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SUICIDAL THOUGHTS AND BEHAVIOURS AND THEIR COMORBIDITY WITH PSYCHOPATHOLOGICAL SYMPTOMS AMONG PATIENTS WITH SCHIZOPHRENIA HOSPITALIZED AT LONG TERM WARD.

Schizophrenia is related with one of the highest risk of suicide, studies indicate that lifetime suicide risk in schizophrenia varies from 5% - 10%. The aim of the work was to establish the relationship between psychopathological symptoms, and the risk of committing suicide, in the group of schizophrenia patients hospitalized at long term care facility.

Study was conducted on total of $n = 52$ patients with schizophrenia hospitalized at long term psychiatric ward in Poland. The risk of suicide was measured using diagnostic module of M.I.N.I neuropsychiatric interview, psychopathological symptoms was determined by SCL27 PLUS questionnaire. Severity of depressive symptoms, agoraphobia and social phobia was significantly ($p < 0.05$), different depending on the risk level of committing suicide, and significantly ($p < 0.05$) higher in patients with a suicidal attempt in the interview. In addition, severity of all psychopathological symptoms was related to current suicidal thoughts occurring in patients.

Our results indicate a significant relationship between the severities of psychopathological symptoms with the risk of committing suicide, providing a proof of necessity to control psychopathological symptoms among group of patients with schizophrenia.

Key words: schizophrenia, suicide, psychopathological symptoms, depression

INTRODUCTION

According to WHO every year over 800 000 people die by suicide, making it the second

leading cause of death among people in the age group 19-25, and 15th leading cause of death worldwide (WHO, 2014). WHO categorizes suicide preventing interventions into categories

aimed at universal risk factors — designed to reach an entire population, along with selective risk factors — targeting, especially vulnerable groups. Among them, mental disorders seem to be particularly relevant. Meta-analysis conducted by Bertolote and Fleischmann (2002) indicated that 90% of those who died by suicide had a psychiatric diagnosis at the time of their death (Bertolote & Fleischmann, 2002). Psychiatric patients are a specific risk group, as social stigma against problems of mental health can be a substantial barrier in seeking help in suicidal behaviors (Niederkröthaler, Reidenberg, Till & Gould, 2012). Therefore, it is crucial to examine suicidal risk and to implement effective suicide prevention strategies in this highly vulnerable group.

According to Bertolote and Fleischmann (2002) schizophrenia is the second most frequent diagnosis in patients of mental facilities (19.9%). Studies suggest that for patients with schizophrenia symptoms like: depression, anxiety and related somatic symptoms, may constitute a significant predictor of suicidal behavior (Fuller-Thomson & Hollister, 2016). It is estimated that depressive symptoms may co-occur in as many as 50% of patients with schizophrenia, constituting a crucial risk factor of suicide in this patient group (Hor & Taylor, 2010; Kocatürk, Eşsizoglu, Askaray, Akarsu & Musmul, 2015). In a recent cross-sectional pilot study conducted on 160 patients with diagnosed schizophrenia, an interesting negative relationship between self-stigma, quality of life and somatic complaints was observed. Moreover, self-stigma starts to elevate one year after the initial diagnosis, possibly by the fact of increased insight into illness (Lin et al., 2016). The research by Casper et al. (1985) suggests that the severity of depression is related to the increase in somatic symptoms observed in patients with schizophrenia. In addition a meta-analysis by Stubbs et al. (2014) concerning the prevalence of clinical pain in people with

schizophrenia demonstrated, that the general distribution of various types of pain in the patient group is amounted to 34.7%. Based on the conclusions above, we could expect increased depression and somatic symptoms in patients having higher risk of suicide.

