



A comparative study of sociodemographic characteristics and clinical risk factors of suicide and suicidal behaviour in bipolar versus unipolar depression

Abstract

Aim of the study: We aim to compare the sociodemographic and clinical risk factors of suicide and suicidal behaviour in patients with bipolar versus unipolar depression. **Material and methods:** An observational cross-sectional study was conducted over one year, in the Department of Psychiatry at Gauhati Medical College Hospital, Guwahati, Assam, India. A total of 60 subjects, 30 each of unipolar and bipolar depression with suicidal ideation/attempt, were assessed using a semi-structured proforma for sociodemographic and clinical variables, and diagnosis was made according to the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) Diagnostic Criteria for Research (DCR). The Montgomery-Asberg Depression Rating Scale (MADRS) was applied for the assessment of the severity of depression, and the Columbia Suicide Severity Rating Scale (C-SSRS) for assessment of suicidal behaviour. Descriptive statistics were used for analysis of the data. **Results:** The mean age of the subjects in the bipolar depression group was 45.67 ± 11.26 years, which is significantly higher (p value < 0.001) than the unipolar depression group, 35.93 ± 10.32 years. Majority of subjects in the unipolar group were married compared to the bipolar group, with $p = 0.028$. Both groups were comparable in terms of sex, religion, locality, education, occupation, and socioeconomic status. Among the clinical variables in the bipolar group, the mean age of illness onset was lower, more family history of psychiatric illness, and prior hospitalisation. The total suicide attempt was comparable in both groups; however, the severity of depressive episodes was higher in the unipolar group. **Conclusion:** Bipolar depression patients with earlier age of onset of illness, lower mean age, and lesser severity of depression had comparable suicidal attempts to those of unipolar depression patients. Further probing regarding the severity and lethality of the suicidal attempts in both groups shall bring more insight to this area.

Keywords: Major depression, suicide risk, attempted suicide

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INTRODUCTION

More than one million people commit suicide each year, accounting for one to two per cent of total global mortality. According to the World Health Organization (WHO), over 800,000 people die by suicide, i.e., one person dies every 40 seconds somewhere in the world.[1] Every year in our country, more than one lakh lives are lost due to suicide, which shows the importance of addressing this issue. Moreover, one in 60 people in our country is found to be affected by suicide. It includes both those who have attempted suicide and the suicide survivors (who have been affected by the suicide of a close family or friend).[2] Suicide is among the top three leading causes of death for those aged 15-44 years globally.[1]

More than two-thirds of suicide completers and suicide attempters have (mostly untreated) major depressive episodes at the time of the suicidal act.[3] The rate of suicide attempt

is found to be highest in bipolar II disorder (33%), bipolar I disorder (28%), and unipolar depression (13%), which is summarised from the data of ten studies published from 1976 to 2004.[4] Moreover, the lethality of suicidal behaviour is higher in bipolar compared to unipolar depression.[5] Among the major mood disorders, unipolar and bipolar disorders differ in genetics, neurobiology, clinical course, treatment regimens, and prognosis. The various sociodemographic and clinical factors associated with suicidal risk differ in each group. The identified risk factors confer different levels of clinical relevance and diverse clinical utility in both groups. So, for proper prevention, detailed evaluation of risk factors can aid in the detection of early warning signs and hence decrease the mortality associated with it. The study aimed to compare the sociodemographic and clinical risk factors of suicide and suicidal behaviour in patients with bipolar and unipolar depression.

