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SUICIDAL ATTEMPTS DURING THE FIRST EPISODE PSYCHOSIS

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Summary
Suicides in the course of schizophrenia are a widely recognized problem, yet the suicides during the First Episode Psychosis (FEP) are not much discussed in the literature, though in many cases it is due to a suicide that the patients gets into a contact with mental health services. Suicide is a serious challenge for treatment as many things have to be taken in mind in order to give an adequate treatment and to prevent suicide in future. Current data states that the estimated incidence of suicides during FEP ranges from 8.5 to 11.3%. The most frequent risk factors are: depressive symptoms, especially hopelessness, substance abuse, longer duration of untreated psychosis (DUP), psychosocial stressors and noncompliance. Suicides of schizophrenics for a long time are considered to be somewhat difficult to understand or prevent due to its impulsive character, yet current data also suggest that in many cases suicides are not as impulsive as it is considered. Many patients have contacts with health, including mental health, specialists before suicidal attempt. There are certain signs of their behavior that can help to predict possible suicidal attempt. Programs of early recognition of psychosis, including informational campaign in the society and easy access to mental health services has proven to be effective in prevention of suicides during FEP.

INTRODUCTION

The problem of suicide in the course of mental illness, and especially suicide in the course of psychosis, is a widely recognized problem that is known for many years, and in the history of psychiatry it was discussed by the most prominent authorities in the field of mental illness. *"Suicide of mentally disordered person differs from that of a healthy one as an illusion or hallucination differs from a normal perception"* – claimed Emile Durkheim (1858-1917) [3]. Commenting on suicides of mentally disordered persons in his book *"Le Suicide"* (1897) he cited P. Jousset and Jacques-Joseph Moreau de Tours who classified suicides of mentally disordered persons into maniacal, melancholy, obsessive and impulsive or automatic. The last one stressed the impulsive character of some suicides of mentally disordered persons. The other famous German psychiatrist and philosopher Carl Jaspers (1883-1969) in his book *"Allgemeine psychopatologie"* (1913) wrote about suicides of psychotic persons: *"...extremely cruel and persistent, attempts are repeated in the case of failure. The psychosis sometimes can be recognized only according that"* [8].

High rate of suicide among schizophrenic patients, including FEP patients, is a well-known problem. Most cited is Miles et al (1977) who reviewed 34 studies about suicides among schizophrenic patients and concluded that 10% of them die from a suicide [14, 15]. It is known that at least 25% of schizophrenic patients make at least one suicidal attempt during the life time [15]. Yet the data about the suicides during schizophrenic psychoses today are rather controversial, some authors find it to be lower than estimated in previous studies, e.g. 4.9% [13] or 6.8% [14]. Still the risk to die from a suicide during the course of schizophrenia is high enough to be taken into account when making treatment and follow-up plans. Though the risk to die from a suicide in the life course during schizophrenia – 4% is lower if to compare with affective disorders – 7% or alcohol abuse – 6% [7] schizophrenic suicides are of extreme interest both in psychiatry and in society. Suicidal attempts as well as a suicidal ideation have a serious impact on the patient's safety and on their overall quality of life. It has an effect on mental health care specialists, too. The rate of suicides in schizophrenic patients is the highest in the early courses of the illness [11], so this period has to be taken seriously into account. The incidence of suicidal attempts before first hospitalization is high enough, and often it is a reason for the hospitalization. There are not so many investigations about the incidence of such attempts. The incidence of suicides during FEP ranges from 8.5% [9] to 11.3 [5]. Well known that suicidal attempts cause more serious consequences from a medical point of view [14], many pa-

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tients tends to make multiply suicidal attempts [14], so, this is an extremely important aspect of the problem. Suicidality in the course of schizophrenia is considered to be difficult to understand, impulsive, so no possibilities to prevent it. The following statement has to be proved or denied in order to organize early diagnosis and prevention programs.

METHODS

The object of the work: scientific bases of suicide analysis during FEP. The methods of the work: theoretical analysis of scientific literature and sources.

