Affective States in Attempted Suicide

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Affective changes immediately preceding the act of attempted suicide were investigated in 65 consecutive referrals in two general hospitals. As evaluated by the depression spectrum of the PSE, depressive disorders were identified in almost 1/3 of the cases (32.3%). Other more transient acute emotional reactions (AER) were detected in 41.5%. The remaining subjects did not show manifest depressive changes, Depressive disorders were more common in the male population. while acute emotional reactions were more frequent in female eases. Being married and having a higher age were significantly more associated with depression. The seriousness of the medical condition on admission as well as the lethality of the method used in the act correlated positively but non-significantly with the appearance of affective changes. However, the degree of intent measured by the Suicidal Intent Scale (Beck et al., 1974) as well as the clinical global rating of the severity of the attempt showed a significant positive correlation with the appearance of depressive affect. Analysis of the profile of the ideo-affective states preceding the act showed that while cases with depression experienced more hopelessness, and helplessness, subjects with acute emotional reactions and cases with no manifest depression presented mostly with frustration and anger.

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Introduction

Western studies indicate that depressive disorders lie behind around 70% of completed suicides (Robins, 1985). The role of depression in attempted suicide on the other hand is far from clear.

The comorbidity of attempted suicide has been the subject of considerable research work (Hawton and Catalan, 1987). Two groups of subjects could be identified; the first group having definite psychiatric disorder, the most common categories being reactive depression and personality disorder (Morgan et al., 1975) and the second group either with no evidence of psychopathology (Kessel, 1965) or with mild disorders referred to under the term "borderline" (Newson-Smith, 1979) or "threshold"

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category (Urwin and Gibbons, 1979). Hawton and Catalan (1987) have described the disorders associated with deliberate self-harm as "relatively transient" and "secondary to the types of difficulty in the patients "lives". Different terms have been used to describe the reaction to stressful events or the crisis preceding the act of deliberate self-harm. These include "acute situational maladjustment" (Harrington and Cross, 1959); "unstable adolescent crisis" (Whitlock and Schapiro, 1967); and "Hysterical reaction" (Sclare and Hamilton, 1963).

Durkheim (1957) described the abnormal mental life of the subject who attempts suicide as characterized by an excessive exaltation, deep depression or general perversion. Lester and Lester (1971) have identified depression as the immediate forerunner of deliberate self destructive behaviour. "..... whatever the diagnosis, all cases of attempted suicide manifest some degree of depressive affect and that it was legitimate to try to measure this in every case "(Birchnell and Alarcon, 1971). Recently, Stenager et al. (1991) could identify depressed mood and other depressive symptoms in 85% of attempters on admission.

Several authors have indicated that prior to suicide the individual undergoes a change in affective reactivity (Spiegel and Acker, 1964 and Spiegel and Neuringer, 1963). The subject contemplating suicide may not be suffering from depression but rather experiences a state of emotional turmoil.

The literature describing the cognitive and affective state of mind of the suicide attempter is considerable (Hawton & Catalan, 1987). It ranges from theoretical formulations based on sociological concepts to evaluations of depression based on rating scales and patients' self-reports. Relatively few investigators have attempted to deffective state beyond the presence or absence of depression, or to investigate the presence of other mood states. Depression is often inadequately defined in clinical terms familiar to psychiatrists. A systematic approach is needed in order to estimate the presence of clinical depression and to study other affective states that may be similar but not identical, and hence require a different approach to mangement.

In a previous work (Hamdi et al., 1989) we described the clinical and demographic characteristics of suicide attempters in the United Arab Emirates. In a second publication (Hamdi et al., 1991) we demonstrated that the Suicide Intent Scale (Beck et al., 1974) correlates strongly with the other measures of the seriousness of a suicide attempt, namely the medical condition on admison and the lethality of the method used. It was also clear that suicide attempters display varying degrees of intent upon dying.

