

RISK FACTORS FOR SUICIDAL BEHAVIOR MOOD DISORDERS IN ADULTS AND ADOLESCENTS

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ANNOTATION

This article states that currently suicide attempts and suicide among adults and adolescents is common and major global clinical and public health problem health among psychiatric patients. It was mentioned that identifying risk factors for certain types of underlying affective disorders can help determine suicide risk, support preventive measures and treatment of patients from risks and improvement forecast. In particular, bipolar disorders and depressive disorder have a particularly high risk of mental illness.

Keywords: depression risk factors for suicide, bipolar disorders, suicide attempts

INTRODUCTION

Relevance among patients with major depressive episodes a diagnosis of bipolar disorder or the presence of concomitant borderline personality traits imply extremely high risk suicidal attempts. Risk factors for suicidal thoughts and suicidal actions overlap, but may not. Estimated severity borderline personality traits, apparently associated with a history of suicidal behavior and the current severity of suicidal thoughts in C 384 ISSN 2181-712X. EISSN 2181-2187 2 (34/3) 2021□ depending on doses in all patients with mood disorder. Therefore, reliable assessment of borderline characteristics may contribute to the assessment of suicidal risk.

MATERIAL AND METHODS

We looked at risk factors before, during and after 32 patients with and without suicidal actions, in general and with bipolar disorder compared with depressive disorder using two-dimensional comparisons. The included patients underwent a reassessment of their medical history and suicidal behavior (attempts or suicide) or have reported suicidal ideation for several years observations. A suicide attempt included any act with self-harm with or without evidence of intent to die him; violent acts included self-inflicted bodily injury with medical intervention or death, and See also hanging, drowning or strangulation, or jumping from a height. Clinical demographic information, descriptive and clinical characteristics, including prospectively assessed incidence over time, characteristics of suicidal behavior and prescribed treatment, were obtained on the basis of semi-structured interviews and life charts built with admission and updated during prospective clinical follow-up weekly through the index episode of the disease), when taken and thereafter with intervals from 1 to 6 months, depending on clinical indications.

RESULT AND DISCUSSION

The study sample included 32 patients with one of the following ICD-10 major mood disorders, with Bipolar I Disorder (BD-I), Bipolar II Disorder (BDII), and Major Depressive Disorder

(MDD) [1-30]. Medium the duration of the disease was 17.0 years s and 11.7 years; 68.6% were women. The age of the patients at the time of examination ranged from 24 to 42 years (mean age 30.1 ± 5.4 years). Suicidal risk identified suicidal ideation was significantly higher among patients with bipolar type II disorder (32.0%) than in patients with bipolar type I disorder (22.2%) and major depressive disorder (MDD) (29.2%) Lifetime risk of suicide attempts was slightly higher among participants with BD-I (19.9%) than among participants with BR-II (14.9%); but this risk was significantly 3.84 times higher among all patients with bipolar disorders (18.8%) than those with a large depressive disorder MDD (4.78%). Frequency of attempts per exposure time (percent per year) was higher in patients with BR-I compared with BR-II (1.18 for BR-I v.0.88 for BR-II, 1.45 times more; and 1.11 for BR-I versus 0.41 for BR-II, 2.52 times higher) and for patients with BR by compared to BDR. The risk and frequency of suicide were similar in patients with BR-I (1.71%; 0.10% per year) and BR-II (1.71%; 0.08% per year), but significantly higher for patients with BD in general (1.63%; 0.11. %year) than patients with MDD (0.48%; 0.03% year)

[2-25]. With regard to the risk and frequency of all suicidal actions (attempts + suicides), patients with BR-I (21.7%; 1.34% year) had the highest rates, followed by patients with BD-II (16.3%; 0.97% yearly). year), and then patients with MDD (4.96%; 0.45% year); these rates were high for BD patients overall (21.4%; 1.19%

year). Attempt-to-suicide ratio (12% per year), measure lethality (greater lethality at a lower ratio), indicates the same mortality among all diagnostic groups:

BR-II (9.69), BDR (11.2), BR-I (10.6) and all BRs (11.1). Percentage of violent attempts or suicide (including jumping, hanging, drowning or suffocation) among all suicidal acts was higher among patients with BR-I than in patients with BR-II (37.1 vs. 22.1%), and was not significantly higher in patients. patients with BR

compared with patients with MDD (32.8 vs. 22.9%). In addition, like expected, suicidal acts were more common among men in 1.58 times (39.8%, 94% CI 31.2–48.7) compared with women (22.6%, 19.2–30.6, $\chi^2 = 10.4$, $P = 0.001$) in both BR and MDD [4–15].

