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Particularities of Suicidal Behavior in Depressive Spectrum

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Abstract

Suicide is one of the leading causes of death in the world, and depression is among the top causes of morbidity and mortality at international level. The main complication of any depression is precisely suicidal behavior, with all its facets. The present work is a succinct study aimed at highlighting the main categories of motivations that lead to suicidal behaviors in the spectrum of depression. The group of patients selected for this study presents all possible variants of diagnoses in the spectrum of endogenous depressions. The research reveals data on psychotic motivation, motivations in the socio-familial and professional sphere, as well as the correlation between the present suicidal behavior and the clinical form of depression. The findings emphasize once again the imperative need not to neglect any of the symptoms of depression, from anxiety to delusional hallucinatory phenomena, in correlation with the patient's entire bio-psycho-social context, to support the prevention of any form of suicidal behavior.

Keywords: suicidal attempt, suicidal ideation, suicidal motivation, depressive spectrum, social insertion.

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Introduction

Suicide is a severe problem, with complex implications, its overall rate being 18/100000, with variations related to gender, age, ethnicity etc. Suicide is, beyond the individual impact, a priority public health issue. According to the WHO, suicide is the act by which an individual seeks to physically self-destruct, with more or less genuine intention of losing his life, being more or less aware of his motives. „ Suicide is 3-12 times more common in psychiatric patients than in the general population (Gulliver *et al*., 2012. The main disorders associated with suicidal behavior are emotional disorders (major depression and bipolar disorder), schizophrenia, alcohol abuse and abuse, personality disorders (borderline and antisocial), organic disorders (epilepsy, dementia), anxiety disorders (posttraumatic stress disorder) , unipolar depression (Franklin, Hessel, & Prinstein, 2011). Of the victims of suicide, 45-64% suffer from a depressive spectrum pathology and, on the other hand, 15% of patients with depression commit suicide. Depressive states appear in many mental illnesses, and may be accompanied by autolithic behavior, which is why depression should be approached as a genuine medical-psychiatric emergency. Identifying suicide risk is one of the most challenging diagnostic challenges in psychiatry, often targeting patients with marked dissimulation behavior (Cassidy, 2011).

Depression is estimated in current practice at primary care at 20% of all patients with psychiatric disorders. The clinical experience suggests that 30% of depressed patients at some point in the development of their psychiatric disorder, experience a mood swing, becoming bipolar depression (Kaplan, McFarland, & Huguet, 2007). Ethnic variations can be significantly correlated with genetic differences in different populations, explaining different epidemiological values and indirectly confirming the neurobiological background (Dombrovski *et al*., 2010). Thus, studies on the Chinese population have estimated prevalence values of 0.4% for bipolar disorder and 1.4% for major unipolar depression (O'Connor *et al.*, 2011). The incidence of depression - 80 - 200 / 100,000 / year in the male population and 250 and 7,800 / 100,000 / year in women (Malone *et al*., 2000). The average age of onset - towards the end of the third decade of life, but the disease can begin at any age, starting from childhood (Kleiman & Riskind, 2012).

Generalities on depression and suicidal behavior

According to biological theory, autolytic conduct is indissolubly linked to the level of 5-hydroxyindolacetic (5-HIAA), a serotonin metabolite, which modulates affectivity, impulsivity, aggressiveness (Nock *et al*., 2010). Thus, a serotoninergic activity decreased in the prefrontal cortex will lead to a behavioral and cognitive disinhibition, resulting in aggressive and consecutive impulses of suicide (Rihmer *et al.*, 2008). Suicidal behavior has several aspects (Tureaki *et al.,* 2012). One

of these is the suicidal ideation, which is the existence of thoughts expressed in various forms, without having a concrete autolithic purpose (Disner *et al.*, 2010). Another aspect is the threat of suicide that constitutes the oral or written expression of suicidal intention without the well-intentioned desire to commit this act (Thompson, 2014). Suicide attempts (parasuicide) are self-action actions performed either with the real intention of committing suicide (unsuccessful suicide) (Azorin *et al.*, 2010), or with the intention of transmitting various states, messages to the entourage (Gibbons *et al.*, 2012). Complete suicide is the end point and irreversible element of self-limiting behavior (Hegerl *et al*., 2006), producing deadly lesions with a clear previous intention of dying (Pirkis *et al.*, 2016).

