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Features of Suicide Behaviour Among the Population of Yakutsk

ABSTRACT

The analysis (para-) suicide behavior among population of Yakutsk city from 2010 to 2013 is carried out. Social and clinical characteristics of incomplete suicide cases are determined. The most widespread model of suicidal behavior among the people addressed for medical care is established, as well as basic principles of preventive measures are elaborated.

Keywords: suicide behavior, alcoholic intoxication, social status, urban population.

INTRODUCTION

Every year the problem of suicide behaviour is getting more and more global character. Today in the world according to data of WHO, more people are affected by suicide as compared with all taken conflicts. Suicides with their level and dynamics are considered one of the major indicators of a social, economic, political situation and its changes, as well as contain information on well-being or trouble of society [2,4].

Nowadays the Republic of Sakha (Yakutia) remains the region with high incidence rate of suicides though for last decade decrease in the given indicator has been marked. According to the Federal Agency of the state statistics the level of suicides in Yakutia for 2013 has amounted to 35,7 on 100 thousand population (4,1 % from all cases of death rate for 2013). By existing position, unfavorable territories have indicators of suicide higher 20 per 100 thousand population. Besides high indicators of death rate from suicide, an indisputable fact can be influence of ethnocultural factor on dynamics of suicides in the republic. So, during the last years all over the Russian Federation the leading regions by quantity of suicides are ethnic republics (Altai, Tyva, Buryatiya, Yakutia), these indices bearing witness to variety of reasons, beginning from the religious factor, ending up to ethnopsychological features of crisis affection, connected with ethnocultural features of regions [3,5].

The aim of the research is to carry out the analysis of (para-) suicide behavior cases among the people who live in Yakutsk from 2010 for 2013 and to reveal the most widespread models of autoaggression among the persons who addressed for medical care in the Yakut republican psychoneurological dispensary.

RESULTS AND DISCUSSION

In total 289 cases of uncomplete suicide have been analysed. Of them suicide attempt has been at 147 (50,8 %) men and 142 (49,2 %) women. Thus, differences concerning to any sexual

signs are not found out. This index proves to be true by last literary data on suicide behaviour [2,6]. Out of 289 cases 59 citizens have been refused for the further hospitalization, though all addressed were examined by a doctor - psychiatrist. More often refusal in hospitalization has been connected with refusal of a person from the psychiatric help or critical somatic condition expressed by alcoholic intoxication. Further such patients either were delivered to somatic hospitals or narcologic clinics or police offices for sobering. More often citizens with uncomplete suicide were delivered by EMS or policemen.

The analysis on the age periods has shown non-uniformity of suicide activity among different age groups (picture 1). The most active peak of suicide behaviour is noted in the age group from 19 - 23 years. For the rest groups, with every 5 years the decrease suicide level has been noted. Such dynamics is explained by features of social functioning and psychological reaction of a person during the various age periods. On this basis, the age period from 19-23 years is the most difficult for the young man as during this period there is a choice of the basic vital reference points (professions, marital status etc.), and emotional strong-willed sphere and personal characteristics have not reached yet the full harmonious development. It often enough leads to disadaptation in the modern environment, making sometimes too high demands to possibility of successful existence. Further with process of growing up the person becomes steadier to various influences of the social environment, accordingly the quantity of suicides in more mature age groups is considerably lower [6]. Some active suicide behaviour also occurs during the retired period when a person already faces ageing crisis.

When studying an educational level of suicidents, the majority of them appeared to have a lower level of erudition. So, 64,7 % have only school education, and higher education - 10,3 % (30 persons). Hence, the level and quality of formation also influences on dynamics of suicides among the population. More educated has a higher social status and accordingly is satisfied by the vital position. This law proves to be true by many researches [2].

