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Original Research Article

Suicide and Bipolar Disorders

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Abstract: The lifetime prevalence of bipolar I disorder is estimated at 1% in adults, while type II affects approximately 0.4%. Bipolar disorder is associated with a reduction in life expectancy of 25 to 30 years, mainly due to comorbidities. Psychiatric disorders, particularly in bipolar patients, represent a major risk factor for suicidal behavior, with these patients constituting a significant proportion of suicide deaths. The main objective of our study is to assess the prevalence of suicide attempts in bipolar patients, to highlight and explore this complication. ***Methodology***: This is a descriptive cross-sectional study on the files of 98 bipolar patients meeting the DSM5 criteria hospitalized at Arrazi Salé Hospital over a period of one year. ***Statistical Tool Used***: SPSS 20. ***Results***: In this study, 36.8% of bipolar patients attempted suicide. Among them, 8.2% had made at least three attempts. All were smokers, 14.5% suffered from polyaddiction, 4.1% had a family history of suicide and 8.2% suffered from comorbidity with borderline personality disorder. Finally, 77.7% of suicide attempts occurred during the depressive phase.

Keywords: Bipolar Disorde, Suicide, Risk Factors.

INTRODUCTION

The one-year prevalence of bipolar disorder (BD) in the general population is between 0.1 and 1.7% in international studies, according to the criteria of the different editions of the DSM. Since bipolar disorder is a chronic disease, its lifetime prevalence is quite like the "lifetime prevalence" and is between 0.2 and 1.6% according to the National Technical Group for the Definition of Objectives (GTNDO) of the Public Health Law of 2004 [1, 2].

Bipolar patients (BP) are particularly exposed to suicidal behavior and represent the greatest participation in deaths by suicide: thus, 20% to 56% of bipolar patients will attempt suicide during their lifetime and 10% to 15% will die by suicide. These rates, 15 to 30 times higher than those found in the general population, indicate the frequency of suicidal thoughts and the lethality of the methods used in this population [3].

The burden of bipolar disorder is currently estimated to be accompanied by a decrease in life expectancy of 25 to 30 years, largely linked to associated somatic pathologies of cardiovascular and metabolic types [4].

It is one of the most serious psychiatric disorders, which most frequently leads to suicide attempts, with numerous comorbidities [5].

Overall, mood disorders are considered responsible for approximately two thirds of suicide deaths. With the bipolar/unipolar ratio being approximately 1/4, the prevalence of suicide in bipolar patients is estimated at 15%, or approximately 1500 deaths per year [6].

METHODOLOGY

This is a descriptive cross-sectional study on files in 98 bipolar patients hospitalized at Arrazi Salé hospital over a period of one year. Bipolar disorder is assessed according to DSM5 criteria. 98 patients (32 men and 66 women) aged 18 to 76 years were collected.

♣**Inclusion criteria:** patient with bipolar disorder according to DSM5 criteria

♣**Exclusion criteria:** patients not meeting the criteria for bipolar disorder

♣A hetero questionnaire was used to collect socio-demographic characteristics, personal and family history, the presence of psychiatric comorbidities, the presence of a history of suicide attempts, the number, circumstances and modalities of suicide attempts as well as the conduct to be adopted. (Appendix 1).

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Statistical Tool: SPSS 20

RESULTS

Our study focused on records of 98 bipolar patients hospitalized at Arrazi Salé hospital over a period of one year including 32 men (32.7%) and 66 women (67.3%) aged 18 to 76 years.

Table 1: Sociodemographic characteristics of the study population

Variables	Values (N :98)
Age*	38,88(écart type: 13,74)
Sex **	
Male	32(32,7)
Female	66(67,3)
Marital status	
single	34(34,7)
Married	36(36,7)
Divorced	28(28,6)
Education level	
Secondary	52 (53,1)
Universitary	46(46,9)
Occupation	
Yes	20(20,4)
No	78(79,6)

*Expressed as mean +/- standard deviation
**expressed as number (percentage)

