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SUICIDE - BETWEEN NORMALITY AND PSYCHIC DISEASE

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Abstract

Scientists now recognize that suicide is generating more and more victims. Suicide prophylaxis efforts do not appear to have proven effective. We believe that currently, efforts must be channeled against psychiatric factors (social anomie, depression, anxiety, panic attacks, neurosis) and socio-familial (disappearance of family support, disappearance of religious support, alcohol and psychoactive substances, internationalization, virtual socialization), which are amplified by the effects of civilization. Our half-century studies confirm that suicide is becoming a global public health problem.

Key words:

Suicide; prophylaxy; depression.

I. Introduction

The instinct of curiosity has always been the basis of the scientist's activity. Thus Descartes laid the foundations of epistemology by elaborating the 11 known rules:

- a method is needed to search for the truth;
- the truth must be clearly demonstrated, etc.

In the same sense, Kant and then Rickert lay the foundations of the logic of value (scientific logic of the spirit) and their selection according to epistemic principles (Camil Petrescu), culture being the ultimate goal of knowing nature.

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This emphasizes the old Aristotelian principle, namely that "truth is the agreement of knowledge with its object."

II. Material and method

Psychiatry therefore operates with interdisciplinary matrices and criteria that help to elaborate scientific truths. Thus, if we start from the criteria of mental normality established by Klinberg we can answer whether suicide is a pathological act, normal or adjacent to them, using criteria such as:

- Does the suicide have the correct image of the self?
- does he perceive reality correctly and independently of desire?
- does he adapt flexibly to different and difficult living environments?
- does he have a unitary conception of life and its values?
- does he aspire to develop and achieve a personal and realistic ideal of life?
- does he have the capacity to make his own decisions? and so on.

How the criteria (signs) of behavioral disorders in suicide (such as behavioral disorganization, infectivity, cyclothymia) do not characterize psychotic states (from the need to avoid such risky abuses in social psychiatry in accordance with the Resolutions of the Council and Parliament of Europe). Such criteria attest that the personality of the suicidal person is a borderline personality, anomic, bordering on health condition and mental illness and not a specific suicidal personality.

Psychiatry is a science that meets the epistemological criteria for defining a science. But science also has a normative structure (Merton) that cannot deny ethics. In the life sciences, psychiatry moves from scientific logic to axiological logic from which derive the qualities of the researcher in the field of having extensive experience, clear judgment, scientific method and moral impartiality.

In conclusion, scientific logic (epistemology or according to some, criteria) must be the basis of any scientific truth, including suicide as a complex medical and social phenomenon.

The correspondence between logical judgments and motivations, conditions, including the manner of committing the suicidal act is the epistemological matrix of the scientific truth about suicide. In this sense, the complex exploration of the suicidal act performed, as we propose in the following, cannot ignore the methodological principles and rules of epistemology.

The frequency of suicide differs from country to country. Thus, according to the WHO, in 2012, in close geographical areas such as Hungary, the frequency of suicide reached 19.11% oooo as opposed to Greece by 3.8% oooo (Culturavietii, 2017).

Figure 1. Source: <https://jakubmarian.com/>

WHO reveals a double frequency of suicide in men compared to women and 8 times higher than attempted suicide in women, with a maximum frequency of suicide between 50-60 years, with reasons in depression (including economic, but not excluded and those with high living), drug addiction, alcoholism. In 2015, according to the WHO (Euronews, 2017), there are approximately 800,000 suicides and 7 million suicide attempts per year on the planet. The increasing trend of suicide at the expense of less socially integrated population groups is a fact revealed by most statistics. In this sense, there is a suicide-industrialization relationship, while the suicide rate increases in Europe compared to the third world, as well as between suicide and political events (Grozing, 1992; Hofmann, 1992).