MATERIAL AND DISCUSSION

Main risk factors for suicide during First Episode Psychosis. Identification of risk factors is important for suicide prevention programs. There are different factors that are considered to be important while evaluating increased risk for a suicide during the FEP. Some of them are the same as in schizophrenia: male, lonely, misusing alcohol or other psychoactive drugs [14]. Yet, there are some factors that are acknowledged by most of the authors as important in FEP. These factors are: depressiveness [2, 5, 11], less life satisfaction [11], longer DUP [5, 11], loneliness [11], lower premorbid education [11], less socialization during premorbid period [11], physical disease [6], family anamnesis [6], psychoactive drugs abuse/misuse [1, 2, 6], low self-esteem [6], akathisia [6]. In a study conducted with 496 patients there is data that 56 (11.3%) had self-harm from symptoms that appeared till the first contact with psychiatric services [5]. Statistically significant risk factors found in that study were male gender, lower social class, longer DUP (more than 66 days), and depression as a symptom [5].

Depression as a symptom is the one that is most likely to influence the occurrence of a suicide during FEP. Thought this symptom is underdiagnosed and undertreated in patients suffering FEP [14]. Sometimes it is masked by negative symptoms and undesirable effects of the drugs. It occurs together with psychosis or after it; in the last case suicidal risk increases extremely. One of the aspects that are stressed is the role of the cognitive component of depression – pessimism and hopelessness [2]. It is estimated that schizophrenics with depressive mood only has a probability to commit a suicide 0.22, depressiveness with hopelessness 0.37 [14]. If there is no depressiveness – with or without hopelessness – probability is equal to 0.06 [14].

DUP, the duration from the onset of illness to the first contact with mental health services, has an influence on the incidence of suicidal attempts during the first episode psychosis; some authors use a 6 month term of it as a marker of a possible future chronicity [1].

The influence of psychoactive drugs is important both to suicidal attempts and hallucinations: some authors consider that schizophrenic patients who misuse psychoactive drugs experience more hallucinations and suicidal attempts [5].

Importance of other psychiatric symptoms for a suicide during FEP. Positive symptoms are less often discussed as risk factors for a suicide during FEP; they are considered to have less relationship with a suicide or suicidal attempt than mood symptoms, depression in particular [1]. Most of the patients with FEP who commit a suicide are in an active phase of the illness, positive symptoms are the ones that prevail in the clinical picture; positive symptoms correlate with higher incidence of suicide – 12% than negative symptoms – 1.5% [4]. Two positive symptoms – suspiciousness and persecution were expressed among severe suicides [4]. Patients who can be diagnosed as suffering paranoid subtype of schizophrenia are more likely to commit a suicide than patients suffering other types of it [14].

Presence of hallucinations especially imperative hallucinations frequently reported by this group of patients is still a question of discussions. Pompili and al. reviews the opinions of previous authors and makes a conclusion that the current point of view is that hallucinations correlate with less risk for suicide; and imperative hallucinations are not considered to be a risk factor; they rather increase the suicide risk for those who already have suicidal tendencies [13].

Uncooperativeness among future suicides is 7 fold higher [14], the fact that has to be taken into account while making treatment and future suicide prevention plans.

Influence of psychotraumatic events. To understand suicide in schizophrenia influence of stress-related events has to be taken into account. Some authors divides stress experienced by suicidal schizophrenic patients to a distal and a proximal ones [15]. Distal stress factors are the ones that create a predisposition to stress and determine the reaction to further stressors, so, it is important when a person is influenced by the proximal stress factors. Childhood trauma can be one of such factors [15], as well as genetic or developmental factors. Some authors find some interesting data such as correlation of patient's mothers' treatment in mental hospital and a suicide [16]. 33-64% experienced psychotraumatic events before suicide [18]. The importance of psychotraumatic events is acknowledged by ICD-10-AM classification distinguishing acute polymorphic psychosis with associated stress and without associated stress. Recent loss or rejection is a risk factor both for suicide and schizophrenia [14]. It is estimated that an average time from psychotraumatic event till suicide 6 weeks [19], and it helps to distinguish suicides of FEP patients from suicides of patients who have personality disorders;

the last-mentioned commit a suicide after short time or sometimes immediately after stressful event. To investigate distal and proximal stress factors Life Events and Difficulties Schedule (LEDS) is used.

