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Suicide among untreated and treated depressives: the role of compliance, drug-resistance and underlying bipolarity

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Suicide, this very complex and multicausal human behaviour, is related to several psychiatric-medical, psychosocial and demographic suicide risk factors. Psychological autopsy studies consistently show that over 90 percent of suicide victims have at least one (mostly untreated) current major mental disorder, most frequently major depressive episode (56-87%) substance-related disorders (26-55%) and schizophrenia (6-13%). As suicidal behaviour in patients with mood disorders seems to be state-dependent phenomenon (i.e., it decreases or vanishes after the clinical recovery), the succesful acute and long-term treatment of mood disorders is crutial for suicide prevention [1]. However, depression is freuently underreferred, underdiagnosed and undertreated (and in the case of unrecognized bipolarity mistreated), and the rate of adequate antidepressant pharmacotherapy among depressed suicide victims is less than 20%, which is disturbingly low [2]. The marked decrease in antidepressant utilization among children and adolescents most recently in the United States, The Netherlands and Canada coincided with a sharp increase in the rates of completed suicide in this subpopulation [3].

The most important pharmacotherapy-related factors of suicide in depression are: 1/ lack of treatment, 2/ inadequate treatment, 3/ the first 10-14 days of the treatment, particularly in the case of insufficient care and/or lack of co-medication with anxiolytics, 4/ early termination of the therapy either by the patient or by the doctor, 5/ lack of the long-term treatment in chronic or recurrent cases, and 6/ nonresponse and treament resistance. Most recent findings strongly suggest that antidepressant monotherapy (unprotected by mood stabilizers or atypical antipsychotics) can worsen the short-and long-term course of bipolar depression and increases the risk of suicidal behaviour [4].

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