It is known that the comorbidity of anxiety symptoms is greater in patients with schizophrenia than in the general population and ranges between 20 - 40 % (Argyle, 1990; Casano, Pini, Saettoni, Rucciand & Dell'Oosso, 1998) to as much as 45% (Goodwin, Lyons and McNally, 2002). The most common type of anxiety disorder, co-occurring with schizophrenia is panic disorder, appearing approximately even up to 20% of patients with schizophrenia (Kiran & Chaudhury, 2016). There are reports concerning higher anxiety symptoms with relationship to suicide rate. For example, research by Pallanti, Quercioli & Holladner, (2014) demonstrates that patients with schizophrenia having social anxiety disorder comorbidity, had a higher lifetime rate of suicide attempts and greater lethality of suicide attempts.

One of the biggest difficulties during suicide risk assessment is fact that based on work of Bakst, Rabinowicz & Bromet (2009), patients with schizophrenia tend not to report suicidal thoughts which constitutes one of the common risk factors for most other psychiatric disorders (Hawton et al., 2009, after: Lopez-Morinigo et al., 2014). As Lopez-Morinigo et al. (2014) point out, the classic suicide prevention model is less efficient and less helpful in the case of patients diagnosed with schizophrenia than in the case of other psychiatric disorders.

Based on above, it seems that developing reliable and easy-to-use methods of evaluating the risk of suicidal tendencies is crucial to the prevention of suicidal behaviors in patients. Epidemiological data from the year 2014 demonstrate that in Poland 5,237 males and 928 females died by suicide. It is known

that around 10% of suicides are committed by patients with schizophrenia (Muller-Oerlinghausen & Berghofer, 1999). It means that, based solely on these data, one should expect at least 600 suicides of patients with schizophrenia every year in Poland alone.

The aim of this study was to determine the existence of current and past suicidal thoughts and behavior among patients with schizophrenia hospitalized at long term care, and estimating the potential relationship between suicide risk and psychopathological symptoms. Group of stable patients in a relatively good condition have been chosen on purpose because such patients are more likely to be discharged and, as the studies carried out by Ho (2003) and Hunt et al. (2009) indicate, the first weeks after the discharge are characterized by a higher risk of suicide.

To this end, the following hypotheses will be verified:

1. A higher suicide risk index will be observed in patients with severe depressive symptoms, as compared with patients showing no depressive symptoms.
2. A higher suicide risk index will be observed in patients with severe somatic symptoms, as compared with patients showing no symptoms.
3. A higher suicide risk index will be observed in patients with severe social anxiety symptoms, as compared with patients showing no symptoms.

MATERIALS AND METHODS

The study covered total of 60 patients with schizophrenia (age 18 - 60; M age = 36.30, SD = 12.10), hospitalized at long-term ward for at least 2 weeks. Further analyses were based on data obtained from 53 patients (16 females and 37 males), including 7 refusals (11%). Participants were diagnosed with schizophrenia by psychiatrist based on the ICD-10 criteria

(WHO, 1993). Patients were stable from at least 7 days, without acute psychotic symptoms. All examined patients were assessed by a practitioner, on the basis of the Clinical Global Impressions Scale — component CGI-Severity (Guy, 1976). The inclusion criterion was obtained by the patient through a score of 3 — mildly ill, corresponding to: “clearly established symptoms with minimal, if any, distress or difficulty in social and occupational function”. Clinical Global Impressions Scale (CGI) is an independent description tool designed to assess general functioning of patients on the basis of an assessment performed by a clinician familiar with the course of the therapy. The patients were evaluated on the basis of the first module of the CGI-Severity scale, allowing for an assessment of the disease in the last 7 days on a 7-point scale.