Some guidelines for diagnostics and treatment. There are some limitations in evaluating depressiveness and suicidality in patients experiencing FEP. Daily used psychiatric scales such as BPRS (Brief Psychiatric Rating Scale), PANSS (Positive and Negative Symptom Scale) and scales used for evaluating specifically depression such as MADRS (Montgomery- Asberg Depression Rating Scale) or HAMD (Hamilton Rating Scale for Depression) are not sufficient in diagnosing both depressive symptoms and suicidal ideation in schizophrenic patients, and the risk of suicide can be evaluated incorrectly. There are scales specially dedicated for evaluating depression in schizophrenic patients, such as Calgary Depression Scale (CDS) constructed using HAMD ir Present State Examination and Psychotic Depression Scale (PDS) that is constructed using HAMD, PANSS, CPRS (Comprehensive Psychopathological Rating Scale). To evaluate suicidal risk in schizophrenic and in FEP experiencing patients Beck Hopelessness Scale and Beck Depression Inventory can be used [2, 14].

Treatment of FEP in the case of suicidal attempt can be a real challenge, as many symptoms have to be addressed [14]. First of all, as in all the cases of psychosis, positive symptoms have to be treated. Depressive symptoms are one of the other options to be taken in account. It has to be treated actively as it is one of the most important risk factors for a suicide [14]. If the patient misuses alcohol or other PAM it has to be taken in mind, too. Akathisia has to be avoided-psychotropic drugs have to be chosen in order not to evoke it as it increases suicidal risk [6].

An essential mistake that is made during the course of treatment is a false conviction that successful treatment of psychosis decreases risk of the suicide [15]. Successful treatment of the psychosis increases insight, and the modern attitude towards the insight consists of three parts: awareness of having an illness, awareness of the necessity of treatment, and the awareness of the consequences of the illness [14]. The last one possibly increases hopelessness that has direct influence to increased suicidal attempts rate.

Relational factors are important in the treatment of suicidal schizophrenic patients, including first time psychotic patients. The role of empathy is stressed by some authors [15]. Some authors put an accent on the work of psychiatric nurses and their relations with suicidal FEP patients [14].

Possibilities for prevention. Some of FEP patients address health, even mental health specialists due to some symptoms (not necessarily psychotic symptoms) such as insomnia or anxiety, or depression. The main question is why does suicidal ideation is un-noticed by mental health care specialists? The fact is that the patients before suicide stops to send emotional "messages": they are unavailable for empathy, as Maltsberger puts it [10]. The ideas of Meninger are important here: the desire to die is considered to consist of a desire to kill, to be killed and to commit a suicide [12]. Pompili et al. cite Jensen and Petty who add one more aspect of the desire to die: the wish to be rescued. In the last case a rescuer appears. Yet in psychosis, including the first Episode Psychosis, there can be not a real person but rather a symbol, so the possibilities to be saved decreases [14].

The other aspect of prevention is the attitude towards the persons who already has tried to commit a suicide before. The factor that represents the highest probability of a suicidal attempt is a previous suicidal attempt – constant awareness is necessary [11]. There are signs of possible suicidal attempt, such as increasing dissatisfaction in the treatment in whole and the increasing amount of somatic concerns. It is the last try to establish emotionally meaningful relationship with the one who can offer help.

Programs for prevention of suicide during FEP exist, actually all the programs or efforts that can bring First Time Psychosis experiencing patients into treatment at a lower level of symptoms can be of value [11]. There are data about successful early psychosis recognition programs in Norway [11]. The program consisted of two parts:

1. Information campaign dedicated to the society, schools, and primary medical specialists.
2. Easy accessible early psychosis detection groups able to recognize the disorder and having possibilities to help.

There was a similar number of persons who participated in the program: 140 from the regions without a program and 141 from the regions with a program. After the program was implemented data from the regions with early detection programs were compared with similar regions without it, and the following was discovered: both the suicidal attempts during the life course (16% in a non-program regions and 5% in the regions with a program) and during one month till the first treatment meeting (10% in the regions without the program and 1% in the regions with it) has decreased in the regions with the suicide during FEP prevention program.

