you take it?

Substance Use

1. How often do you consume caffeinated products? (Like coffee, tea, energy drinks, etc.)

____ Never

____ Once a month or less

____ Once a week or less

____ A few times a week

____ Every day

____ Multiple times per day

2. On days when you drink caffeinated beverages, what times do you drink them?

[ ] I never drink caffeinated beverages.

[ ] Early morning (5AM-8AM)

[ ] Morning (8AM-11AM)

[ ] Noontime (11AM-2PM)

[ ] Afternoon (2PM-5PM)

[ ] Early Evening (5PM-8PM)

[ ] Evening (8PM-11PM)

[ ] Late Evening (11PM-2AM)

[ ] Middle of Night (2AM-5AM)

3. Do you smoke cigarettes or other tobacco products?

____ Current smoker (daily)

____ Current smoker (occasionally)

____ Former smoker

____ Never smoked

4. On days that you smoke cigarettes or use other tobacco products, what times of the day do you smoke?

[ ] I never smoke or use other tobacco products

[ ] Early morning (5AM-8AM)

[ ] Morning (8AM-11AM)

[ ] Noontime (11AM-2PM)

[ ] Afternoon (2PM-5PM)

[ ] Early Evening (5PM-8PM)

[ ] Evening (8PM-11PM)

[ ] Late Evening (11PM-2AM)

[ ] Middle of Night (2AM-5AM)

5. How often do you use tobacco products to help you wind down at night?

____ Often

____ Rarely

____ Never

6. How often do you drink alcohol?

____ Never

____ Once a month or less

____ Once a week or less

____ A few times a week

____ Every day

____ Multiple times a day

7. On days that you drink alcohol, what times of the day do you drink?

[ ] I never drink alcohol

[ ] Early morning (5AM - 8AM)

[ ] Morning (8AM - 11AM)

[ ] Noontime (11AM - 2PM)

[ ] Afternoon (2PM - 5PM)

[ ] Late Afternoon (5PM - 8PM)

[ ] Evening (8PM - 11PM)

[ ] Late Evening (11PM - 2AM)

[ ] Late Night (2AM - 5AM)

8. How often do you use alcohol to help you sleep?

____ Often

____ Rarely

____ Never

9. How often do you use marijuana/cannabis? (Remember -- this is completely private and confidential. We use this information for scientific purposes only.)

____ Never

____ Once a month or less

____ Once a week or less

____ A few times a week

____ Every day

____ Multiple times a day

10. On days that you use cannabis/marijuana, what times of the day do you use it?

[ ] I never use cannabis/marijuana

[ ] Early morning (5AM - 8AM)

[ ] Morning (8AM - 11AM)

[ ] Noontime (11AM - 2PM)

[ ] Afternoon (2PM - 5PM)

[ ] Late Afternoon (5PM - 8PM)

[ ] Evening (8PM - 11PM)

[ ] Late Evening (11PM - 2AM)

[ ] Late Night (2AM - 5AM)

11. How often do you use marijuana/cannabis to help you sleep?

____ Often

____ Rarely

____ Never

Demographics

1. What is your date of birth? Month _____ Day _____ Year _____
2. What is your sex? ____ Male ____ Female
3. What is your race (select all that apply)?

[ ] White / Caucasian

[ ] Black / African American

[ ] Native American / Alaska Native

[ ] Asian American

[ ] Native Hawaiian / Pacific Islander

4. What is your ethnicity?

[ ] Hispanic or Latino

[ ] Non-Hispanic / Non-Latino

5. Please describe your sexual orientation:

[ ] Heterosexual [ ] Homosexual (lesbian or gay) [ ] Bisexual [ ] Asexual

6. Are you transgender? [ ] Yes [ ] No
7. Which is your dominant hand? [ ] Left-handed [ ] Right-handed [ ] Both
8. What is the highest level of education you have completed?

[ ] Less than high school

[ ] High school or equivalent

[ ] Some college

[ ] Bachelors or Associates degree

[ ] Master's Degree

[ ] Doctoral Degree

9. What is your current income?

[ ] <$25,000

[ ] $25,000 - $50,000

[ ] $50,000 - $100,000

[ ] $100,000 - $200,000

[ ] >$200,000

Thank you!

You have completed the entire survey.

We know it was pretty long, but your information is very valuable. We really appreciate the time and effort that you have put into this.

If you ever have any questions or concerns, please do not hesitate to contact us at atubbs@email.arizona.edu.

Thanks again!

Sincerely,

Andrew Tubbs

MD/PhD Candidate

Sleep and Health Research Program

University of Arizona Department of Psychiatry