The risk of suicide was measured using the ‘C’ diagnostic module of M.I.N.I. 5.0 (Mini International Neuropsychiatric Interview), in the Polish elaboration by Masiak and Przychoda, (1998). The interview is a structured diagnostic tool used to recognize psychiatric disorders as defined by DSM-IV and ICD-10. The diagnostic module featured 5 questions about suicidal thoughts and behaviors in the previous month along with a question about a suicide attempt in the past; each having assigned a point value, with the total score of 29 points. Patients were assigned to low, moderate or high suicide risk group based on recommendations from M.I.N.I; no risk < 1 point, low risk 1-5 points, moderate risk 6-9 points and high suicide risk >10 points. The Polish version of Symptom Checklist-27-plus Questionnaire (SCL27 PLUS), was developed by Hardt, and used for determination of the psychopathological symptoms and also as auxiliary tool for measurement of current suicidal thoughts and suicide attempts in the past. The tool contains 29 items selected from the SCL 90 version. The Polish adaptation of the questionnaire (Kuncewicz,

Dragan & Hardt, 2014) is characterized by good psychometric properties ($CFI > 0.90$). The questionnaire allows to measure the symptoms based on 5 subscales indicating the following values: depressive symptoms, vegetative symptoms, agoraphobic symptoms, symptoms of social phobia and pain symptoms; each subscale consists of 4–6 items.

PROCEDURE

The patients were recruited at long term general psychiatric wards of Professor Jan Mazurkiewicz Mazovian Special Health Centre in Pruszków and Institute of Psychiatry and Neurology in Warsaw. The interviews were conducted in a quiet and neutral place. Before the interview, participants were presented with a written description of the study containing information about the aim and the procedure as well as patient's rights. Then, the participants were asked to sign a form of informed consent to their participation in the study. Following this procedure, CGI-based assessment by the clinician was collected; afterwards the interviewers asked the five questions of the 'C' module of the M.I.N.I. 5.0 interview; finally, the patients were asked to fill in the Symptom Checklist 27 PLUS questionnaire. The study has been approved by the Bioethics Committee of the Medical University of Warsaw.

RESULTS

Severity of psychopathological symptoms in relation to the suicide risk

The patients were divided into three subgroups on the basis of the risk level of suicide as determined using the M.I.N.I. diagnostic module. The following subgroups were created: "no suicide risk", "low risk of suicide", "moderate risk of suicide", "high suicide risk". Group size were as follows: no suicide risk ($N = 3$), low suicide risk ($N = 20$), moderate risk ($N = 14$), high risk ($N = 16$). The group of "no suicide risk" was removed from further analyses due to low representativeness.

The ANOVA assumptions have been met: the comparable groups were of equal size, which is confirmed by the non-significant result of the χ^2 test ($N = 53$) = .007; $p = 11.981$, and the distribution of the dependent variables in the comparable groups were consistent with the norm.

Psychopathological symptoms were obtained on the basis of the five subscales in SCL 27 PLUS.

The analysis showed a significant main effect of the factor "suicide risk" for the scales: Depressive Symptoms $F(2;47) = 6.30$ $p < .05$, Agoraphobic Symptoms $F(2;47) = 13.48$ $p < .001$ and Symptoms of Social Phobia $F(2;47) = 5.68$ $p < .05$.

Table 1. Psychopathological symptoms relationship with suicide risk

Source	Dependent Variable	df	f	p	Partial Eta Squared
Suicide risk	Depressive symptoms	2	6.297	.004	.211
	Vegetative symptoms	2	2.355	.106	.091
	Agoraphobic symptoms	2	13.481	.000	.365
	Symptoms of social phobia	2	5.679	.006	.195
	Pain symptoms	2	1.034	.364	.042

The main effect of the variable did not occur in the case of two scales:

Vegetative Symptoms: $F(2;47) = 2.36$, $p = 0.106$, and Pain Symptoms Scale $F(2;47) = 1.03$, $p = 0.364$.

between patients with low suicide risk and moderate suicide risk ($M = 10.28$; $SD = 5.8$). No significant difference between the moderate suicide risk and high suicide risk groups was observed.

DEPRESSIVE SYMPTOMS

In the depressive symptoms scale, post-hoc analysis revealed one significant difference. Patients with high suicide risk ($M = 15$; $SD = 4.96$) had significantly ($p = .003$), higher severity of depressive symptoms than patients with low suicide risk ($M = 9.6$; $SD = 3.86$). In addition, patients with moderate suicide risk ($M = 11.57$; $SD = 5$) did not differ significantly from patients with low and high suicide risk.