In the analysis of marital status we revealed that suicide activity is close to citizens who do not have families (51,2 %) and divorced (11,7 %). Married people rarely come to suicide actions (26,2 %) though the majority of researches point out presence of children to be the most statistically significant antisuicide factor. More frequently uncomplete suicide is made by jobless citizens (46,7 %). The factor mentioned is natural, as really a person who does not have constant work and earnings, is exposed to emotional pressure, suffers from depressions, so these factors lead to the expressed adjustment disorder. On the second place there are invalids (20 %) on

frequency rate of suicides (more often on mental disease) who suffer from permanent adjustment disorder (picture 2).

There were 157 persons (54,2 %) initially addressed for medical aid, the other 139 persons have already been addressed earlier for the psychiatric help. For the first time 180 persons tried to make a suicide accounting 62,2 %, and repeatedly - 109 persons (37,8 %).

According to nosologic structure there were 124 suicidents (42,9 %), who were registered at a doctor - psychiatrist (Tabl.2). Most frequently among the citizens who have addressed with suicide behavior, psychopathy-like state in alcoholic intoxication (30,7 %) was diagnosed, this indicator being third of all cases that coincided with the data of some Russian authors [1]. In general it is possible to note the highest frequency of alcoholic intoxication. Among all cases the given indicator has amounted to 42,2 % (122 persons), and alcoholic abuse as comorbid pathology was noted at 102 persons (35,2 %). On the second place on frequency of suicides the patients with schizophrenic spectrum (paranoidal schizophrenia, schizoaffective frustration, schizotypical frustration, acute psychoses) were revealed, on the third thee were patients with short-term depressive reaction to a situation. Patients with "a pure" affective pathology suffering from endogenous depressions made less suicide attempts (10,7 %), than patients with personality disorder and schizophrenic frustration. Thus, it is possible to assume that endogenous depression within the limits of circular affective psychoses is less «causing a suicide», than depressive frustration within the limits of reactive response. It would be also desirable to notice that the patients suffering from endogenous psychoses more often made a suicide in sober state [4]. For example, out of 45 persons suffering from schizophrenic spectrum there were only 2 cases with ascertained alcoholic intoxication.

When studying precipitating agents, we revealed that the interpersonal intrafamily conflict was noted most often. So, the given factor was accurately in 119 case (41,7 %). On the second place was the depression - 43 cases (14,8 %), on the third place on frequency there were hallucinatory experiences - 25 cases (8,6 %), and hallucinosis in this case had imperative, mandative character and was accompanied by the expressed alarm and fear. The classical example for a suicide of such model is alcoholic hallucinosis.

Most often suicide was noted during winter time (28,7 %), and rarely during the autumn period (21,1 %). No considerable difference in frequency of suicide attempts depending on a season in the given research was revealed, though it is possible to assume that in autumn - winter time it being more suicides noted, than in spring - the summer period.

The basic way of uncomplete suicide in the given research is the poisoning (41,8 % or 121 cases), and in most cases this is drug poisoning. Less often patients use the household chemical goods, the most popular of which is acetic acid (9 cases or 3,1 %). In general, cases of poisoning with acetic acid are very heavy in clinical aspect and in further forecast. Many of such patients do not come across with doctors - psychiatrists because die in reanimation departments because of severity of the somatic condition. Almost all patients registered with the diagnosis of schizophrenia, also have para-suicide action through drug poisoning. But in this case often enough such patients use psychotropic preparations, such as clozapin ("Azaleptin", "Leponeks"), being a strong sedative preparation. The persons who are not registered in YRPND, more often as "poison" use tablets drotaverin ("No-shpa"), aspirin, reducing pressure preparations etc. On the second place on frequency suicides through bleeding are noted (cutting of veins on wrists of hands) amounting 23,8 % (69 cases). On the third place on frequency suicides through suffocation - 47 cases (16,2 %) have. Rare cases of falling from height - 16 cases (5,5 %), a knife wound - 19 (6,5 %), a gunshot wound - 3 (1 %). A small amount of cases with use cold or fire-arms is connected first of all with fatality of such attempts which in most cases is fatal.