MATERIALS AND METHODS

This is a hospital-based cross-sectional observational study. The study was undertaken in the Department of Psychiatry, Gauhati Medical College Hospital (GMCH), Guwahati, Assam, India, extended for one year period (July 2018 to July 2019). A total of 60 patients (30 each of unipolar and bipolar depression) admitted to the psychiatry ward of GMCH, diagnosed as per the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) Diagnostic Criteria for Research (DCR) criteria, are included in the study using a consecutive sampling technique.[6] Each subject is interviewed once they are medically stable and emotionally communicable. The inclusion criteria were subjects aged 18-65 years, both sexes, who met the criteria for depression and bipolar affective disorder with a current episode of depression based on ICD-10-DCR, and those who gave informed written consent.[6] Affective illness secondary to psychoactive substance use, subjects with other comorbid psychiatric illness, severe cognitive impairment, and mental retardation were excluded on clinical assessment. A written informed consent was obtained from the subjects and the caregiver who met the study selection criteria. All the relevant clinical data (age of illness onset, family history of psychiatric illness, prior hospitalisation, and suicide attempts) and sociodemographic data (age, sex, religion, education, occupation, locality, marital status, and socioeconomic status) were recorded using a semi-structured proforma. Socioeconomic status was classified using the Modified Kuppuswamy Socioeconomic Scale. The Montgomery-Asberg Depression Rating Scale (MADRS) was administered to measure the severity of depressive episodes in patients already diagnosed with mood disorders.[7] It is a ten-item questionnaire used to measure the severity of depressive episodes in patients already diagnosed with mood disorders. It is found to be more sensitive to the changes brought on by any form of treatment than the other rating scales. The Columbia Suicide Severity Rating Scale (C-SSRS) was created by researchers at Columbia University, the University of Pennsylvania, the University of Pittsburgh, and New York University.[8] It is a suicidal ideation and behaviour rating scale to evaluate suicide risk. An individual's degree of suicidal ideation is rated on a scale, ranging from "wish to be dead" to "active suicidal ideation with specific plan and intent, and behaviours." Questions are mostly framed to be used in an interview format, but the C-SSRS can also be completed as a self-report measure if needed. The scale also identifies intensity of suicidal ideation (one to five), frequency of suicidal ideation (zero to four), actual lethality (zero to five), and potential lethality (zero to two) that may be indicative of an individual's intent to complete suicide. Ethical approval for the study was received from the Institutional Ethics Committee of Gauhati Medical College and Hospital (MC/190/2007/Pt-1/IEC/47).

Statistical analysis

The sociodemographic data of both the groups, i.e., unipolar and bipolar depression, are depicted using descriptive statistical methods. The comparison of continuous variables between the groups was done using an unpaired t-test. The comparison of categorical variables between the groups was

done using the chi-square test. For ascertaining statistical significance, the p-value is kept as <0.05.

RESULTS

Sociodemographic variables

In this study, a total of 60 patients, 30 each of unipolar and bipolar depression, were assessed (Table 1). The mean age of the subjects in the bipolar group was 35.93 ± 10.32 years compared to 45.67 ± 11.26 years in the unipolar group, with a p-value <0.001. Both groups were found to be comparable in terms of gender, religion, education, employment, socioeconomic status, and locality. The number of married patients was higher in the unipolar group than the bipolar group (p value 0.02).

Clinical variables

Among the clinical variables in Table 2, age of illness onset was comparatively lower in the bipolar group than the unipolar (28.23 ± 8.48 versus 41.93 ± 10.37 years). Both groups were comparable in terms of family history of psychiatric illness, prior hospitalisation, and suicide attempts. In the unipolar depression group, 29 (96.67%) patients were in severe depression and one (3.33%) in moderate depression; in the bipolar depression group, 19 (63.33%) patients were in severe depression, nine (30%) in moderate depression and two (6.67%) in mild depression with p value 0.001 as depicted in Figure 1.

Suicidal behaviour

Table 3 represents the comparison of suicidal behaviour in subjects with unipolar and bipolar depression. The intensity of suicidal ideation was highest in 43.34% of the unipolar group compared to 16.67% in the bipolar group, with p value of 0.035. The frequency and lethality (actual and potential) of suicidal behaviour were comparable between the two groups.