CONCLUSIONS

1. There is not enough evidence about suicides at the FEP, and about the role of impulsiveness in it. Some data suggests that there are other than impulsiveness important factors in FEP.

2. Not enough daily "instruments" such as structured psychiatric scales to evaluate impulsiveness in the structure of psychiatric disorders, especially in FEP.

3. Suicide during FEP evokes due to many factors, and impulsiveness is not the prevailing factor; so, programs of early psychosis and suicidal tendencies diagnostics and prevention of it can be useful.

References

1. Bakst S, Rabinowitz J, Bromet EJ. Antecedents and Patterns of Suicide Behaviour in First- Admission Psychosis. Schizophrenia Bulletin. 2010; 36(4): 880-889.
2. Carlborg A, Winnerback K, Johnsson EG et al. Suicide in Schizophrenia. Expert Rev Neurother. 2010; 10(7): 1153-64.
3. Durkheim E. Savižudybės. Vilnius, 2002.
4. Fenton W, McGlashan TH, Victor BJ at al. Symptoms, subtype, and suicidality in patients with schizophrenia spectrum disorders. American journal of psychiatry. 1997 (abstract).
5. Harvey SB, Dean K, Morgan C et al. Self-harm in first-episode psychosis. The British Journal of Psychiatry. 2008; 192: 178-184.
6. Hor K, Taylor M. Suicide and schizophrenia: a systematic review of rates and risk factors. J Psychopharmacology. 2010: 81-90.
7. Inskip HM, Harris EC, Barraclough B. The lifetime risk of suicide for affective disorder, alcoholism and schizophrenia. Br J Psychiatry. 1998; 172: 35-37.
8. Jaspers C. Allgemeine psychopatologie. Springer-Verlag, 1973.
9. Levine SZ, Bakst S, Rabinowitz J. Suicide attempts at the time of the first admission and during early course schizophrenia a population based study. Br J Psychiatry. 2010; 177: 55-59 (abstract).
10. Maltsberger JT: Suicide Risk. The Formulation of Clinical Judgment. New York: University Press; 1986.
11. Melle I, Johannsen JO, Friis S et al. Early Detection of the First Episode of Schizophrenia and Suicidal Behaviour. Am J Psychiatry. 2006; 163: 800-804.
12. Menninger KA. Man Against Himself. New York: Harcourt, Brace & Co, 1938.
13. Palmer BA, Pankratz VS, Bostwick JM. The Lifetime Risk of Suicide in Schizophrenia: a re-examination. Arch Gen Psychiatry. 2005; 62(3): 247-53.
14. Pompili M, Amador XF, Girardi P et al. Suicide risk in schizophrenia: learning from the past to change the future. Annals of General Psychiatry. 2007; 6: 10.
15. Shrivastava A, Johnston ME, Shah N et al. Persistent suicide risk in clinically improved schizophrenia patients: a challenge of the suicidal dimension. Neuropsychiatric Disease and Treatment 2010; 6: 633-638.
16. Stenager K, Qin P. Individual and parental psychiatric history and risk for suicide among adolescents and young adults in Denmark. Soc Psychiatry Psychiatr Epidemiol. 2008; 43: 920-926.
17. TLK-10-AM, tarptautinės statistinės ligų ir sveikatos sutrikimų klasifikacijos, dešimtasis pataisytas ir papildytas leidimas, Australijos modifikacija. Sisteminis ligų sąrašas. Vilnius, 2011; 131-132.
18. Tousignant M, Puliot L, Routhier D. Suicide, Schizophrenia, and Schizoid-type Psychosis: role of life events and childhood factors. Suicide and Life-Threatening Behaviour. 2011; 41(1): 66-78.
19. Zouk H, Tousignant M, Seguin M. Characterization of impulsivity in suicide completers: clinical, behavioral and psychosocial dimentions. Journal of Affective Disorders. 2006; 92: 195-204.

BANDYMAI NUSIŽUDYTI PIRMO PSICHOZĖS EPIZODO METU

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Santrauka

Raktažodžiai: savižudybė, šizofrenija, pirmas psichozės epizodas, negydytos psichozės trukmė.