The present study deals with the affective changes befalling the individual in the short period prior to the act of self harm. The aim is to identify the patterns of affective states that may play an instrumental role in the sequence of events leading to the act. The role of depression, and other affective states will be studied in relation to the clinical characteristics of the subjects, and in relation to the various indicators of the seriousness of the suicide attempt.

Subjects and Method

The study sample consists of 65 consecutive referrals of medical admissions in two general hospitals for attempted suicide. The subject was included in the study if he had deliberately injured himself, ingested a poisonous substance or a drug in excess of therapeutic dosage. Drug dependent patients who took an overdose but denied making a suicide attempt were not included. Subjects were interviewed by one of the researchers as

early as possible; in all cases within 1-5 days after the attempt.

A-In the initial phase, a semi-structured interview was used to collect the data. The interview ranged widely over social, demographic and clinical information with special emphasis on the sequence of events and circumstances leading to the act of attempted suicide. Relatives and key informants were interviewed in the majority of cases. During the interview the researcher had to cover the following areas:

1- The presence of a depressive disorder immediately before the act using 30 related items covering the depressive spectrum in the Present State Examination (Wing et al., 1974). After reviewing all criteria in relation to the period preceding the act, the researcher would judge whether depression was present or absent and whether it was mild or moderate or severe. The evaluation is based on both the patient's retrospective report about his condition before the act and on the mental state examination. Depression was scored as present if the subject exhibited at least 5 PSE depression-related symptoms in addition to a depressed mood. The persistence of depressive symptoms after the attempt weighed in favour of a diagnosis of depression. The judgement about severity was a qualitative one depending on the range and severity of symptoms.

2- The presence of delinquent or dyssocial behaviour based upon a list of traditionally unacceptable norms of conduct such as sexual indiscretion, alcohol or drug abuse.

3- The presence of psychotic manifestations and.

4- A psychiatric diagnosis whenever applicable. Diagnoses were formulated according to DSM-III-R (1987).

The suicidal Intent Scale (SIS) devised by Beck et al. (1974) was used to make a qantitative evaluation of suicidal intent. The scale consists of 15 items which are rated on a three point scale (02) according to severity then summed up to give the suicidal intent score. The first section includes 8 items and is concerned with the circumstances of the act (isolation, timing, precautions against discovery, seeking help during or after the act, degree of planning, suicide note, communication of intent before the act and purpose of the act). The second section (self-report) includes 7 items. It is based on the subject's own reconstruction of his feelings and thoughts at the time of the attempt (expectation offatality, conception of lethality, conception of seriousnes, ambivalence towards living, conception of the act'sreversibility and premeditation).

B- In the second phase of the study, the data collected was subjected to content analysis in each case by three researchers. The raters evaluated the medical seriousness of the attempt according to: (state of consciousness, vital signs, medical and neurological signs recorded by the receiving medical officer and emergency laboratory investigations such as paracetamol blood level; treatments necessary on admission and during inpatient care such as the use of anti-shock measures, ventilator and duration of admission to an intensive care unit. The medical condition on admission was scored along 4 degrees of severity (not serious, mildly and moderately serious and critical).

The lethality of the method used for the suicide attempt was also evaluated on a continuum of 4 degrees of severity. In cases of drug overdose, the number, brand, and availability of tablets were considered together with the patient's awareness of their risks. In non-overdose cases the technique used and the extent of injury were studied. Both, medical seriousness and lethality of the method were

assessed independently from the assessment of suicidal intent. The evaluation in each of these items was done along a scale of absent, mild, moderate or severe However, during analysis the last two scores were dealt with together as a moderate-to severe score. The scoring was made in the second phase without reviewing the content of the SIS responses. A global rating of the seriousness of the attempt was assigned to the subject taking in consideration all the available information. The scoring was done on a four point scale (not serious, mild and moderately serious, and very serious).

The diagnosis of each case was reviewed and discussed by the three researchers in order to reach a common consensus.