Table 2: Anamnestic data of the population studied

Variables**	Values (N:98)
Psychiatric history Depressive episode	
0	40(40,8)
1	30(30,6)
2	10(10,2)
≥3	18(18,4)
Hypomanic episode	
0	80(81,6)
1	8(8,2)
2	8(8,2)
≥3	2(2,0)
Manic episode 0	8(8,2)
1	8(8,2)
2	16(16,3)
≥3	66(67,3)
Addictive history Tobacco	98(100)
Cannabis	22(22,4)
Alcohol	4(4,1)
Polyaddiction	14(14,5)
Psychiatric family history	
None	48(49)
Bipolar disorder	24(24,5)
Schizophrenia	14(14,3)
Recurrent depressive disorder	6(6,1)
Suicide attempt	4(4,1)
Comorbidities	
None	80(81,6)
Histrionic	10(10,2)
Borderline	8(8,2)
Type of bipolar disorder I	8(8,2)
II	90(91,8)

**expressed in numbers (percentage)

Table 3: Prevalence of suicide attempts in the population studied and treatment methods:

Variables**	**Values (N:98)**
Suicide attempts	
0	62(63,2)
1	26(26,6)
2	2(2)
≥3	8(8,2)
Framework	
Dépressive	28(28,6)
Impulsive	8(8,2)
wherewithal	
Drowning	8(8,2)
Phlebotomy	22(22,4)
Eloctrucusion	2(2)
Drug poisoning	20(20,4)
Caustic	4 (4,1)
Hanging	2(2)
Defenestration	2(2)
Thymoregulator	
Lithium	10(10,2)
Sodium valproate	42(42,9)
Carbamazepine	34(34,7)
Lamotrigine	12(12,2)
Antipsychotiques	
Olanzapine	56(57,1)
Risperidone	16(16,3)
Aripiprazole	10(10,2)
Quetiapine	16(16,3)
Antidepressant therapy	
Sertraline	6(6,1)
Venlafaxine	2(2)
Escitalopram	6(6,1)

**expressed in number (percentage)

DISCUSION

In our study, approximately 36.8% of bipolar patients had attempted suicide. Our results corroborate those in the literature. Indeed, according to APA, 35% of bipolar patients make at least one suicide attempt. Indeed, the risk of suicide in bipolar subjects is ten times higher than in the general population [7].

Mood disorders are at the forefront of the pathologies represented in suicides and suicide attempters: 50 to 80% of suicides are linked to a mood disorder [8]. Bipolar patients are particularly exposed to suicidal behavior and constitute the greatest contribution to deaths by suicide: thus, 20% to 56% of bipolar patients will attempt suicide in their lifetime, and 10% to 15% will die by suicide [9].

People with mood disorders are at very high risk of death by suicide. The incidence of death by suicide in patients with bipolar disorder is high [10], and can be more than 20 times higher than in the general population [11], particularly when bipolar disorder is untreated [12]. Approximately one-third to one-half of patients with bipolar disorder attempt suicide at least once in their lifetime, and approximately 15 to 20%.

In our population, 8.2% of bipolar patients have made at least 3 suicide attempts, and 4.1% of bipolar patients had a family history of suicide. According to the literature, personal or family history of suicidal behavior, expressions of aggressive impulsiveness (such as violent behavior, for example), or pessimism, history of childhood trauma, particularly sexual, are very common in the psychiatric population and represent a significant suicidogenic risk factor, observed very significantly in bipolar patients: half of those who committed ST were victims of a form of violence in their childhood (physical, emotional, sexual, witnessing domestic violence) [13]. Concerning addictive behavior, all patients had a tobacco use disorder and 14.5% had polyaddiction. Addictive behavior is the leading comorbidity. Alcohol intoxication is common. The rate of substance abuse is 6 times higher than in the general population. This comorbidity, especially present in men under 30, increases the risk of suicide by 2 [8]. In bipolar patients as in the general population, it is mainly the abuse of psychoactive substances such as tobacco, benzodiazepines, and more particularly alcohol and

cocaine, which is associated with the frequency of suicide attempts [14], these substance abuses have a suicidogenic impact because they are correlated with the appearance of negative emotions, stress, deterioration of the living environment and behavioral disinhibition.