AGORAPHOBIA

Patients with high suicide risk had significantly ($p < .001$) higher severity of agoraphobic symptoms ($M = 13.12$; $SD = 4.58$), than patients with low suicide risk ($M = 6$; $SD = 1.71$). In addition there were significant ($p = .043$) difference

SOCIAL PHOBIA

As far as the scale of social phobia symptoms is concerned, significant ($p = .005$) differences were noted between patients with high suicide risk ($M = 15.87$; $SD = 5.53$) and patients with low suicide risk ($M = 10.35$; $SD = 3.24$). No significant differences were noted between patients with high risk of suicide in addition to patients with moderate risk of suicide.

Depression, anxiety, somatic symptoms and pain in relation to the presence of a suicide attempt in the past

The results turned out to be significant in respect of the scales: Depressive Symptoms $t(51) = 4.25$; $p < .001$, Agoraphobic Symptoms $t(51) = 4.06$; $p < .001$ and Symptoms of Social Phobia $t(51) = 3.50$; $p < .001$. Results are presented in detail in Table 2.

Table 2. Psychopathological symptoms relationship with past suicidal behavior

	<i>Suicide attempt</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Variances</i>	<i>Student's-t test</i>	<i>df</i>	<i>p</i>																																															
Depressive symptoms	YES	27	13.63	5.39	unequal	2.80	45.37	.007																																															
	NO	26	10.12	3.58					Vegetative symptoms	YES	27	12.56	4.15	equal	1.62	51	.113	NO	26	10.92	3.11	Agoraphobic symptoms	YES	27	11.81	5.33	unequal	4.29	40.83	.000	NO	26	6.77	2.94	Symptoms of social phobia	YES	27	14.44	5.96	unequal	2.43	43.60	.019	NO	26	11.15	3.68	Pain symptoms	YES	27	14.93	5.88	unequal	1.75	39.20
Vegetative symptoms	YES	27	12.56	4.15	equal	1.62	51	.113																																															
	NO	26	10.92	3.11					Agoraphobic symptoms	YES	27	11.81	5.33	unequal	4.29	40.83	.000	NO	26	6.77	2.94	Symptoms of social phobia	YES	27	14.44	5.96	unequal	2.43	43.60	.019	NO	26	11.15	3.68	Pain symptoms	YES	27	14.93	5.88	unequal	1.75	39.20	.088	NO	26	12.69	3.03								
Agoraphobic symptoms	YES	27	11.81	5.33	unequal	4.29	40.83	.000																																															
	NO	26	6.77	2.94					Symptoms of social phobia	YES	27	14.44	5.96	unequal	2.43	43.60	.019	NO	26	11.15	3.68	Pain symptoms	YES	27	14.93	5.88	unequal	1.75	39.20	.088	NO	26	12.69	3.03																					
Symptoms of social phobia	YES	27	14.44	5.96	unequal	2.43	43.60	.019																																															
	NO	26	11.15	3.68					Pain symptoms	YES	27	14.93	5.88	unequal	1.75	39.20	.088	NO	26	12.69	3.03																																		
Pain symptoms	YES	27	14.93	5.88	unequal	1.75	39.20	.088																																															
	NO	26	12.69	3.03																																																			

Tabela 3. Psychopathological symptoms relationship with current suicidal thoughts

	<i>Suicidal Thoughts</i>	<i>N</i>	<i>Average rank</i>	<i>Mann-Whitney U test</i>	<i>p</i>
Depressive symptoms	Yes	6	45.67	29.00	.001
	No	47	24.62		
Vegetative symptoms	Yes	6	42.83	46.00	.006
	No	47	24.98		
Agoraphobic symptoms	Yes	6	46.00	27.00	.000
	No	47	24.57		
Symptoms of social phobia	Yes	6	43.75	40.50	.003
	No	47	24.86		
Pain symptoms	Yes	6	39.75	64.50	.029
	No	47	25.37		

Psychopathological symptoms in relation to current suicide thoughts

A comparison of the severity of psychopathological symptoms in relation to current suicide thoughts (obtained from item 27d of the SCL-27 PLUS questionnaire) was performed using Mann-Whitney U test, because the compared groups differed significantly in size.