In a separate analysis of suicide attempts, Grecu (1991) on 703 cases finds 146 cases of suicide, noting the increase in its frequency in the elderly and generated in 90% of cases in conflict situations, in 70% cases with anticipation of the gesture, with predominance in men (74%) over women (25%), with a

hereditary history of suicide in 33% of cases and achieved by hanging in 60% of cases.

In Iasi, between 1991-1992, Andrei (1993) on 128 cases gives a frequency of 2.4 / 1 in men compared to women, with a maximum frequency between 20-60 years, alcohol being the catalyst of the act in 64% of cases, attempts in antecedents being encountered in 31% of cases, psychiatric antecedents in 26% of cases and its maximum frequency being explained by family conflicts (the family being the place of atonement for these conflicts). In 1991, in Iasi, the frequency of suicide was 16.2% oooo, ie 22.8% of violent death.

In terms of employment, Terbancea (1976) reveals that 18.8% were workers and 17% retired. In all statistics, suicide among the poor appears lower, a phenomenon attributed to the fact that deficiencies would have the ability to keep the conservation instinct in a vigilant state. According to some authors (Bîlcea, 1979), depressed subjects would react more easily to hot air fronts and anxious (meteorosensitive) subjects to cold air ones. For Ștefan (1979), suicide would be more frequent when the atmospheric pressure registers sudden increases and decreases. Terbancea (1976) gives a maximum frequency in June-August.

P. Pandrea (1941), in a criminological paper on suicide, cites 6 statistics from 1927 in which 37% of suicides were due to mental illness, 26% to organic disorders, 11% to economic crises, the rest having unknown causes. Lăzărescu (1989) finds that psychiatric pathology is more common in suicide than in parasuicide and suicide attempts. Crișan (Euronews, 2017) reveals a doubling of the frequency of suicide between 1973-1977 compared to 1963-1967, with a frequency of 15-20% oooo, consistent with the data of the Institute of Psychiatry in Bucharest which reveals a frequency of 14% oooo. From the point of view of the association of suicide with some mental disorders, the study of Grecu Gh., Grecu-Gabor Marieta (Revista Romana de Psihiatrie, n.d.) considers that alcoholism appears quite rarely as a pathology in an isolated manner. Numerous clinical and epidemiological studies confirm the frequent association of mental disorders and alcohol abuse. Moreover, the authors conclude that depression and anxiety are the main psychiatric comorbidities of alcoholism and as such they must be detected in advance in order to specify their primary or secondary character.

The persistence of an untreated depressive or anxiety disorder worsens the quality of life and is accompanied by a high risk of suicide.

There is a rich literature that attributes to alcohol the role of promoting good mood, but it is not uncommon for the consumer to become sad, anxious, desperate and hopeless after some alcohol consumption, situations in which some also have autolytic behaviors. However, in most cases, the consumption of alcoholic beverages leads to a decrease in anxiety and a sense of

responsibility at the same time as an increase in inclinations towards unsafe actions, easily accepting the risks of the action that in non-alcoholic conditions he would not accept.

The existence of interactions between mood disorders and alcoholism or between alcoholism and depression has been reported by many authors. Bleuler (1916) describes "alcoholic melancholy" and other depressions secondary to alcoholism. The data reported in recent decades show the existence of links between alcoholism and mood disorders, which are predominantly depressive. Perris (1971) argues that neither dominant nor recessive transmission can be considered responsible for affective psychoses. Perris considers that primary affective psychoses cannot be transmitted either through a dominant or a single recessive basis, but through a polygenic mechanism.

Winokur et al. (1970, 1971) reveals that bipolar affective disorders can be transmitted through a mechanism consisting of two dominant genes, one autosomal (manic) and one linked to the X chromosome (depressive), while unipolar mood disorders would be transmitted through a complex multifactorial mechanism. Thus, it can be concluded that in addition to the dominant factor, with a chromosomal X-link, other factors are involved in the transmission of mood disorders, among which an important role would play alcoholism, which would be a separate feature of bipolar disorder, activating the -the second genetic factor that could not trigger the disorder unless the specific X chromosomal factor is also present. In this sense, the second factor can also manifest itself as alcoholism outside the dominant factor X.