DISCUSSION

In the present study, the mean age of patients in the bipolar depression group is 45.67 ± 11.26 years, compared to the unipolar depression group, 35.93 ± 10.32 years, and the

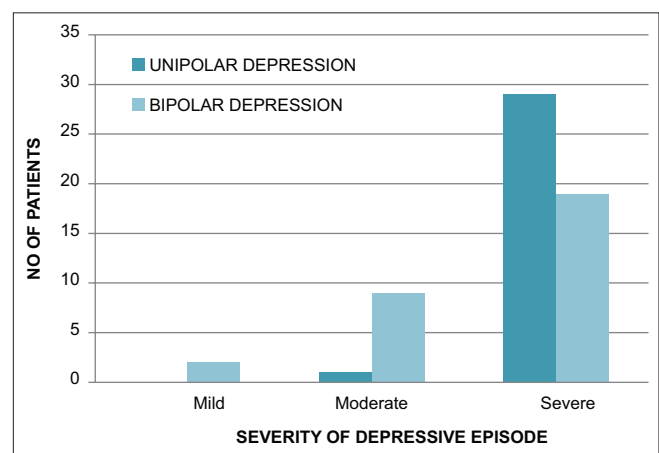


Figure 1: Comparison of the severity of depressive episodes according to The Montgomery-Asberg Depression Rating Scale (MADRS) severity score in subjects with unipolar depression versus bipolar depression.

Table 1: Comparison of sociodemographic characteristics in subjects with unipolar versus bipolar depression

| Variable | Unipolar (mean±SD/n) | Bipolar (mean±SD/n) | Test statistics | Significance (p) | Degree of freedom |
|---------------------------|-------------------------|------------------------|--------------------|---------------------|----------------------|
| Age (in years) | 45.67±11.26 | 35.93±10.32 | t=3.49 | <0.001 | |
| Gender | | | | | |
| Male | 14 | 13 | $\chi^2=0.06$ | 0.795 | 1 |
| Female | 16 | 17 | | | |
| Marital status | | | | | |
| Married | 27 | 20 | $\chi^2=4.81$ | 0.028 | 1 |
| Single/divorced/separated | 3 | 10 | | | |
| Education | | | | | |
| Illiterate | 5 | 6 | $\chi^2=0.29$ | 0.961 | 3 |
| High school | 11 | 12 | | | |
| Higher secondary | 8 | 7 | | | |
| Graduation | 6 | 5 | | | |
| Employment | | | | | |
| Unemployed | 12 | 17 | $\chi^2=3.91$ | 0.141 | 2 |
| Self-employed | 9 | 10 | | | |
| Employed | 9 | 3 | | | |
| Family type | | | | | |
| Nuclear | 18 | 17 | $\chi^2=0.06$ | 0.793 | 1 |
| Joint | 12 | 13 | | | |
| Religion | | | | | |
| Hindu | 25 | 23 | $\chi^2=0.42$ | 0.518 | 1 |
| Islam | 5 | 7 | | | |
| Locality | | | | | |
| Rural | 15 | 18 | $\chi^2=0.60$ | 0.436 | 1 |
| Urban | 15 | 12 | | | |
| Socioeconomic status | | | | | |
| Low | 14 | 14 | $\chi^2=0.14$ | 0.933 | 2 |
| Mid | 10 | 11 | | | |
| High | 6 | 5 | | | |

Statistical tests: unpaired t-test, Chi-square test. SD: Standard deviation, n: frequency. p<0.05 is considered statistically significant

difference is found to be statistically significant ($p<0.001$). This is comparable to a study conducted by Nunez *et al.* and Nisha *et al.*, where the mean age of the subjects in the bipolar depression group was younger than unipolar depression group.[9,10] In our study, 27 (90%) of the patients with unipolar depression were married compared to 20 (66.67%) in the bipolar group, and the difference is found to be statistically significant ($p=0.0283$). The rates of marriage in bipolar disorder patients are lower than in the general population.[11] However, studies have shown inconsistent findings when the marital rate of bipolar disorder is compared to other psychiatric illnesses. However, the stigma associated and relatively early age of onset of bipolar disorder are the potential explanations for the low marriage rate. Moreover, bipolar disorder is associated with poor marital adjustment, low fertility rate, and high divorce rates.[12]