Thus, more often uncomplete suicide is made by young citizens with a low educational level (frequently 10 classes of education), absence of constant working place, suffering alcoholic abuse. Suicide from alcoholic intoxication after the interpersonal conflict (more often between spouses) by taking medicines which are available in a house first-aid set more often has bright demonstrative character with brutal threats, psychomotor excitation.

Taking into account the basic model of uncomplete suicide, the preventive work on decreasing the level of suicides should carry mostly socially - focused character, instead of medical. First of all, starting with a school stage, where powerful psychological monitoring, and an expert should be applied - the psychologist should be competent and acquainted with some medical aspects of suicide behaviour. In this stage risk groups where the schoolpupils who have shown deviant, autoagressive , antisocial and addictive behaviour should be registered. Further this database should be accessible for psychologists, social workers working in other educational institutions. Certainly, timely employment, and also preventive work of narcologists under the prevention of development of various dependences has an important value. Within the limits of rendering of rehabilitation work with the citizens who have made suicide, the timely psychotherapeutic help first of all should be rendered. Now in Yakutia there is no specialised crisis department of round-the-clock stay where there is medical and psychotherapeutic help to

such contingent that appreciably deprives of rehabilitation potential and assumes formation of suicide relapse in the future.

Conclusions: 1. Suicide activity sharply increases in the age of 19-23 years. Further with each fifth year the given indicator decreases

2. More often uncomplete suicide is made by the citizens having a low educational level, single and jobless. About third people who made suicide suffer from alcoholic abuse. Suicide in half of cases is made in alcoholic state.

3. The most popular way of attempting suicide is the drug poisoning. More often the tablets containing drotaverin («No - shpa») are used.

4. Because suicides in a greater degree are considered to be a social problem, preventive and rehabilitation work should have a social character, instead of medical one.

REFERENCES:

1. Bisaliev R. V. Psikhopatologiya suisidalnogo povedeniya [Psychopathology of suicide behavior] / R.V. Bisaliev, L. P. Velikanova // The Second Scientifically-practical conference of psychiatrists and experts in narcology Southern Federal Districts with the international and All-Russia participation. - Rostov-on-Don, 2006. - P. 41-53.
2. Vaulin S.V. Suisidalnye popytki i nezavershennye suisidy (gospitalnaya diagnostika, optimizasiya terapii, profilaktika [Suicide of attempt and not complete suicides (hospital diagnostics, therapy optimisation, preventive maintenance]: abst. dis. … dr. med. sciences/ S.V.Vaulin. - M, 2012. - P. 45
3. Vorsina O. P. Psikhologicheskie kharakteristiki suisidentov, gospitalizirovannykh v psikhiatricheskiy stasionar [Psychological characteristics people who made the suicide, hospitalised in a psychiatric hospital] / O. P. Vorsina, N.P. Barkova // Siberian bulletin of psychiatry and narcology. - 2012. - № 1. - P. 50-54.
4. Vojtseh V. F. Sravnotelnyi kliniko-epidemiologicheskiy analiz suisidalnykh popytok v gorode Moskva za 1978 i 1998 gody [Comparative the cliniko-epidemiological analysis of suicide attempts in the city of Moscow for 1978 both 1998] / V. F. Vojtseh, A. G. Ambrumova //Social and clinical psychiatry. - M. - № 3. - 2001.- P. 15-18.
5. Polozhy B. S. Klinicheskaya suisidologiya. Etnokuturnye podkhody [Clinical suicidology. Ethnocultural approaches] / B. S. Polozhy. - M: RIO FPI «SRC for SFP named V.P.Serbsky», 2006. - P.15.

6. Tsygankov B. D, Vaulin C.B. Suisidy i suisidalnye popytki (klinika, diagnostika, lechenie [Suicides and suicide attempts (clinic, diagnostics, treatment)] / B. D. Tsygankov, C.V. Vaulin. - Smolensk: SFMA, 2012 - P. 232.