Among all patients with mood disorders, factors that were present before entering the study object and who were in significantly associated with suicidal actions during lifetime, included: family history of major affective disorder, suicide; be single or 2(34/3)2021 ISSN 2181-712X. EISSN 2181- 2187 385 divorced and have fewer children; unemployment and low socioeconomic status; have experienced early violence or trauma and are relatively early loss of a parent; be younger at the onset of illness and older be at risk; have more than four previous depressions; and hospitalization for mental illness. Comparison of proportions or values of indicators among patients with suicidal behavior and patients without suicidal behavior (attempt or suicide) to patients without suicidal actions include only patients with suicidal ideation [5-20]. Factors largely unrelated to suicidal behavior

included: post-high school education, anxiety and hyperthymia temperament. MDD major depressive disorder, BR bipolar

disorder; BD-I, BD type I; BD-II, BD type II; Adult Self-Esteem Scale

(ASRS-A), the Attention Deficit Disorder Screening Self-Assessment Scale and

hyperactivity in adults ADHD, part A; validation of the short version of the instrument with self-assessment, designed to measure variations in temperament TEMPS-A, HRSD Hamilton Depression Rating Scale; MDQ questionnaire for mood disorders [6-19]. When evaluating receipts, factors related to lifetime risk of suicidal acts included: advanced current age; BR (BR-I > BR-II) versus a diagnosis of MDD; comorbid disorder attention deficit hyperactivity disorder (ADHD), especially with inattention (higher score on the A-scale for adults ADHD); drug or alcohol abuse or smoking; absence anxiety disorder; mixed (hypomanic) symptoms in depressive episodes (with MDD or BD); transition to (hypo) mania with BRI; higher scores for dysthymic, cyclothymic, or irritable temperament (assessment of temperament); somewhat higher ratings on the Hamilton Depression Rating Scale (HRSD); and higher assessment of lifelong BD-like symptoms (assessment of the questionnaire mood disorders) [10-16]. Factors associated with suicide behaviors that were prospectively assessed during a follow-up observations included: longer exposure time (years at risk), higher incidence (as percentage of time carried out by sick, depressed or (hypomanic) and psychiatric hospitalization. In addition, although treatment was administered clinically, it is noteworthy that monotherapy antidepressants are much less likely to be given to suicidal patients, whereas the use of mood stabilizers or antipsychotic drugs alone or with antidepressants are much more common among suicidal patients.

CONCLUSIONS

This study presents the risks and average annual indicators for patients with suicidal actions (attempts or suicide), the relative risks of violent and non-violent suicidal acts, as well as estimates of suicidal thoughts among 32 equally and consistently assessed patients with serious affective disorders in one study. Overall, we found that the lifetime risk of suicidal thoughts is about

58%, suicidal attempts of varying severity - 29%, suicidal actions - 2.4% and for all actions - 29% with an average exposure time, which is 13.8 years.

The ratio of attempts and suicides was the same in patients with BD (10.9) and patients with MDD (10.2) and several times lower the study also identified quantitative associations of many demographic and clinical factors with suicidal actions, as well as their relative likelihood among individuals diagnosed with BD or MDD [8-28]. As expected, signs of less successful social functioning were associated with an increased risk of suicidal behavior. Such factors risk included being unmarried or divorced and therefore having children, as well as lower socioeconomic status and more unemployment. These factors are also independently associated with the presence of the disorder. Also associated with suicides and attempts were earlier disease onset, longer time from onset to admission, and more high current age, indicating a greater impact or more years risk. Higher suicidal risk was more associated with Br than with MDD, and the risk was similar among patients with BR-I and patients with BR-II. These results are consistent with previous observations regarding MDD sample cases by disease severity. Accompanying illnesses, associated with suicidal acts included ADHD and substance