Savižudybės šizofrenijos eigoje yra plačiai pripažįstama problema, tačiau savižudybės pirmo psichozės epizodo metu nėra taip plačiai diskutuojami literatūroje, kaip pirmuoju atveju, nors daugeliu atveju būtent dėl savižudybės pacientai pirmą kartą patenka į psichinės sveikatos tarnybos akiratį. Savižudybė – tai rimtas gydymo iššūkis, nes daugybė aspektų turi būti įvertinti, kad būtų pritaikytas adekvatus gydymas ir užkirstas kelias galimai savižudybei ateityje. Dabartiniai duomenys nurodo, kad pirmo psichozės epizodo metu nusižudo nuo 8,5% iki 11,3%. Dažniausi rizikos faktoriai yra šie: depresiniai simptomai, ypač beviltiškumas, piktnaudžiavimas psichoaktyviomis medžiagomis, ilgesnė negydytos psichozės trukmė, psichosocialiniai stresoriai bei nebendradarbiavimas. Savižudybė tarp šizofrenija sergančių asmenų, įskaitant ir pirmą psichozės epizodą patiriančiųjų, ilgą laiką buvo laikoma iš dalies sunkiai nuspėjamu įvykiu, ir juo labiau tokiu, kuriam sunkiai užkertamas kelias dėl impulsyvumo, tačiau dabartinių tyrimų duomenys rodo, kad jie nėra tokie impulsyvūs, kaip manoma. Daugelis pacientų susisiekia su sveikatos sistemos, tarp jų ir su psichinės sveikatos sistemos, specialistais, prieš bandymą nusižudyti. Yra visa eilė jų elgesio ženklų, kurie gali padėti nuspėjant galimą savižudybės bandymą. Suicidiškumas pirmo psichozės epizodo metu sukelia tam tikrų diagnostinių bei gydymo sunkumų. Įprastinės psichiatrinės skalės nėra pakankamai veiksmingos vertinant šizofrenija sergančiųjų, tarp jų ir pirmą psichozės epizodą patiriančiųjų asmenų, depresiškumą ir suicidiškumą. Yra skalės, kurios sukurtos kitų psichiatrinių skalių pagrindu ir kurios padeda tiksliau įvertinti tokių asmenų depresijos gylį, tokios kaip Kalgario Depresijos Skalė (Calgary Depression Scale, CDS) ar Psichozinės Depresijos Skalė (Psychotic Depression Scale, PDS). Jei pirmą psichozės epizodą patiriantis asmuo dar pasižymi ir padidinta savižudybės rizika, gydymas gali būti tikras iššūkis, nes reikia įvertinti ne tik pačios psichozės gydymo ypatumus, bet ir kitus faktorius - tokius kaip depresijos gylį ar piktnaudžiavimą psichoaktyviomis medžiagomis. Ankstyvosios psichozės atpažinimo programos, įskaitant informacinę kampaniją visuomenėje ir lengvą psichinės sveikatos sistemos tarnybų prieinamumą, pasirodė esančios efektyvios užkertant kelią galimoms savižudybėms pirmo psichozės epizodo metu.

Išvados. Nėra pakankamai duomenų apie savižudybes pirmo psichozės epizodo metu bei apie impulsyvumo vaidmenį juose. Kai kurie duomenys leidžia galvoti, kad impulsyvumas nėra toks svarbus savižudybei pirmo psichozės epizodo metu, kaip yra įprasta galvoti tradicinėje psichiatrinėje praktikoje, o savižudišką elgesį apsprendžia visa eilė kitų faktorių. Nėra pakankamų kasdieninėje psichiatrinėje praktikoje naudojamų „instrumentų", tokių kaip struktūruotos psichiatrinės skalės, kurios padėtų įvertinti impulsyvumą psichinių sutrikimų, ypač pirmo psichozės epizodo metu. Savižudybė pirmo psichozės epizodo metu yra susijusi ne tik su impulsyvumu; taigi, ankstyvosios psichozės atpažinimo ir intervencijos programos gali būti naudingos.

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