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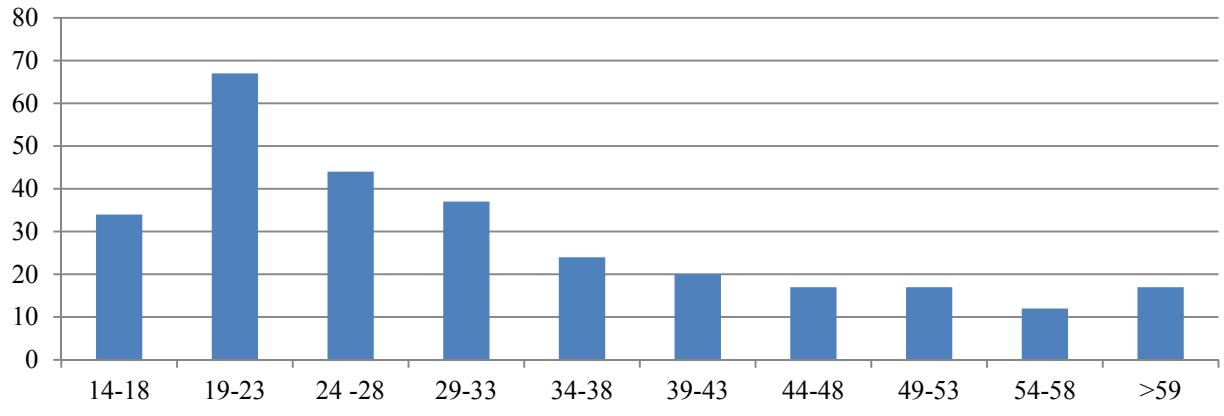
Picture 1. Distribution on age groups



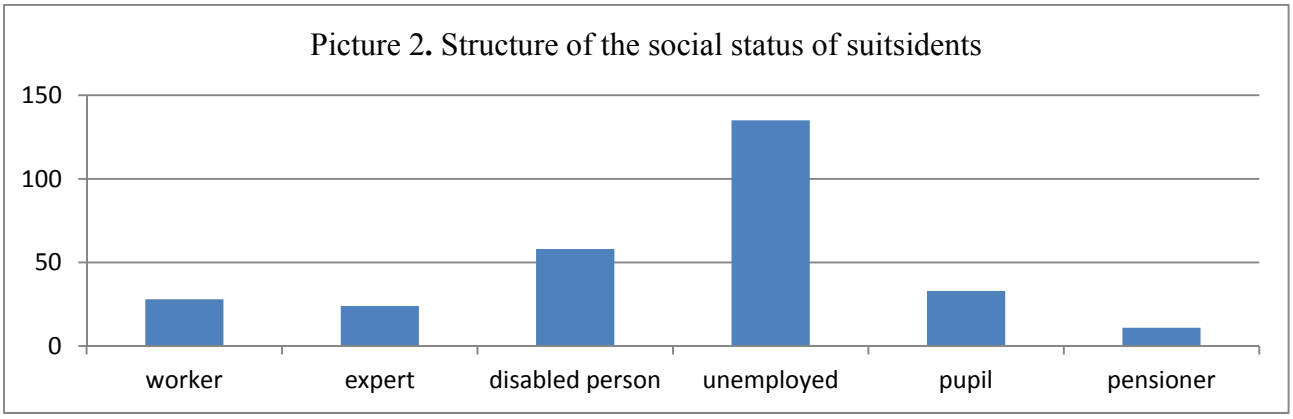


Table 1. The structure of diseases of people with not complete suicide

№	Illness	Abs.	%
1.	Schizophrenia	45	15,5
2.	Depressive frustration	31	10,7
3.	Frustration of the personality	34	11,7
4.	Intellectual backwardness	10	3,4
5.	Dementia	9	3,1
6.	Depressive reaction to a situation	38	13,1
7.	Disorder of adaptation	2	0,6
8.	Violation of behavior in alcoholic intoxication	89	30,7
9.	Epilepsy	7	2,4
10.	Violation of behavior	17	5,8
11.	Alcoholic psychoses	5	1,7
12.	Obsessive – fobia frustration	2	0,6