abuse psychoactive substances, and smoking. However, contrary to expectations, comorbid anxiety disorders were associated with more low risk of suicidal acts, possibly due to a lower degree impulsivity [9-19]. BD diagnosis, risk factors associated with suicidal behavior included indicators of greater severity of the disease: in particular, time spent in illness or depression, multiple early relapses of depression, psychiatric hospitalization hospital and comorbid abuse psychoactive substances. Also with suicidal behavior strongly associated history of heart disease or suicide among family members first degree of relationship. We also found more high scores for certain types of affective temperaments, especially dysthymic and cyclothymic, among suicidal patients, as previously reported. It should be noted that the present results also confirm the well-known strong association of suicidal risk with mixed features, including patients diagnosed with BD or MDD. Elements that can be connected BR, mixed states and suicidal risks include aggressiveness and other mania associated characteristics in both adolescents and adults. Suicide methods or attempts were identified in 27.2% (85% CI 7.21–49.6) all suicidal actions (attempts + suicides), more with a diagnosis of BR-I, than BR-II or RDD and it is expected that there are more suicides than attempts, and more among men than among women. General the level of violent acts is slightly lower than recently recorded rates averaging 35.1% (91% CI 13.8–65.4; 37% for attempts vs. 52.3% for suicide, 33.1% among women versus 52.4% among men), probably due to regional and cultural differences [11-22]. Another interesting observation is that the use of antidepressants alone was much less common among suicidal patients than those who are not suicidal, as opposed to more widespread use antipsychotics and mood stabilizers alone or in combination with antidepressants. This clinical, non-randomized choice treatment reflects the clinical practice at the research center, in which antidepressants were avoided in favor of neuroleptics or stabilizers mood in agitated or mixed patients to avoid potentially increasing suicidal risk. Factors significantly and independently from each other differentiated patients with suicidal acts and patients without suicidal actions based on multivariate logistic modeling regressions: hospitalization in a psychiatric hospital, higher rating depression at admission, BD diagnosis, earlier age at onset, and presence of mixed signs in one or more episodes of the disease. Some of these factors may reflect a more serious illness. ROC (chart, allowing to assess the quality of the binary classification) analysis showed that these risk factors distinguish patients with suicidal intent from those who do not suicidal, with an AUC of 68.3%, and that any two of these are independently related factors optimally differentiate those who are suicidal from those who are not suicidal, with maximum sensitivity and specificity. Factors risk may be associated with suicidal risk, but have a limited value in predicting suicidal behavior for specific patients and at a certain time. It is noteworthy that they should be combined with attention to clinical conditions and behaviors that may be associated with suicide planning, including verbal statements, organizing personal and business affairs or giving away valuable property. These results include factors derived from medical records and therefore may include errors establishment. However however, they must be equally likely in all the comparisons diagnostic groups. Observations made at the center treatment of mood disorders may introduce bias, such as bias associated with the severity of the disease, although most of the studied patients were referred by primary care physicians² (34/3) 2021 ISSN 2181-712X. EISSN 2181-2187 387 health care or themselves were sent. In addition, two-dimensional testing of a large number risk

factors for association with suicidal status allows you to identify random associations. The present results test and expand on extensive previous research on risk factors for suicidal behavior among subjects with a severe mood disorder as described in the appendix, and add quantitative estimates of the strength and independence of the association of risk factors with suicidal status by comparing them among certain diagnostic groups. Factors with a particularly strong association with suicidal acts ($P < 0.0001$;) include: diagnosis of BD and suicide, no marriage, early onset illness, hospitalization, substance abuse or smoking, years of illness, and the estimated proportion of time he was sick or in depression, and less use of antidepressants. alone or more widespread use of mood stabilizers or antipsychotic medications. The data obtained should contribute earlier identification of suicidal risk, support preventive interventions and improve the treatment and prognosis of patients with mood disorders with a particularly high risk of suicide.

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