According to the Practical Intervention Guide of the American Psychiatric Association (APA), suicidal risk assessment is a multi-axial process that corroborates data gathered on the subject's behavior and behavior as well as its psychosocial factors and history (Mann *et al*., 2008). The purpose of the suicide risk assessment is to identify the factors that may increase or decrease the risk of suicide and allow the rapid formulation of a safety plan that addresses those favorable factors (Wahto & Swift, 2016).

The purpose of the assessment is to quickly guide the subject to a certain degree of risk and then to allow an immediate individual intervention to secure the subject and attack the targets of the care program (van Order, 2012). Granello & Granello (2007) identifies 12 principles underpinning the suicide risk assessment process. He starts from the idea that trying to evaluate a suicidal individual, the clinician is tempted to adopt a detailed, focused, detail-based attitude and thus presents a vision in the tunnel that ignores the wider picture of the subject's life, interests, and situation.

Essential Principles of Suicidal Risk Assessment are: (1) Every person is unique, different; (2) Evaluation is complex and challenging for both subject and clinician; (3) Evaluation is a continuous process that extends throughout the care of the subject; (4) Leads to possible errors generated by excessive caution (eg false positives); (5) Evaluation is an activity that is based on collaboration, collaboration and consultation; (6) Evaluation is based on clinical judgment; (7) Take seriously all threats, alarm signs and risk factors; (8) Ask hard questions, incommode, embarrassment; (9) Suicidal risk assessment is part of the therapeutic intervention; (10) Evaluation seeks to uncover the hidden messages of the subject; (11) The evaluation is done in a cultural context that must be taken into account; (12) All evaluation actions must be documented in the subject file.

Motivation of the study

Depression is undoubtedly one of the most common disorders in the population; the risk of developing a depressive disorder throughout life is 15% (Arsenault-Lapierre, Kim, & Turecki, 2004). According to the World Health Organization

(WHO), depressive disorder is currently the fourth most disabling cause and is expected to reach the second place after the cardiovascular disease in 2020. The exact prevalence of this disorder is not yet established due to the variety of diagnostic criteria used in epidemiological studies, estimated to be 5-12% in males and 12-20% in females (Szantok *et al*., 2007). The term „depression" is inappropriate because it refers to a single illness (Cavanagh *et al*., 2003), while depression has a number of clinical manifestations, and the phrase „depressive disorders" is more appropriate (Jollant *et al.*, 2005, Jollant *et al.,* 2011). In the American Psychiatric Association (2000) data, the incidence of major depressive disorder was 1% in males and 3% in females, the mean age is 40 years for both sexes, 50% of cases starting 40 years ago, and 10% 60 years old. The present paper refers to the detection of basic clinical correlations in order to highlight patterns of depression that associate suicidal behavior, including ruminative, ideological, and autolithic attempts.

Participants and procedure

This integral part of the research on the motivational pattenings of suicidal behavior in the depression spectrum focuses on the detection of clinical correlations and implicitly diagnostics of various forms of depression with or without psychotic symptoms that associate rumina, or even self-help attempts. The batch targets only male patients to avoid including an additional variable and to provide better homogeneity to the group as it is a narrow study that highlights behavioral peculiarities that may undergo variations on gender. Thus, we have recruited a consignment of 170 patients admitted to the Socola Institute of Psychiatry, having main diagnostics of the depression spectrum, including: (1) Severe Depressive Episode with Ideation or Autolytic Attempt; (2) Severe Depressive Episode with Psychotic Symptoms and Autolithic Ideation or Tentative; (3) Major recurrent depressive disorder, current severe episode with suicidal ideation or attempt; (4) Major recurrent depressive disorder, current severe episode with psychotic symptoms and autolithic ideation or attempt; (5) Bipolar affective disorder, current depressive episode with psychotic symptoms and with suicidal ideation or attempt; (6) Bipolar affective disorder, current depressive episode with suicidal ideation or attempt.