Both groups are comparable in terms of gender, and a similar distribution was found in other studies.[9,13] Our study is a hospital-based inpatient study, so it does not explain the gender differences in the prevalence of suicide in depression. Rather, it may denote the service utilisation with respect to gender. The difference between the two groups in terms of religion is not statistically significant ($p=0.518$). Majority of patients in both groups belong to Hinduism, which implies the religio-ethno-cultural background of a place. Both groups are comparable in terms of education, employment, family type, and locality. Similar findings were obtained from other studies conducted in different parts of the world.[9,10,14,15]

The mean age of illness onset in the unipolar group is 41.93 ± 10.37 years, and the bipolar group is 28.23 ± 8.48 years,

Table 2: Comparison of clinical variables in subjects with unipolar versus bipolar depression

| Variable | Unipolar Mean±SD/n (%) | Bipolar Mean±SD/n (%) | Test statistic | Significance (p) | Degree of freedom |
|---------------------------------------|---------------------------|--------------------------|-------------------|---------------------|----------------------|
| Age of illness onset (in years) | 41.93±10.37 | 28.23±8.48 | t=5.60 | <0.0001 | |
| Family history of psychiatric illness | | | | | |
| Absent | 22 (73.33) | 14 (46.67) | $\chi^2=4.44$ | 0.035 | 1 |
| Present | 8 (26.67) | 16 (53.33) | | | |
| Past suicide attempt | | | | | |
| Absent | 10 (33.33) | 8 (56.67) | $\chi^2=0.32$ | 0.573 | 1 |
| Present | 20 (66.67) | 22 (43.33) | | | |
| Prior hospitalisation | | | | | |
| Absent | 17 (56.67) | 12 (40) | $\chi^2=1.67$ | 0.1965 | 1 |
| Present | 13 (43.33) | 18 (60) | | | |

Statistical tests: unpaired t test, Chi-square test. SD: Standard deviation, n: frequency. p<0.05 is considered statistically significant

Table 3: Comparison of suicidal behaviour as rated in the Columbia-Suicide Severity Rating Scale (C-SSRS) in subjects with unipolar versus bipolar depression

| Columbia-Suicide Severity Rating Scale | | Unipolar n (%) | Bipolar n (%) | Test statistic | Significance (p value) | Degree of freedom |
|--|---|-------------------|------------------|-------------------|---------------------------|----------------------|
| Intensity of suicidal ideation (score) | 1 | 1 (3.33) | 3 (10) | $\chi^2=6.679$ | 0.035 | 2 |
| | 2 | 9 (30) | 4 (13.33) | | | |
| | 3 | 4 (13.33) | 13 (43.33) | | | |
| | 4 | 3 (10) | 5 (16.67) | | | |
| | 5 | 13 (43.34) | 5 (16.67) | | | |
| Frequency of suicidal ideation (score) | 0 | 0 | 1 (3.33) | $\chi^2=0.292$ | 0.864 | 2 |
| | 1 | 0 | 3 (10) | | | |
| | 2 | 12 (40) | 6 (20) | | | |
| | 3 | 11 (36.67) | 12 (40) | | | |
| | 4 | 7 (23.33) | 8 (26.67) | | | |
| Actual lethality of suicidal behaviour (score) | 0 | 15 (50) | 13 (43.3) | $\chi^2=5.245$ | 0.1547 | 3 |
| | 1 | 3 (10) | 10 (33.3) | | | |
| | 2 | 10 (33.33) | 6 (20.00) | | | |
| | 3 | 2 (6.67) | 1 (3.34) | | | |
| Potential lethality of suicidal behaviour (score) | 0 | 8 (26.67) | 9 (30) | $\chi^2=0.424$ | 0.8088 | 2 |
| | 1 | 7 (23.33) | 5 (16.67) | | | |
| | 2 | 15 (50) | 16 (53.33) | | | |

Statistical tests: Chi-square test. SD: Standard deviation, n: frequency. p<0.05 is considered statistically significant

and the difference is found to be statistically significant with a p value of 0.0001. This finding was also replicated in earlier studies, where the age of illness onset was found to be earlier in bipolar depression than that of unipolar depression [10,13,14,16] Family history of psychiatric illness is higher in the bipolar depression group than unipolar and the difference is statistically significant with p=0.035, which is similar to the results obtained in a study by Nisha *et al.*, Nunez *et al.*, and Perlis *et al.*[9,10,13] Prior history of hospitalisation is found to be comparable in both groups. Studies carried out in different parts of the world found an association of suicide risk in patients with depression (both unipolar and bipolar) with a history of prior hospitalization.[17-20]

