Bipolar Disorder and Suicide

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• About 1,000,000 people die because of suicide each year.

• Suicide is possibly the most important recurrent risk presented by mood disorders.
Terminology

- Fear of dying
- Thoughts of death
- Suicide ideation/contemplated suicide
- Suicide rehearsal
- Suicide intent
- Suicide plan
- Pseudosuicide/Parasuicide
- Aborted suicide attempt
- Interrupted suicide attempt
- Suicide attempt/act
- Committed/completed/fatal suicide
- Extended suicide
Bipolar Disorder

• Suicide in BD may account for \( \frac{1}{4} \) of all committed suicides.
  

• Suicide, cardiovascular diseases, and cancer are the three most prevalent causes of death among BD cases.
  
Lifetime suicide prevalence

- Nonaffective Psychiatric: 0.5%
- Mood disorder: 2.2%
- Hospitalized mood disorder: 4%
- Suicidal hospitalized mood disorder: 8.6%
Index of lethality

• Index of lethality = Ratio of attempts/suicides

• BD patients, especially BD-II cases, use more lethal suicidal methods compared to patients with unipolar depression.

• The index of lethality was 5.1 in BD-II and 10.8 in BD-I patients.

**Bipolar Disorder**

- Without treatment, about **10/1000** BD patients commit suicide and **40/1000** attempt suicide **every year**.
  

- **25 to 50%** attempt suicide at least once during the lifetime, and **6% to 19%** complete suicide.

- **BD patients in general, and BD-II subjects in particular, carry the highest risk of both attempted and completed suicide.**

Risk factors in Bipolar Disorder (SUICIDE)

- The risk of suicide among those with BD was greatest in men and early during the course of BD-I.

Risk factors in Bipolar Disorder (SUICIDE)

- Family history of suicide
- Previous suicide attempts
- Younger age of onset
- Comorbid psychiatric illnesses
- Psychological symptoms like hopelessness

Bipolar Disorder Patients Follow-up (BDPF)

Shabani, et al.

MAY 2008

2016
Bipolar Disorder Patients Follow-up (BDPF)

- **SCID-I**: Structured Clinical Interview for DSMIV axis I disorders
- **HDRS-7**: Hamilton Depressive Rating Scale-7
- **Y-MRS**: Young-Mania Rating Scale
- **SAPS**: Scale for the Assessment of Positive Symptoms
- **CGI**: Clinical Global Impression
- **GAF Scale**: Global Assessment of Functioning scale
- **WHOQOL-BREF**: World Health Organization Quality of Life-BREF
- **DAI-10**: Drug Attitude Inventory-10
- **FIGS**: Family Interview for Genetic Studies

*(Shabani, et al.)*
Suicide attempt risk factors: 21-month follow-up

- 2008-2011; N=100
- Only one patient attempted suicide
- 33% had history of previous suicide attempts.
- Female gender, divorce, and early age at onset of the disorder were independently correlated with suicide attempt.

(Shabani A., Teimurinejad, S., et al., 2013)
Suicide attempt risk factors

- BD-I = BD-II
- Women > men
- Risks were greater with longer exposure, whereas incidence rates decreased with longer time at risk, possibly through ‘dilution’ by longer exposure. (Tondo and Pompili, 2016; Review)
- Suicide attempts are less likely in patients with a preponderant manic or psychotic course of the illness. (Finseth, et al. 2012)
Risk factors concerning pharmacotherapy

- **Antidepressant** medications, particularly after sudden discontinuation of a **mood stabilizer** or in a period while the individual has stopped taking **lithium**

Antidepressants

- Antidepressants may protect patients with BD but not unipolar depressive disorder from suicidal behavior.  

(Leon, et al, 2014)
Lithium and suicide

• ↓80% in suicides and attempted suicides among patients with BD and other major mood disorders treated with lithium for an average of 18 months: It was not observed in STEP-BD.


• Li has been associated with a decreased rate of suicide in randomized studies and in observational studies: compared with VLP or to anticonvulsants in general.

Lithium and suicide

- Decreasing the rate of suicidal acts, and reducing the ‘lethality of suicide’.

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<thead>
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<th>Bipolar</th>
<th>General population</th>
<th>Lithium</th>
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<tbody>
<tr>
<td>Ratio of attempted to</td>
<td>5:1</td>
<td>20–30:1</td>
<td>↑ by about 3 times</td>
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<td>completed suicide</td>
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(Baldessarini et al, 2006)
Suicide

- In 2009, the FDA issued an advisory that the use of AEDs for any indication can increase the risk of suicidal behavior or ideation, based on a meta-analysis of 199 RCTs yielding an odds ratio of 1.87 for patients on AEDs compared with patients on placebo. [the number needed to harm=769] (Postmarket Drug Safety Information for Patients and Providers. Suicidal behavior and ideation and antiepileptic drugs, 2013)

- A 30-year prospective observational study found no evidence for increased suicide attempts or completions for bipolar patients while they were taking AEDs compared with these same patients during intervals when they were not. (Leon AC, Solomon DA, et al. Antiepileptic drugs for bipolar disorder and the risk of suicidal behavior: a 30-year observational study, 2012)
Impact of psychotropics on suicidal risk (BD)

- The available evidence is largely methodologically flawed and, except for a few instances, clinically not useful at this point.
- Antidepressants may increase suicidal risk in BD, this possibly being related to the induction of broadly defined mixed states.
- There is no evidence that antiepileptic drugs as a class increase suicidal risk in patients with bipolar disorder.
- Only lithium provides convincing data that it reduces the risk of suicide over the long term.
- There is little known regarding the effects of antipsychotics, as well as anti-anxiety and hypnotic drugs, on suicidal behavior.

(Yerevanian and Choi, 2013)
Clinicians need to be particularly sensitive to their patient's thoughts and beliefs about death, particularly during:

- Stressful times of life
- a depressive episode of BD, especially with mixed features
- anxiety/agitation
- first few days of the treatment
- the first six months after discharge, particularly in the first three months
- a rapid cycling course