Positive diagnostics (WHO, APA)

- Disposition: depressive, irritable or anxious.
- Associated psychological manifestations: lack of self-confidence, low self-esteem, concentration deficit, loss of interest in ordinary activities, negative expectations, death and suicide ideas.
- Somatic manifestations: psychomotor inhibition (or agitation), anorexia with

weight loss (or weight gain), fatigue, insomnia (or hypersomnia), anhedonia, loss of sexual desire.
- Psychotic symptoms: delusions of devaluation and sin, reference and persecution, negative health change, poverty, depressive hallucinations.
- Exclusion criteria: absence of a somatic and / or cerebral condition, and the possibility of inducing symptomatology by a psychoactive substance.

Evaluation

For the standard depression assessment, the following scales were used Hamilton Depression Scale (HAM-D). The clinical evaluation of the patients included in this section of the study necessarily included the following: (1) family history and heredocolateral history; (2) psychiatric history, treatment history (compliance issues, responsiveness to treatment, duration of treatment; (3) Somatic resistance factors (ferrites anemia, hypoproteinaemia, thyroid dysfunction), alcohol addiction and alcohol consumption, lack of socio-familial support.

The exclusion criteria aimed precisely not to include cases of: (1) depressive disorder due to a general medical condition; (2) substance-induced depressive disorder; (3) mourning; (4) schizoaffective disorder; (5) schizophrenia; (6) personality disorders; (7) depressive mood disorder; (8) primary sleep disturbances; (9) anxiety disorders with depression. The present study is retrospective, descriptive, clinical anamnestic and paraclinical information being omitted from patients' clinical charts.

Results and discussion

The results of this study outline the predominant symptoms of depressive episodes, highlight the distribution of depressions depending on the anxious or inhibited form and mark different patterns of autolithic behavior. This analyzes the frequency of autolithic ruminations, the actual autolithic idea, and the unique and multiple attempts at patients in the study group. It also includes the category of autolitician ruminaticii in the context of the appearance of these as suicidal thoughts, which can gradually evolve towards ideation and suicidal attempt. In addition, the results highlight the frequency of psychotic symptoms associated with depressive episodes. As well as its relationship with the motivation of suicidal behaviors. Later, the correlation between ideation / suicidal rumination / suicidal attempts and the presence of the main motivational springs revealed by the observation sheets of the patients included in this study is analyzed. Finally, Hamilton scores for depression are associated with the different types of suicidal behavior.