Winokur et al. (1971) and Schuckit et al. (1972) states that in some cases alcoholism can only be a variant of primary unipolar affective disorders and as such they consider that there are three types of alcoholism, the first encountered outside of mental illness, the second in within sociopaths and the third in close connection with unipolar mood disorders.

Essentially, alcohol dependence rarely occurs in an isolated manner, and its main comorbidities are depression, anxiety, sociopathy, hetero-aggressive and self-aggressive behavior, etc. Recent epidemiological studies show that 65% of alcoholic women and 44% of alcoholic men have at least one mental disorder.

In fact, the prevalence of depression in alcoholics varies from one study to another, and these variations are favored by:

- heterogeneity of the patients studied (alcohol addicts, excessive alcohol users during the evaluation, seniority, socio-professional and family status; social support, various somatic complications and others);
- diversity of methods for assessing depression (questionnaires, scales).

A study by Davidson (1995) found that at the beginning of withdrawal 67% of patients were depressed, and after 7-10 days of deprivation, the

prevalence of depression dropped to 13% and that over 50% of depressions - they dissipated only under the effect of withdrawal. Alcohol dependence associated with a depressive disorder carries a high autolytic risk, which argues for the need to actively detect and treat depressed alcoholics (and alcoholics). The presence of mental disorders was observed in 98% of cases, in which depression was more common in women (85%) than in men (64%), while alcohol dependence was more common in men (64%) than in women (21%).

Inskip et al. (1998), based on the study of 37 papers focusing on mortality in depressives and 27 papers on alcoholics, estimated that the risk of suicide mortality is 7% in alcoholics and 6% in depressed people. The occurrence and persistence of a depressive state in alcoholism must be dichotomized into: primary or secondary. This differentiation can be achieved through the following elements:

- primary depression is characterized by the fact that it does not improve only through alcohol withdrawal;
- secondary depression is characterized by incomplete withdrawal (accompanied, without the doctor's knowledge, by moderate alcohol consumption or episodic re-alcoholization), which did not allow a significant improvement secondary to alcoholism.

Wilsnack and Wilsnack (1995) and Mourad and Lezoxeux (1997) show that in women, the links between depression and alcoholism are closer because:

- alcoholism increases the risk of depression and as such the prevalence of depression in alcoholic women is three times higher;
- Primary depression, complicated by alcoholism, is more common in women than in men.
- In bipolar and alcoholic patients, mood disorders occur earlier, and mixed episodes occur more frequently than in non-alcoholic bipolar.
- Persistence of depression after one month of withdrawal requires the establishment of antidepressant treatment.

Along with depression, anxiety is the second most common comorbidity in alcohol addicts. In ICD-10 (1993), forms of anxiety secondary to alcoholism are included in the category of 'psychoactive substance-induced mental disorders', and in the DSM-IV (1996) they are grouped in the category of 'substance-induced mental disorders'. Usually, the anxious symptoms caused by chronic alcohol consumption or withdrawal dissipate once the period of addiction is over and a true abstinence is established (John and Miller, 1995). The main forms of anxiety encountered in alcoholics are: generalized anxiety, panic attacks and social phobia.

Quite often, anxious patients resort to alcohol consumption due to its anxiolytic, disinhibitory and psychostimulant properties, facilitating more relaxed exposure and endurance to phobogenic and anxiogenic situations. In

fact, patients who use alcohol for its anxiolytic properties often experience an increase in anxiety during alcohol intoxication.

Many authors (Cardot & Et Lejoyeux, 1997; Lepine & Pelissolo, 1998; Thomas et al. 1999) show that the periods with the highest alcohol consumption are accompanied by an exacerbation of symptoms. phobic-anxious and especially of socio-phobia.