A content analysis was performed on the total responses from attempters in order to identify the ideo-affective states concomitant with deliberate self harm. During the analysis all responses were taken in consideration with special emphasis on the enquiry about the immediate reasons behind the act. Responses were sorted out by the three researchers and accordingly ten ideo-affective states (IAS) could be identified. The list of IAS included feelings of loss (expression of the fear of impending loss or the experiencing of actual loss by death, separation etc), helpelessness (feelings associated with living in an inescapable situation, whether delusional or real) hopelessness, isolation (feeling that nobody is there to help, to care or to understand, frustration (blocking of ongoing goal-directed behaviour, anger (manifest arousal with expression of verbal anger), shattered self-esteem (the impending realisation of wrong doing or pain for example after discovery of misbehaviour or psychological trauma from a significant or key figure), incompetence or inadequacy (feeling that compared with others, the subject is unable to have a successful role in life because of discontinuation of academic career, failure of marriage), self-hatred (expression of hostile feelings towards self) and conscious feelings of guilt. An operational definition was formulated for each criterion. At the end of the review of all information collected for the subject the presence of each of the associated affects was screened. A consensus was required for the identification of the presence of any motivational IAS. Subjects were scored on more than one variable if the operational criterion is satisfied.

Results

A depressive disorder was identifid in 21 (32.3%) subjects. It was estimated to be mild or moderate in 14 cases (21.5%) and severe in 7 cases (10.8%). No evidence of depression wasdetected through the PSE and consensual rater opinion in 17 subjects (26.2%). The remaining 27 subjects (41.5%) showed an acute and transient emotional reaction with mixed emotional features. These reactions were characterized by being intense and short-lived ranging from minutes to few days. The emotional reaction was temporally and sequentially related to the pre-suicide crisis. Depressive affects (low mood, despair, crying spells) were experienced but did not constitute a complete disorder in terms of range or duration starting de-novo from a previously non-depressed state. The depressive manifestations were superseded by other affective reactions in the form of anger, frustration or rage. These states were described by the subjects as intolerable and they were not communicated to others. It was noticed that they would disappear within few days of the act as if the act itself exerts a rapid cathartic effect on the experienced affects. Emerging from the data, this group is qualified for separate consideration under the termacute emotional reactions (AER).

The affective state of the subject is

Table 1
Affective State in relation to Demographic variables

	Depressive disorders		Acute Emotional R.		No Depression		Chisquare
	n	%	n	%	n	%	X2
Sex							
Male	9	52.9	4	23.5	4	23.5	4.89
Female	12	25	23	47.9	13	27.1	NS
Civil Status*							
Married	12	44.4	12	44.4	3	11.1	6.93
Single	8	22.2	14	38.9	14	38.9	Sig
Nationality							
Foreign	14	36.8	16	42.1	8	21.1	1.5
National	7	25.9	11	40.7	9	33.4	NS
Frequency							
First-ever	14	30.4	21	45.7	11	23.9	X2=1.11
Repeater	7	36.8	6	31.6	6	31.6	NS
Age:							
Mean±SD @	29.76±9.3		22.07±7.2		18.29±3.3		F=12.73 Sig
Education							
Mean±SD	7.71±4.8		7.89±3.9		7.52±4.1		F= 0.04 N.S.

* P<0.05
@ P<0.005
Two cases were divorced ; one manifested with a depressed mood and the second with an acute emotional reaction.