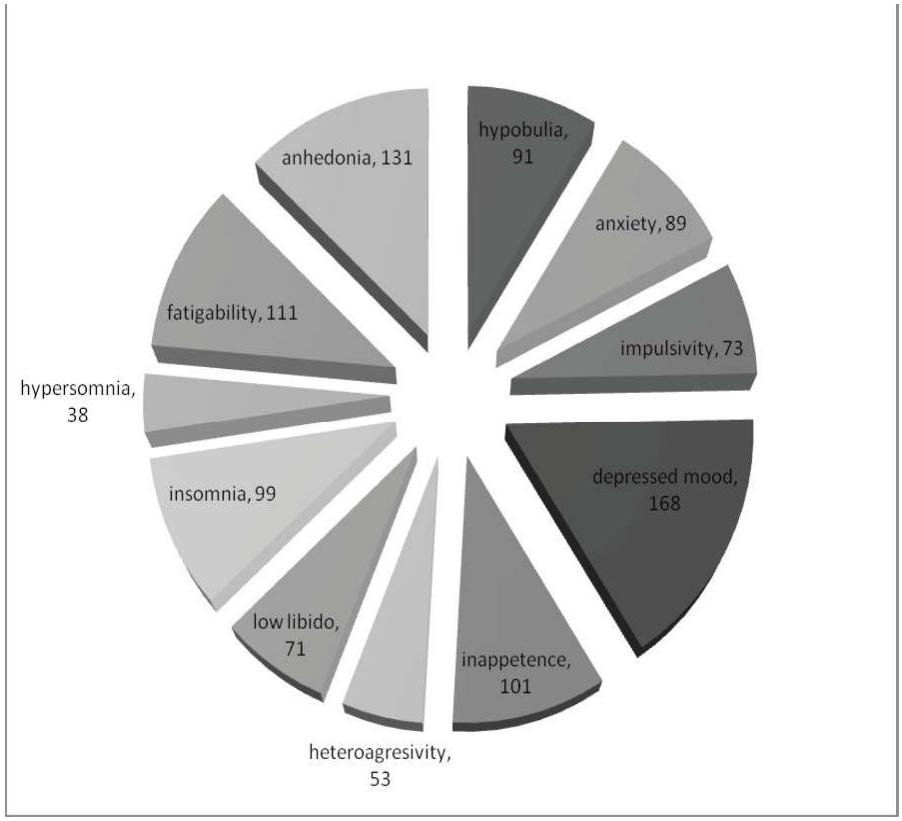

Figure 1. Distribution of main symptoms in depression

The frequency of main symptoms of depression in the study group is similar to international statistics, depressed mood, anhedonia and fatigability are the most consistent signs of depression. These symptoms create by themselves, an unfavorable context to the patient, making room for thoughtless thoughts that gradually evolve towards the only viable solution that the patient can think of, namely self-annihilation (*Figure 1*).

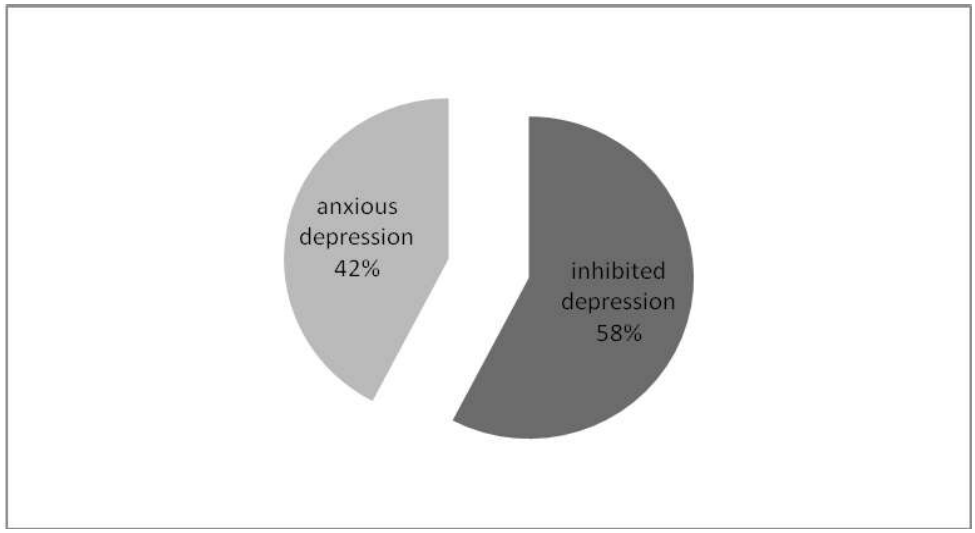

Figure 2. Distribution of cases by depression type

Inhibited depression correlates sensitively with several cases of suicide versus anxiety. However, the increased incidence of suicidal behavior among patients with dominant anxiety elements is explained by the fact that paradoxically, anxiety is a universally acknowledged predictor / risk factor for suicide. On the other hand, inhibited depressions imply marked hypobulia, so the patient requires a strong determination to move to the act, the suicide remaining for him, the only solution to exit from a seemingly unresolved situation (*Figure 2*).

In addition, it is important to note that in the study group, the most common manifestation of suicidal behavior is a single attempt, followed by persistent suicidal ideation and recurrent attempts. Suicidal rumination have the lowest frequency precisely because they often remain unidentified / undeclared by patients.

The unique attempts detected in this study occurred in 38% of cases after ingestion of alcoholic beverages, the patients included in the batch not being alcohol dependent and having no psychiatric pathology related to the use and abuse of alcohol, due to the debilitation state it can cause ethanol on the central nervous system (*Figure 3*). In 42% of cases of a single suicide attempt and the new cases of attempted recurrent attempts are made by voluntary drug or polymedicine intake, while 12% of them have tempted suicide by ingestion of pesticides or other toxic substances. Of the 42% who ingest the medication, 85% have ingested psychotropic medication, the rest having suicidal attempts by ingestion of various drugs, from non-steroidal anti-inflammatory drugs to prescription medication for cardiac pathology. Of the patients who inhaled psychotropic meditation, 62%

used their own medication, prescribed for depression, and the rest had ingested medication from relatives who had a psychotropic background medication. The most commonly used psychotropic agents were benzodiazepines, and in most cases where benzodiazepines were involved in the patient's personal prescriptions, they were present in the baseline treatment regimen of at least 60 days.