The interactions between alcoholism, depression and anxiety are very complex, and the persistence of depression and / or anxiety, untreated in time and integrated, worsens the quality of life and increases the risk of suicide. Alcoholism increases the risk of depression and anxiety, which are in fact the two main comorbidities of alcohol dependence. The source of the association between alcoholism and the two comorbidities is variable. Social phobias and agoraphobias often precede alcoholism, while panic and generalized anxiety disorders usually occur secondarily and simultaneously. Finally, depression and anxiety in alcoholics are more often a consequence of intoxication itself, as well as withdrawal syndromes, somatic, social and family disorders of alcohol addiction behaviors.

III. Results:

The analyzed data support the Iasi concept of the common etiology of the attempt and suicide to be consumed in a potential stage through the personality structure of a mental imbalance and a real one of motivation and circumstances that precipitate the autolytic gesture. In other words, the personality structure incubates the motivation and the circumstances precipitate its realization (transition to action) by narrowing the affective-relational nature of the field of consciousness. As the choice for life or death therefore depends on personality and situation, representing a self-aggressive decompensation of a fragile personality in an emotionally traumatic situation, generated by anomic circumstances, the explanation of suicide is inevitably oriented towards such a suicidal environment (entourage) and not the conception of suicide as a suicidopathy (as a disease).

Our study is carried out over three generations, in the period 1982 - 2017 (35 years) comprising at the beginning (1982 - 1993) the cases in the region of Moldova (approx. 8 million inhabitants) and later (1994 - 2017) the cases in the county Iasi (approximately 800,000 inhabitants). A total of approximately 6800 cases were conducted, distributed approximately equally in urban and rural areas. But regarding the annual increase in the number of cases, we can show that if in 1994 we encountered 83 cases, in 2015 it reached 143 cases, even if the population in this region decreased significantly by the departure of residents abroad. Without referring to other statistical aspects, we found that the percentage of victims with a psychiatric history remains between

25 and 30% during this period. Depression is the main disease with suicidal risk but is followed by anxiety, panic, psychosis or mental illness on an organic basis.

In a parallel study we analyzed a batch of 112 cases of depressive-reactive states determined by judicial impacts in a period of 5 years, derived from 1641 psychiatric-legal expertise. In 6.7% of cases we noticed that 68.7% were male, 67.5% from urban areas, 75.3% with secondary education and more frequently involved (34.6%) in crimes against public goods (embezzlement), where the sanction was more drastic. In 84.6% of the subjects, the depressive state started after the start of the judicial investigation and only in 10.2% before. The depressive state was motivated mainly by the fear of sanction and less often by the person's feelings of guilt. Likewise, 60.7% of the subjects had a somatic and psychiatric history, but minor. Of the group, 64.5% had previous suicide attempts (12.6% two attempts each, 8% three each and 2.3% four attempts each) and 81.2% did so by swallowing products toxic.

Mental depression, especially reactive depression, is therefore constantly at the root of suicidal behavior, thus representing a maximum suicide risk. The analysis of the observation sheets revealed that depression with long-term insomnia, especially in the second part of the night, depression accentuated in the morning with states of anxious agitation, social or existential uselessness, with feelings of guilt, self-blame, inferiority and self-depreciation and insensitivity to environmental influences, was a major risk factor. Coupling the mentioned sufferings increased the risk of suicide. Thus, in the determinism of suicidal behavior there is a decrease in the frequency of psychotic states and an increase in the frequency of borderline states, especially depressions, in which, due to the intertwining of environmental and constitutional situational factors and personality, there is a deletion of depressions. endogenous and reactive ones. Hence the need for emotional and vital security as a task of health care for depressive states and thus reducing the risk of suicide.