In this study, majority of the patients, 20 (66.67%) in the unipolar group and 22 (73.33%) in the bipolar group, had a prior history of suicidal attempts. However, the difference between the groups is not statistically significant (p=0.573). A prior history of suicide attempt is found as a risk factor for suicidal ideation and attempt in patients with depression in earlier studies.[21-26] In our study, the lifetime history of suicidal attempts was found to be comparable in both groups.[27] Severity of depression was higher in patients with unipolar depression than bipolar depression (p=0.035). Similarly, studies conducted earlier reported more severe depressive episodes in patients with unipolar depression than in bipolar.[9,10,28] However, few studies reported higher depression severity in bipolar depression than in

unipolar depression.[18,29] The depression severity is an established risk factor for suicide in patients with affective disorder [20,30-32] Our study reflects that the severity of depressive episodes in bipolar disorder does not confer a similar risk of suicide as compared to unipolar depression, which needs further investigation. Similarly, studies also reported a higher risk of suicide during the mixed state in bipolar disorder.[33]

The suicidal behaviour in this study is comparable in subjects with unipolar and bipolar depression, except for the intensity of suicidal ideation. More number of subjects in the unipolar depression group scored high intensity of suicidal ideation than the bipolar depression group, and the difference is found to be statistically significant ($p=0.0355$). Similarly, a study reported that the thought of death was found to be more in unipolar depression than bipolar, but wanting to die and the thought of suicide were found to be comparable.[29] Moreover, in our study severity of depression is found to be higher in the unipolar depression group than bipolar which explains the high intensity of suicidal ideation in the unipolar depression group. The frequency of suicidal ideation is comparable in both groups, but the results in prior studies are inconclusive, warranting further exploration.[29,34] Additionally, the groups were found to be comparable in terms of actual ($p=0.1547$) and potential lethality of suicidal behaviour ($p=0.8088$). In a similar study, the lethality of suicide attempts was found to be comparable in both groups.[35] Although in a few studies, bipolar patients were found to adopt more lethal suicidal behaviour, which is in contrast to our findings.[5,36] Findings in our study are explained by the fact that the unipolar depression group had more severe depression than the bipolar and the severity of depression is linked to higher mortality.

Limitations

This was a hospital-based inpatient study with a small sample size, so the generalisability of results to patients with unipolar and bipolar depression in the community is doubtful. Patients were assessed cross-sectionally; follow-up for any death by suicide after discharge was not done. The study has a few components that are based on recall of events and facts, which is an important limitation of the study.

Conclusion

Suicide is one of the fatal outcomes of psychiatric disorders and needs special attention. It is not a disease per se; rather, it is a cry for help. Assessment of suicidal risk is an important area yet to be explored. Suicide in the real world is most often related to mood disorders, mostly depressive episodes, during the act. Depressive episodes may be either unipolar or bipolar; though many studies have assessed the risk factors of suicide in depressive disorder, there is a paucity of research in this part of the world to compare the suicidal risk in both groups. Our study tries to compare the suicidal risk factors, including sociodemographic and clinical characteristics, suicidal thoughts, and behaviour in both groups. The severity of depressive episodes is found to be higher in unipolar depression than in bipolar disorder in our study. Although it is stated in the literature that suicide is more common in bipolar

depression than in unipolar depression. This study highlights that suicide attempts and behaviour are comparable in both groups. So, patients with both disorders should be assessed and managed with equal importance to prevent premature mortality. However, further multicentric longitudinal studies are needed to explore further the suicidal behaviour and predictive factors in both groups.

AUTHOR CONTRIBUTIONS

PC: Concepts, clinical studies, data acquisition, data analysis, manuscript preparation, statistical analysis, guarantor;
SD: Design, definition of intellectual content, manuscript review, manuscript editing, guarantor.

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