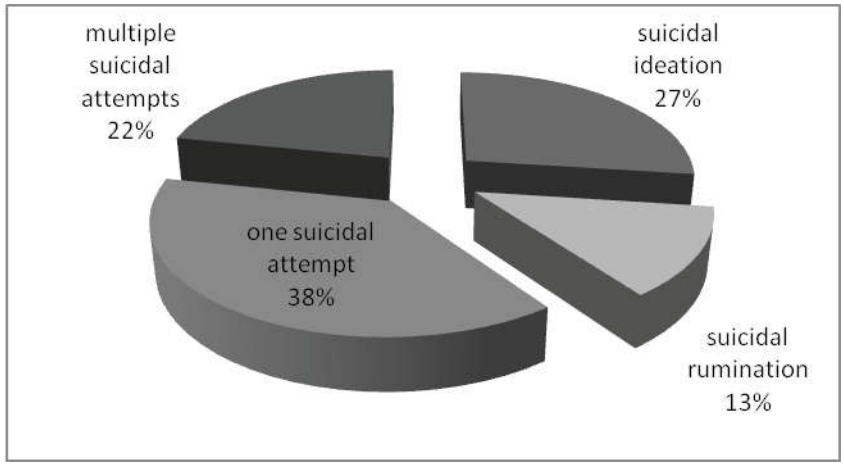

Figure 3. Type of suicidal behavior

With regard to cases of depressive episodes with psychotic symptoms, most patients have committed suicide attempts under the influence of psycho-productive phenomena, especially against the background of a delusional idea. A smaller proportion of patients with depressive episode with psychotic symptoms had suicidal motivations independent of associated psychotic phenomena (*Figure 4*).

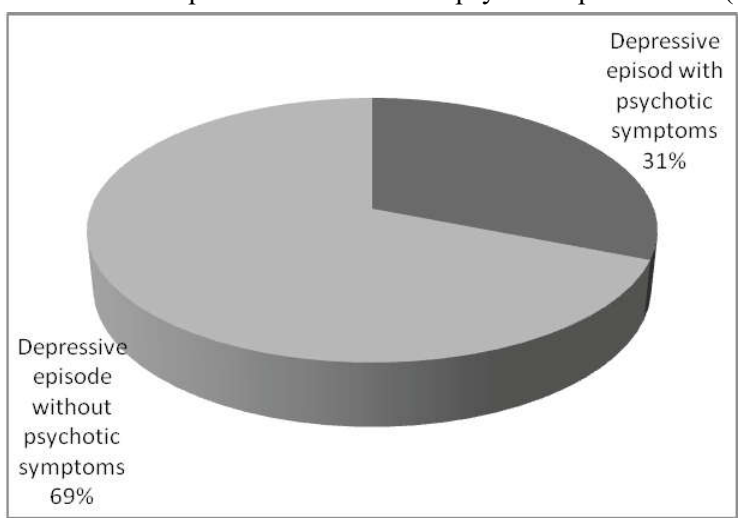

Figure 4. Distribution of cases by presence/absence of psychotic symptoms

Thus, among those who have experienced suicidal behavior in a psychotic context, most have presented a delusional idea of futility and self-deprivation, the rest having either other delusional forms of depressed delusional ideas or even hallucinations in the context of a true Cotard syndrome (2 % of patients in the study group). Of the patients who experienced degrading or defamatory hearing hallucinations, 41% committed suicide attempts, and 36% of those experiencing imperative hallucinations, who dictate suicidal acts, autolitized themselves. The rest presented only suicidal behavior independent of psycho-productive phenomena *(Figure 5, 6, 7)*.

In this respect, the fundamental importance of the correct management of delusional-hallucinatory symptoms associated with depressive episodes, which by their content can increase the suicidal risk of the targeted patients, is underlined.