From the data of the 112 analyzed cases of depressive-reactive states, of which 102 depressions and 10 PMDs over a period of five years, 68.7% were male and 31.3% female. The reversal of percentages is due to the more common forensic implications in men. At the time of the crime, 80% of the subjects did not have mental disorders but embezzlement generated 34.6% depression, theft 23.6%, speculation 11.6%, murder 18.5%, attempted murder 4.6%, rape 3.2% and attempted rape 2.1%. Reactive depressions (following judicial implications) were motivated by fear of punishment and less guilt (5.2%). By age, 3.9% of cases were between 15-20 years, 6.7% between 21-30 years, 13.9% between 31-40 years, 23.4% between 41-50 years, 35.6% between 51-60 years and 14.7% over 60 years.

A percentage of 60.7% of the subjects had a psychic and somatic history (42% hypertension, 18% with post-traumatic brain sequelae, 16% with digestive disorders) and 29.6% suffered from chronic alcoholism that began as a vice and it ended like a disease, between depression-alcoholism and delinquency being a direct causal relationship. Among the subjects, 65.7% had discernment, 14.7% a diminished discernment and 19.6% being lacking discernment. The percentage of attempts included 69.3% women and 30.7% men and the modalities of suicide attempts consisted of 81.2% by ingesting toxic (equal by sex) and 8.2% in mechanical asphyxiation such as hanging.

In conclusion, depression is a major suicide risk (60-70%), the risk being maximum at the beginning of depression (30%) and for 15% for life. The envelope of this crisis is the state of acute depression, suicide thus becoming the expression of the impossibility to reduce a tension, hence the transition to action. Suicide thus becomes a way out of a psychic impasse, following the consideration of adaptation mechanisms.

IV. Conclusions

1. Although there has been an increase in the suicide rate in the world and in the transition society due to economic difficulties and the moral decline of society, the data of the analyzed group confirm such an increase, provided that suicide cannot be dissociated from the physical context, temporal and social in which it occurs. This reveals the decrease of family group cohesion and the erosion of religious and cultural traditions towards life and death, existing in the population from which the analyzed group comes. This can be related to the finding that the suicide rate increases with well-being when people expect more from life, which through failure, leads to frustration and suicide, the suicide rate varying inversely with the stability of social relationships. Whenever the level of social integration is low, the suicide rate increases and vice versa.

2. Consistent with the data in the literature and in our analysis, suicide was 3 times more common in men than in women. The fact reveals that from a behavioral point of view, the man is more inclined to external and certain aggression, while the woman to internal and uncertain aggression, proves the much higher frequency of suicide attempts in women as an impulsive reaction to a conflict state especially family.

3. The maximum frequency of suicide occurred in May, July, October, which may be correlated with the frequency and / or exacerbation of depressive-reactive states to social, work and family conflicts, marital and probably also with the increase of strong alcohol consumption. in hot weather conditions. These data also coincide with the higher frequency of suicide on Sunday, Monday and early in the morning.

4. The fact that 25-30% of suicides occur in people with a psychiatric history leaves room for interpretation that this percentage can rise to 45-50% if we take into account the large number of undiagnosed or masked depression of victims.

5. Depression and anxiety are psychiatric disorders with a very high risk of suicide but at the same time very frequently masked by the victims. In the initial stages, these conditions go slightly unnoticed by those around them, especially in communities where caring for tomorrow is a rule. The behavioral discrepancy gradually deepens and becomes evident in the advanced stages of the disease when the suicidal decision can already be put into practice.

6. The general data analyzed assume that anomie is the common denominator (source) of current aggression, both self and heteroaggressive, which was correlated during the study with the analysis of risk factors and personality traits of subjects.

7. Our final opinion is that the evolution of society towards hypercivilization generates a number of factors with suicidal potential, both psychiatric (social anomie, depression, anxiety, panic attacks, neurosis) and socio-familial (disappearance of family support, disappearance of religious support, alcohol and psychoactive substances consumption, internationalization, virtual socialization). The only solution to reduce suicide is to organize an effective prophylaxis system worldwide. But an equally important role is played by the members of the social support group, which must be real and not virtual.