All psychopathological symptoms acquired from SCL-27 PLUS turned out to be significantly higher in patients with current suicidal thoughts, which were confirmed by higher average ranks in this group. Results are presented in detail in Table 3.

DISCUSSION

The study demonstrated significantly higher severity of the symptoms of depression, agoraphobia and social phobia in patients in relationship with higher suicide risk.

The clinical similarity between depressive symptoms and negative schizophrenia symptoms may be problematic in the context of diagnose; however, as some researchers suggest, the presence of negative symptoms in schizophrenia patients does not constitute

a significant risk factor of suicidal behaviors (Jones et al., 1994; Nordentoft et al., 2002; Tarrrier et al., 2007).

The international classification of diseases ICD-10 places social phobia and agoraphobia in the group of phobic anxiety disorders, in which the feeling of fear is connected with precisely defined situations. In the case of social phobia — social exposition, and in the case of agoraphobia — fear of leaving safe space (WHO, 2007). Identical (anxiety-related) grounds of both factors allow for common interpretation of social phobia and agoraphobia as a group of symptoms related to the risk of committing suicide. Moreover, fears of leaving safe place or being socially exposed causing major suffering in social and relationship functioning, and enhanced by social stigma connected with diagnosis of schizophrenia, can lead to serious prolonged distress, avoidance and withdrawal from everyday activities (Pallanti, Quercioli & Hollander, 2004). All together they contribute to lower quality of life and worst social adjustment than in patients without anxiety symptoms (Pallanti, 2014).

As follows from the meta-analysis by Achim et al. (2011), social phobia can co-occurs in the

course of schizophrenia in as many as 14.9% of patients. Methodological problems may arise here due to the lack of a clear distinction and the similarity between negative symptoms of schizophrenia and social anxiety (Sutliff, Roy & Achim, 2015). The impossibility to clearly determine the grounds of the anxiety exhibited by patients may constitute a justification of the conclusion of Bentley et al.'s meta-analysis (2016), which pointed out that anxiety disorders and the symptom of anxiety in itself were a significant, yet poor index of suicidal thoughts and behaviors.

The relationship between the level of anxiety and increased risk of committing suicide by patients can be explained by reference to the theories positing suicide attempts as a consequence of inability to cope with intolerable distress of various causes (Allan et al., 2015). On the other hand, as SinyorSchaffer & Remington (2015) pointed out, only slightly over one fourth of the patients with schizophrenia who committed suicide experienced a clear stressor in the previous year. The significantly higher severity of symptoms of social phobia and agoraphobia in patients with high risk of suicide observed in this study, suggests that these patients may be characterized by a higher level of anxiety and poorer functioning in the society.

Our results indicate that patients having a suicide attempt in the past, as compared with patients without such an attempt, had significantly higher indices of the symptoms which were characteristic also of the patients with current high risk of suicide (social phobia, agoraphobia and depression). This analogy may be result from the fact, that suicide attempt in the past is crucial for assessing current suicide risk (Hor & Taylor, 2010).

Further analyses demonstrated that patients with current suicidal thoughts, as compared with patients without current thoughts, suf-

fered from more severe symptoms of all kinds: depressive, agoraphobic, vegetative, symptoms of social phobia and pain symptoms. One of the explanation of this result, may be the fact that occurrence of suicidal thoughts is related among which with self-depreciation, guilt and depression, which may contribute to social exclusion (Kontaxakis, et al., 2004).