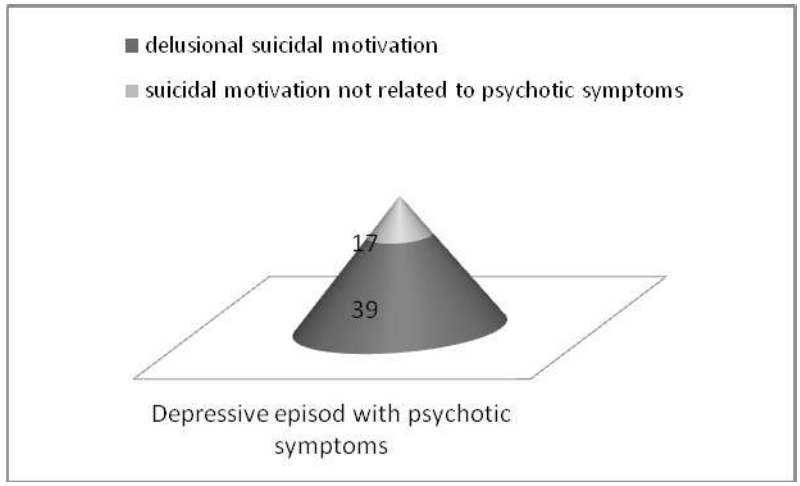

Figure 5. Presence/absence of psychotic motivation for suicidal behavior in depressive episod with psychotic symptoms

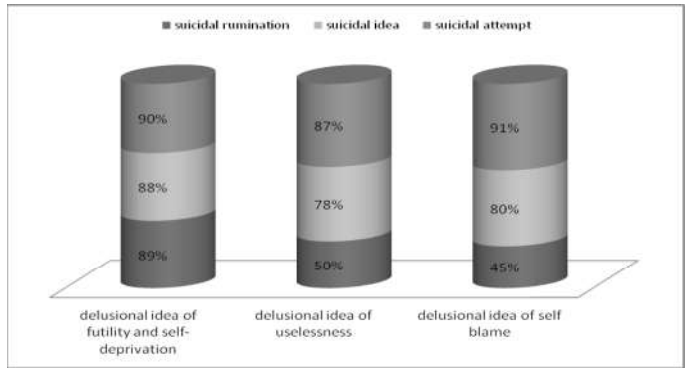

Figure 6. Correlation between type of delusional idea and type of suicidal behavior

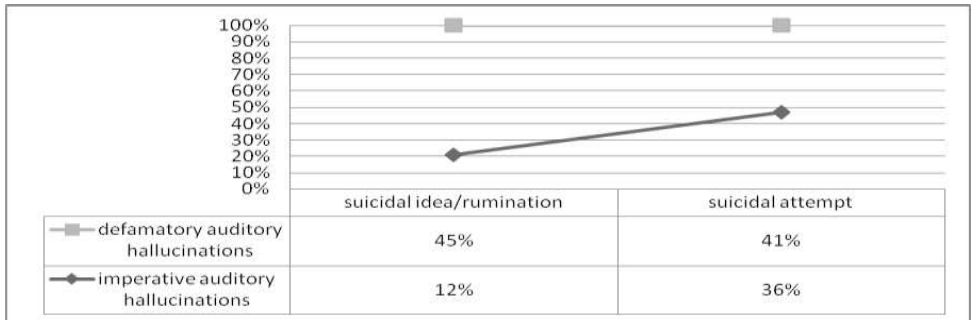

Figure 7. Main types of hallucinations in psychotic depression and type of suicidal behavior

Regarding unrelated motifs of psychotic phenomena, occurring in all types of depressive episodes in the endogenous pseudo, the most common reasons were the rationale for financial difficulties, those related to poor family affiliation (including couple issues) and those related to poor social and professional insertion (*Figure 8*).