Table 2
Affective State in Relation to Seriousness of Medical Condition, lethality of Method, Global Clinical Rating & Intent

	Depressive disorders		Acute Emotional R.		No Depression		Chisquare
	n	%	n	%	n	%	X2
			Medical seriousness				6.43
Absent	9/21	42.9	14/27	51.9	12/17	70.6	
Mild	7/21	33.3	11/27	40.7	2/17	11.8	
Mod-severe	5/21	28.8	2/27	7.4	3/17	17.6	
			Lethality				4.37
Absent	3/21	14.3	10/27	37	8/17	47.1	
Mild	10/21	47.6	10/27	37	6/17	35.3	
Mod-severe	8/21	38.1	7/27	26	3/17	17.6	
			Global seriousness*				16.25
Absent	4/21	19.1	16/27	59.3	12/17	70.6	
Mild	7/21	33.3	8/27	29.6	4/17	23.5	
Mod-severe	10/21	47.6	3/27	11.1	1/17	5.9	
			Intent**				12.03
Low	2/20	10	6/27	22.2	6/15	40	
Medium	5/20	25	13/27	48.1	7/15	46.7	
High	13/20	65	8/27	29.7	2/15	13.3	

* P< 0.005
** P<0.025 (N.B Three cases were omitted for self-report was unreliable)

Table 3
Ideo-Affective Profile and Depression

	Depressive disorders		Acute Emotional R.		No Depression		Chisquare
	n=21	%	n=27	%	n=17	%	X2
Helplessness	16	76.2	12	44.4	4	23.5	10.85**
Frustration	8	38.1	18	66.7	13	76.5	6.32*
Lost Self-esteem	9	42.9	16	59.3	8	47.1	1.4
Anger	4	19.1	16	66.7	12	70.6	11.84**
Isolation	13	61.9	10	37	5	29.4	4.73
Hopelessness	14	66.7	6	22.2	2	11.8	15.43**
Loss	5	23.8	6	22.2	3	17.6	0.22
Incompetence	5	23.8	3	11.1	5	29.4	2.46
Self-hatred	3	14.3	2	7.4	0	00.0	.....
Guilt	0	00.0	2	7.4	2	11.8	.....

* P<0.05, ** P<0.005

Table 4
Types of Depression

Type of depression	N	%
Endogenous (primary)	6	28.6
Reactive	6	28.6
Situational	6	28.6
With psychosis	5	23.8
With obsessions	1	4.8
With drugabuse	1	4.8
Total@	25	

@ Some subjects fit in more than one type of depression

significantly related to his / her age and marital status (Table1). The depressed group has a higher mean age (29.8 years, SD± 9.3) compared to cases with acute emotional reactions (22.1 years, SD± 7.2) and non-depressed subjects (18.3 years; SD± 3.3). The difference is significant even though the depressed subjects have a low mean age (F =12.37 P<0.005) compared to other studies. Depressive disorders were more manifest in the married subjects (44.4%) compared to single cases (22.2%). Acute emotional reactions tend to appear with similar frequency in both married (44.4%) and single cases (38.9%) (X2=6.93; P<0.05). While males showed the tendency to present with depressive disorders, females experienced more acute emotional reactions. The overall tendency to make a suicidal attempt was more common among females (2.8-1). Foreign nationals showed a higher tendency to manifest a depressive disorder in association with attempted suicide (36.4%) than local citizens (25.9). It was evident that first-ever attempters show more depressive disorders than the repeaters. Among the first-ever (76.1%) manifested with either depressive mood changes (30.4%) or non specific emotional reactions. While in the first-ever group (23.9%) did not show any tangible depressive change. However, such trends did not show significant correlations.

As illustrated in Table 2, the severity of the act as evaluated in terms of global clinical rating correlates with the occurrence of a depressive disorder as a forerunner affect to the act of attempted suicide.

Depressive disorders were found in 47.6% of cases whose act has been evaluated as severe gradually becoming less frequent with a decreasing seriousness of the act. (33.3% and 19.1% respectively). The non-depressed group and the group with acute emotional reactions show the opposite trends (X2 = 16.25, P<0.005).

The presence of depression was less clearly related to the medical condition on admission and the lethality of the

method used to fulfil the act. Although 52% and 70.6% of of the AER group and the non-depressed group were in the non-medically serious category the differences were not significant. Likewise, non-depressed and AER subjects appeared less frequently with an increasing estimate of the lethality of the suicide method, while depressed subjects showed more subjects in the more lethal attempts.