Interesting finding of this study is that there is no relevant connection between somatic and pain symptoms, in relation to suicide attempt in the past. According to Bonnot & Tordjman (2009) in most situations behavioral pain reactivity and self-reported responses to pain are reduced in schizophrenia. As there is no convincing psychophysiological data on this, the question can be asked if prolonged exposition to treatment, social exclusion, and emotional distress causes subjectively lower pain responses in patients or the cause lays deeper in the neurobiology of the illness. In addition, according to Interpersonal Theory of Suicide by Joiner (2005), individuals who are capable of suicide are characterized by increased physical pain tolerance, through prolonged habituation to physically painful experiences. Above conclusion stands as possible explanation for lack of relationship of pain symptoms in relation with suicide risk or suicide attempt in the past (Van Orden et al., 2010).

The significantly higher severity of symptoms in patients with high suicide risk points to a relationship between the psychopathological symptoms and the risk of committing suicide. The study also demonstrated that higher severity of psychopathological symptoms may be characteristic of patients with current suicidal thoughts and also a suicide attempt in the past. The data obtained in this study suggest that it is necessary to strictly observe and treat psychopathological symptoms in patients diagnosed with schizophrenia, especially those who are in the group of an increased risk.

LIMITATIONS

As the presence of current suicidal thoughts was stated on the basis of an item of the SCL-27 PLUS questionnaire, the significantly higher indices of both scales in patients with current suicidal thoughts may be explained by the low diagnostic value of the questions concerning suicidal thoughts in the Polish adaptation of the SCL-27 PLUS questionnaire.

Due to the specifics of the study: strictly determined group of patients, absence of a control group, conducting interviews only in long term care, the presented results are limited only to the patients who meet the inclusion criteria for the present study.

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MYŚLI I ZACHOWANIA SAMOBÓJCZE, I ICH ZWIĄZEK Z OBJAWAMI PSYCHOPATOLOGICZNYMI, W GRUPIE PACJENTÓW Z DIAGNOZĄ SCHIZOFRENII, HOSPITALIZOWANYCH NA ODDZIAŁACH CAŁODOBOWYCH

STRESZCZENIE

Jedną z grup posiadającą najwyższy wskaźnik zamachów samobójczych stanowią pacjenci z diagnozą schizofrenii. Ryzyko popełnienia samobójstwa w skali całego życia szacuje się w tej grupie pacjentów, na 5-10%. Celem niniejszej pracy, było oszacowanie związku pomiędzy objawami psychopatologicznymi i ryzykiem samobójstwa na grupie pacjentów z diagnozą schizofrenii, hospitalizowanych na całodobowych oddziałach psychiatrycznych. Badanie przeprowadzone zostało na grupie 53 pacjentów z diagnozą schizofrenii hospitalizowanych na całodobowych oddziałach szpitalnych w Pruszkowie. Ryzyko samobójstwa oszacowane zostało

przy użyciu modułu diagnostycznego wywiadu M.I.N.I 5.0, w celu określenia nasilenia objawów psychopatologicznych posłużono się kwestionariuszem SCL27 PLUS.

Uzyskane wyniki wskazały, iż nasilenie objawów depresji, agorafobii oraz fobii społecznej okazały się być istotnie ($p < 0.05$) zależne od ryzyka popełnienia samobójstwa, oraz istotnie ($p < 0.05$) wyższe u pacjentów posiadających próbę samobójczą w przeszłości, w porównaniu do pacjentów bez przeszłej próby samobójczej. Dodatkowo, pacjenci posiadający aktualne myśli samobójcze uzyskali wyższe nasilenie wszystkich wskaźników psychopatologicznych, w porównaniu do pacjentów bez aktualnych myśli samobójczych.

Uzyskane wyniki pozwalają wnioskować na temat związku objawów psychopatologicznych z ryzykiem samobójstwa w grupie pacjentów z diagnozą schizofrenii, stanowiąc dowód na konieczność kontroli objawów psychopatologicznych w tej grupie.

Słowa kluczowe: schizofrenia, samobójstwo, objawy psychopatologiczne, depresja