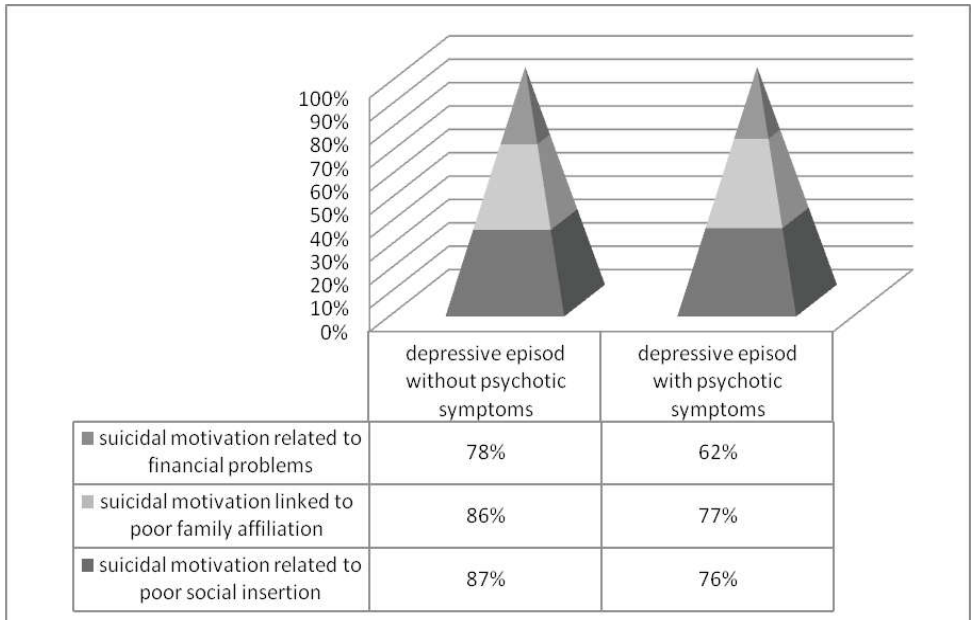

Figure 8. Main social reasons for suicid

Regarding the correlation between the presence of different types of suicidal behavior and the scores of the Hamilton scale for depression, there is a direct proportionality between the inward scores and the increase in the frequency of

suicidal attempts, while for inferior scores defining all the severe depression, the suicidal ideation is more frequent (*Figure 9*).

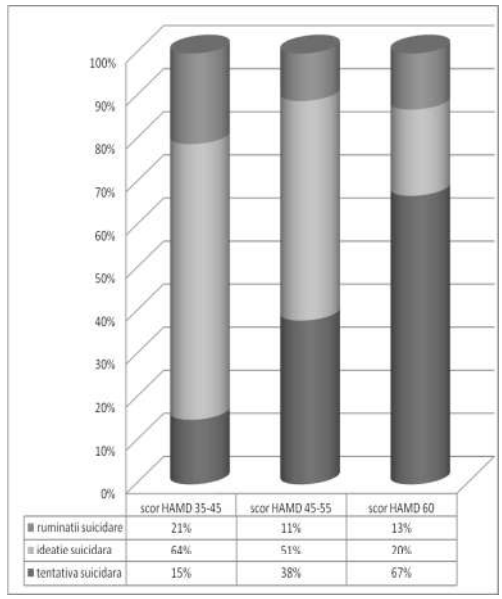

Figure 9. Suicidal behavior correlated to HAMD

Conclusion

The results obtained in this section of the research on motivational patterns of suicidal behavior are related to major milestones, re-analyzes and trends in international suicide research. The relationship of direct proportionality of the severity of depression with the higher ability to commit suicide is confirmed, in the context of reaching an unbearable ceiling of despair. This paper is a preamble for more specific future research that takes into account particular items on depression and suicide scales and correlations between items that directly target suicidal behavior and different forms of suicidal behavior. The results also reveal that the usual scales used to quantify the severity of depression can be important predictors of potential suicidal behavior. In addition, the present study requires an extension to provide a comparative picture of the revealed elements related to male gender and in terms of female population, with specific gender specifics.

At the same time, we can observe the polymorphism of the suicidal motivational profile, reflecting once again the imperious need to not neglect the psychotic symptoms that can be associated with depression, which can often bring about an autolithic behavior. In addition, there are a number of differences regarding

suicidal behavior according to the socio-familial insertion level of patients with depression. Thus, the importance and relevance of the biopsychosocial concept in the integrated and multidimensional understanding of the motivational resorts of suicidal behavior is reconfirmed.

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