Social phobia and in women eating disorders are also associated with an increased risk of suicide in bipolar patients.

Concerning psychiatric comorbidities, 8.2% had a comorbid borderline-type pathological personality and 10.2% histrionic. This is consistent with the literature review. Indeed, personality disorders are found in 82% of bipolar patients. The risk of suicide is greater for personalities marked by traits of impulsiveness. Antisocial personality is at risk of non-compliance with treatment [8]. In addition, more than a third of patients with bipolar disorder have a comorbid personality disorder, particularly borderline personality disorder [15]. Indeed, psychiatric comorbidities darken the prognosis of the disease. They are associated with an early age of onset [16]. They are present in 31% and 60% of subjects with bipolar disorder type I and type II, respectively. A quarter of patients have several comorbidities [8].

Frequently found comorbid anxiety disorders are panic disorder and social anxiety disorder. The presence of panic disorder increases the risk of suicide and prolongs the remission time of mood episodes.

Eating disorders are less often mentioned. There is a relationship between the severity of bipolar disorder, a high body mass index and the repetition of suicide attempts [8].

In our study, 77.7% of suicide attempts were in a depressive context. It turns out that it is mainly during depressive phases that the vast majority of TS occur (78% to 89% compared to 0% to 7% during manic phases [12]. Indeed, depressive and mixed episodes are at major suicidal risk. Dysphoric manias are at greater risk than simple manias [8].

Concerning mood stabilizer-based drug treatment, sodium valproate was prescribed in 42 (42.9%) followed by carbamazepine in 34 (34.7%) and 10.2% were on lithium.

Concerning antipsychotics, 56 (57.1%) were on olanzapine, 16 (16.3%) risperidone, 16 (16.3%) aripiprazole and 10 (10.2%) quetiapine. According to the literature review, Optimizing the treatment of bipolar disorder is an important issue for the prevention of suicide risk. Only lithium [17], and Clozapine [18], have demonstrated their effectiveness in preventing suicide risk. In practice, the existence of a significant suicide risk in a bipolar patient may lead to preferring lithium salts as one of the elements of their long-term treatment. Anticonvulsants and antipsychotics have not demonstrated "anti-suicide" efficacy in mood disorders.

From another point of view, it is important to involve the family circle in the care, after the patient's consent.

Concerning psychological care, in addition to crisis interventions, psychoeducation is a psychological technique of choice aimed at helping the patient better understand their disorder and its treatments: the causes and consequences of the disease, the triggering factors, the main psychopathological drivers.

Another aspect of psychological care targets the dysfunctional behaviors and cognitions of bipolar patients, through problem-solving techniques aimed at leading the patient to find solutions not based on despair or impulsiveness [19]. This practice makes it possible to treat residual depressive symptoms by following a cognitive-behavioral approach (CBT). Clinical studies on the subject report an effectiveness that remains limited for methodological reasons and have not tested to our knowledge the effects of this technique on bipolar suicidal people [13].

The Profile of the Bipolar Suicidal Person:

After examining the risk factors, a profile of bipolar subjects at high suicidal risk can be established. These are subjects with:

- A family history of mood disorders,
- An early-onset or type II bipolar disorder,
- A personal history of suicide attempts,
- A family history of suicidal behavior
- A comorbid substance use disorder
- A comorbid personality disorder

CONCLUSION

Bipolar disorders are common, potentially disabling and sometimes fatal pathologies, particularly due to the high risk of suicide, 15 to 30 times higher than that of the general population. An accurate diagnosis and adequate management of the disorder is essential.

This work demonstrates that bipolar disorder, due to its high prevalence in the population and its very high suicidal risk, should be the subject of particular interest in suicide prevention. It is one of the diseases with the highest risk of completed suicide. The assessment and treatment of suicide risk will target both BD and suicidal vulnerability. Efforts to better screen for and treat BD and suicidal risk are effective.

Therefore, it is suggested that further studies are needed to establish a closer relationship between bipolar disorder and its risk factors that lead to suicide.

DECLARATIONS

Consent for Publication: Not applicable.

Ethics, Consent to Participate, and Consent to Publish Declarations: Not applicable.

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