Subjects with high intent (total score on Suicidal Intent Scale of 11 or above) tend to manifest depressive disorders before the act of deliberate self harm (56.5%). Depressive disorders are less represented with the decrease in suicidal intent (20% in subjects with medium intent and 14% in cases with low intent). The majority of cases presenting with acute emotional reactions manifest medium scores on the SIS. Intent scores are commonly low in cases who do not show depression (42.9%) a small proportion present with high intent (8.7%). The differences between the three groups are statistically significant X2= 12.03, P<0.025).

Content analysis of the ideo-affective state immediately before the suicide attempt (chart I) shows that the majority of subjects studied present with a mixture of ideo-affective states rather than single affects as evidenced by the high prevalence of a group of affects viz frustration (60%) are the least experienced IAS and could not be statistically analyzed in the three groups of affective states. Loss of self-esteem, a sense of incompetence, isolation from others, and the occurrence of an impending or actual object loss occurred with similar frequencies in the three groups. Hopelessness, and helplessness were detected in a significantly higher proportion of the depressed group (P<0.005), while anger and frustration showed the opposite trend being significantly higher in the AER and no-depression groups (P<0.05).

In the present study an attempt was made to separate the psychiatric diagnosis when present from the affective state of the individual immediately before the attempt. In subjects presenting with a depressive disorder, the assumption was that the depression led directly to the attempt. Sometimes, the patient's description warrented an additional psychiatric diagnosis to that of depression (33.3%). In a significant proportion of our sample no psychiatric label could be allocated even though the subject was experiencing a social and consequently emotional crisis (30.8%). Conditions not attributable to a mental illness (V codes) were detected in 12.3% of the whole sample. Personality disorders, conduct disorders, and antisocial behaviour comprised another 12.3% (8 subjects). Adjustment disorders were diagnosed in 4 subjects (6.15%). Cases of depression were most frequently of the reactive (responses to acute events) and situational (responses to chronic difficulties) (57.2%. Purely endogenous depressions accounted for 28.6% of depressive disorders. A signficant proportion of depressions (23.8%) were secondary or associated with a psychotic disorder (Table 4).

Discussion

The study of the individual's affective state just before the act of attempted suicide revealed a wide range of variation. Three groups of subjects may be identified. The changes in affevtive state amounted to a depressive disorder in almost 1/3 of the cases, while in the remaining two thirds depression either played a secondary role or was absent before the act. The proportion of depressive disorders is understandably lower than that in completed suicides reportd in Western populations (Robins, 1985). It may have been still lower by the fact that the present sample has a low overall mean age (23.4 years). In a minority of cases the depression was rated as severe

(10.8%). In a recent study, Stenger et al., (1991) stated that depressive symptoms occur in the majority of patients with attempted suicide but slight non-endogenic depressive states are most commonly concerned and that many of these improve rapidly during hospitalization without medicinal treatment. Nevertheless, the genuinety of the clinical presentation of depressive states associated with the act has been confirmed in studies examining subjects in the emergency room. The comparison of scores of suicide-attempters on admission with depressive cases receiving ECT revealed no significant difference on depressive scores (Birchnell & Alarcon, 1971).

Our results suggest that cases who present with depressive disorders in association with significantly high suicidal intent, their attempt was rated globally as serious and they had the highest psychiatric comorbidity. Diagnoses of depression as well as psychotic states were mostly represented in this group. Our results agree with other findings that highlight the association of suicidal behaviour and depressive illness, and affective psychoses especially delusional depression (Wolfesdorf, 1991). The concomitant motivating affects were identified as mostly helplessness and hopelessness in cases manifesting with depression. Beck et al. (1985) and Salter and Platt (1990) state that greater depression and hopelessness are associated with greater suicidal potential and that hopelessness acts as a cognivtive mediator of the relationship between depression and suicidal behaviour. Hale et al (1990) reported that suicide attempters were significantly more likely to have mood disorders and Axis II disorders. The follow-up of suicide attempters showed that those who were to have had further episode of deliberate selfharm had significantly higher levels of hopelessness andintropunitive hostility after the index episode than those who did not repeat.