BIBLIOGRAPHY

- Andrei, R. (1993). Considerații asupra suicidului, în Psihopatologia clinică. 236.
- Bîlcea, J. & colab. (1979). Meteorol. în suicide. *Probleme medico-legale și criminologice*, 12, 210.
- Bleuler, E. (1916). *Lehrbuch der Psychiatrie*. Verlag von Julius. Springer. 207.
- Cardot, H., & Et Lejoyeux, A. (1997). Anxietate et alcoolisme. In A. Et Lejoyeux (Ed.), *Alcoolisme et Psychiatrie*. Masson. pp. 103-122.
- Culturavietii. (2017). <http://www.culturavietii.ro/2017/09/26/rata-suiciderii-tarile-europei-grafic/>
- Davidson, K. M. (1995). Diagnosis of depression in alcohol dependence. *Brit. J. Psychiatry*, 166, 199-204.
- Euronews. (2017). <https://www.euronews.com/2017/05/18/suicide-rate-is-highest-in-europe-un-health-agency-report>
- Grecu, G., & colab. (1991). *Studii asupra tentativelor de suicide*. Neurol., psih., neurochir., 83, 115.
- Grozinger, G. (1992). *Suizid prophylaxes*. pp. 73, 193.

- Hofmann, K. (1992). *Suizidprophylaxe*. pp. 72, 173.
- Inskip, H. M., Harris, E. C., & Barraclough, B. (1998). Lifetime risk of suicid for affective disorder, alcoholism and schizophrenia. *Brit. J. Psychiatry*, 172, 35-37.
- John, S., & Miller, M. S. (1995). *Anxiety disorders and addiction in the principles and practice of addictions in psychiatry*. (Miller, Ed.). Saunders. pp. 249-254.
- Lăzărescu, M. (1989). Contrib. la epidemiol. comp. autolitic. *Neurol, psih., neurochir*, January, 965.
- Lepine, J. P., & Pelissolo, A. (1998). Social phobia and alcoholism: a complex relationship. *J. Affective Disorder*, (Suppl. 1), 50, 23-28.
- Mourad, I., & Lejoyeux, M. (1997). L'alcoolisme féminin. In A. Et Lejoyeux (Ed.), *Alcoolisme et Psychiatrie*. Masson. pp. 201-220.
- Pandrea, P. (1941). Notă criminologică (despre 5 regularități în materie de suicid). Buc.
- Perris, C. (1971). Abnormality on paternal and maternal sides observation in bipolar and unipolar depressive psychosis. *Brit. J. Psychiatry*, 118, 207-210.
- Revista Romana de Psihiatrie. (n.d.).
<http://www.romjpsychiat.ro/article/corelatii-ale-alcoolismului-cu-depresia-anxietatea-si-suicidul>
- Schuckit, M. A., & Winokur, G. (1972). A short term follow up of women alcoholics Dis. *Nerv, Syst.*, 33, 672-678.
- Ștefan, F. (1979). Corelații meteorologie-suicid. *Probl. de med. leg.*, 12, 314.
- Terbancea, M. & colab. (1976). Aspecte medico-legale ale suicidului. *Probl de med. Leg.*, 12, 1.
- Thomas, S. E., Thevos, A. C., & Randall, C. L. (1999). Alcoholics with and without social phobia. *J. Stud. Alcoholism*, 60, 472-479.
- Wilsnack, S. C., & Wilsnack, R. W. (1995). Drinking and problem drinking in US women. In M. Galanter (Ed.), *Recent developments in alcoholism, Vol. 12 Alcoholism and women*. Plenum Press. pp. 30-60.
- Winokur, G., Reich, T., & Rimmer, J. (1970). Alcoholism: diagnosis and familial psychiatric illness in 259 alcoholic probands. *Arch, Gen. Psychiatry*, 23, 104-111.
- Winokur, G., Rimmer, J., & Reich, T. (1971). Alcoholism: is there more than one type of alcoholism? *Brit. J. Psychiatry*, 118, 525-531.