These findings confirm that, as a subgroup of suicide attempters, depressives come closest to the profile of completed suicides and constitute the area where the two groups overlap (Roy, 1986). Although cases of depression are associated with more medically serious conditions, the relation was not statistically significant. This may be due to the fact that the medical condition on admission is influenced to a large extent by the time elapsing from attempting suicide and reaching the hospital, by the availability of resecussitation measures and the policy of the medical staff attending the patient. The method used in the attempt and its lethality e.g. the number of tablets taken and their type, are dependent to a certain extent on the subject's previous knowledge of possible damage and its availability, in addition to the intent upon dying. This may explain the incomplete positive association with the presence of depression.

Depressed attempters seem to differ in certain respects from depressives who complete suicide. They tend to have a lower mean age, and their depressions although clinically significant are more commonly reactive and situational rather than endogenous (52.4%).

The majority of subjects attempting suicide in our series were not directly related to a persistent or complete depressive syndrome. They could be divided into those who exhibited intense affective reactions immediately prior to the attempt and those who did not show any visible depressive manifestations. These two groups share common characteristics. They are still younger than the depressed group, more females, more commonly single, make less serious attempts, and suffer more frustration and anger before the act. Such motivating affects point to a colouring of impulsivity and supports the view that they constitute a group that is clinically and aetio-

logically distinct from depressed subjects (Roy, 1986, Robins, 1985). In a study conducted on youths, nonimpulsive attempters were significantly more depressed and more hopeless than the impulsive attempters (Brown et al. 1991). Conduct problems and depressive thinking emerged as the most powerful predictors of attempted suicide in youth (Myers et al. 1991).

Analysis of the ideo-affective state of suicide attempters requires further comments. First, there is considerable overlap so that it seems that each subject experiences a number or associated, sometimes contradictory affect srather than a single predominant one. This agrees with the opinion of Brown et al. (1991) who have postulated that hopeless depressed subjects may harbour a good deal of anger but differ from others in that it is turned inwards in an intropunitive manner. Inspite of attempts at consensual agreement and content analysis of the details of each subject's attempt, it is often difficult to speculate completely and retrospectively about the exactideo-affective state of the suicide attempter. We feel that a fuller understanding may be served in subsequent studies by follow-up interviews some time after the act and its consequences have been resolved. Second, there is a notable lack of guilt and self-blame in conncection with our cohort of suicide attempters even in the depressed subjects. Much has been said of the notable absence of guilt in depressions of non-Western countries. These findings have been contradicted recently (e.g. Ghubash, 1991). In our sample the lack of association is apparent but may have a different explanation. A suicide attempt in itself is a shameful act in certain societies and in many cases who have to deal with the resentment and hostility of their family members. A reflex defensive attitude may conceal guilt feelings. Again, guilt feelings in younger subjects may be largely unconscious and difficult to elicit except in an ongoing therapy relationship rather than in a single interview.

The examination of all cases on two levels one related to traditional nosological discipline and the second in relation to the affective state prior to the act revealed that almost one third of the subjects could not be given. When present psychiatric disorders consist of a mixed group of behavioural and adjustment disorders together with clearcut depressive and psychotic disorders.

In our 65 subjects 6 (9%) were diagnosed as suffering from primary endogenous depression and another 5 (7.7%) suffered from depression associated with a psychotic disorder. These figures are higher than those of Stenger et al., (1991) who stated that subjects who were diagnosed as endogenous depression corresponded to only 5% of all admissions. The method of assessing depression and the criteria used for defining a case are relevant to estimating the role of depression in attempted suicide. Thus according to the criteria established by Feighner et al., (1972) on admission 51% of subjects with attempted suicide suffered from depressive illness and according to Zung's depression scale, 60% were depressed. Further observation during hospitalization showed that the number of cases who were identified as suffering from depressive illness was reduced to 25% (Stenger et al. 1991). The authors suggest that restraint should be observed in prescriptin of antidepressants to patients with attempted suicide until the diagnosis of depressive disease is verified. We may further add that due consideration should be given to depression developing after an attempted suicide. The awarenss of the threat to life may contributer to the production of such a post-attempt depression. The latter may be the starting point for benefi-

cial alterations in a therapy relation rather than a psychopathological phenomenon.

Conclusions

1. Depression as a clincal disorder plays a lesser significant role in attempted suicide than in completed suicide being detected in almost one third of the cases.

2. The presence of depression is indicated by a higher mean age and married status of the attempter as well as high suicidal intent, and to a lesser extent the use of a lethal method and a poor medical condition on admission. Helplessness and hopelessness are significant antecedent ideo-affective states in this group.

3. The majority of suicde attempters experience acute emotional crises rather than depression. These crises are characterized by a mixture of emotions in which frustration and anger play a prominent role. Females, single young adults and adolescents are more likely to fall in this group. The act is displayed with lesserintent, a non-lethal method is used, and the subject experiences little medical hazards.

4 There is a notable absence of guilt and self-reproach in the majority of suicide attempters which reflects the younger age of this group as a whole, hence the readiness towards denial, and rationalization.

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États affectifs dans les Tentatives de Suicide

Les changements affectifs précédant immédiatement les tentatives de suicide ont été étudiés chez 65 patients adréssés à deux l'hôpitaux généraux. Des troubles dépressifs ont été identifiés, utilisant l'eechelle de la dépression du PSE, dans presque le tiers des cas (32.3 %). Dans 41,5%, nous avons identifié d'autres reactions émotionnelles aigues (AER). Les troubles dépressifs étaient plus fréquents chez les hommes tandis que les reations émotionnelles aigues étaient plus fréquentes chez les femmes. Le fait d'être marié et plus agé étaient significativement associés avec la dépréssion. La sévérité de l'état médical ainsi que la dangerosité de la méthode utilisée étaient positivement, mais non significativemnt, associés avec la présence de troubles affectifs. L'analyse des états ideo-affectifs précédant l'acte suicidaire indique que tandis que les cas souffrant de dépression éxpriment plus de desespoir et d'incapacité les patients souffrant de reactions émotionnelles aigues et les patients ne souffrat pas de dépression manifeste ont présenté essentiellement avec la frustration et

الحالة الوجدانية قبل محاولة الانتحار

تمت دراسة التغيرات الوجدانية السابقة لمحاولة الانتحار فى ٦٥ حالة متعاقبة حولت إلى قسم الطب النفسى فى مستشفيين عامين حيث تبين من خلال تطبيق قياس الاكتئاب فى اختبار الحالة النفسية الحاضرة تواتر الاكتئاب بصورة إكلينكية فى حوالى ثلث الحالات (٣٢,٣٪) كما تبين وجود انفعالات نفسية حادة ومؤقتة فى ٤١,٥٪ من الحالات، ولم يمكن الاستدلال على اضطرابات وجدانية ذات دلالة فى ٢٦,٢٪ من الحالات، وقد تبين من خلال التحليل الإحصائى التفصيلى أن الاكتئاب السابق لمحاولة الانتحار متواتر بصورة دالة احصائياً بين الذكور، والمتزوجين، والأكبر سناً، بينما ترتبط جدية المحاولة وخطورتها بوجود الاكتئاب قبلها أما التحليل النوعى للحالة الوجدانية قبل المحاولة فقد أظهر أن حالات الاكتئاب تعانى بصورة أكبر من خليط من فقدان الأمل فى الحياة وفقدان القدرة على المواجهة قبل الإقدام على محاولة الانتحار بينما تظهر مشاعر الغضب والإحباط بصورة كبيرة فى بقية الحالات.