Hacia una anatomía de la melancolía y el suicidio

M. Roca Bennasar

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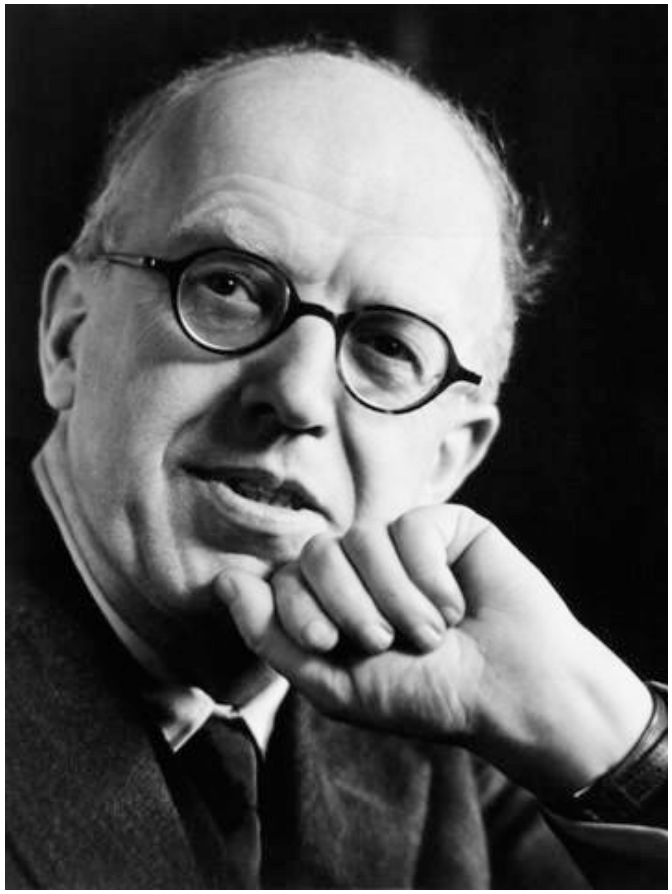
30 Enero 2020

“Presenta tu evidencia -dijo el Rey- y no te pongas nervioso o haré que te ejecuten de inmediato”

LEWIS CAROLL.
Alicia en el País de las Maravillas



Las “dos culturas” de C.P. Snow

- “*Ciencias*”: Obras de Shakespeare
- “*Letras*”: Segundo Principio de la Termodinámica

Las “dos culturas” de C.P. Snow

El “síndrome de Stendhal” o “síndrome de Firenze” (Psiquiatría)

Las arterias vertebrales o basilar (Neurología)

Prevalence of Depression in the Community from 30 Countries between 1994 and 2014

Grace Y. Lim[1], Wilson W. Tam[2], Yanxia Lu[3], Cyrus S. Ho[4], Melvyn W. Zhang[5] & Roger C. Ho[4]

The prevalence of depression may be affected by changes in psychiatric practices and the availability of online mental health information in the past two decades. This study aimed to evaluate the aggregate prevalence of depression in communities from different countries between 1994 and 2014 and to explore the variations in prevalence stratified by geographical, methodological and socio-economic factors. A total of 90 studies were identified and met the inclusion criteria (n = 1,112,573 adults) with 68 studies on single point prevalence, 9 studies on one-year prevalence, and 13 studies on lifetime prevalence of depression. A random-effects model meta-analysis that was performed to calculate the aggregate point, one-year and lifetime prevalence of depression calculated prevalences of 12.9%, 7.2% and 10.8% respectively. Point prevalence of depression was significantly higher in women (14.4%), countries with a medium human development index (HDI) (29.2%), studies published from 2004 to 2014 (15.4%) and when using self-reporting instruments (17.3%) to assess depression. Heterogeneity was identified by meta-regression and subgroup analysis, and response rate, percentage of women and year of publication, respectively, were determined contribute to depression prevalence. This meta-analysis allows benchmarking of the prevalence of depression during the era when online health information emerged, facilitating future comparisons.

10,8% prevalencia-vida

Más alta en mujeres
(Lim et al, 2018)

90 estudios entre 1994-2004

N=1.112.573 adultos
30 países

68 estudios prevalencia puntual
9 estudios prevalencia-año
13 estudios prevalencia-vida

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Research report

Prevalence and comorbidity of common mental disorders in prim

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ABSTRACT

Objective: To estimate the prevalence and comorbidity of the most commo in primary care practice in Spain, using the Primary Care Evaluation of (PRIME-MD) questionnaire.
Design: A systematic sample of 7936 adult primary care patients was recruit practitioners in a large cross-sectional national epidemiological study. The PF to diagnose psychiatric disorders.
Setting: 1356 primary care units proportionally distributed throughout the
Results: 53.6% of the sample presented one or more psychiatric disorder. T were affective (35.8%), anxiety (25.6%), and somatoform (28.8%) disor patients had more than one current mental disorder. 11.5% presented co affective, anxiety, and somatoform disorders.
Conclusions: The study provides further evidence of the high prevalence an of mental disorders in primary care. Given the large overlap between affe somatoform disorders, future diagnostic classifications should recon separation between these entities.

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The mental health risks of economic crisis in Spain: evidence from primary care centres, 2006 and 2010

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Background: Nearly all European countries have been affected by the economic crisis that began in 2007, but the consequences have been among the worst in Spain. We investigated the associations of the recession on the frequency of mood, anxiety, somatoform, alcohol-related and eating disorders among those visiting Spanish primary care settings. **Methods:** Primary care physicians selected randomized samples of patients attending primary care centres representing Spain's consulting populations. A total of 7940 patients in 2006–07 and 5876 in 2010–11 were administered the Primary Care Evaluation of Mental Disorders (PRIME-MD) instrument to diagnose mental disorders. Multivariate logistic regression models were used to quantify overall changes in the frequency of mental disorders, adjusting for potential socio-demographic differences in consulting populations unrelated to economic factors. **Results:** Compared with the pre-crisis period of 2006, the 2010 survey revealed substantial and significant increases in the proportion of patients with mood (19.4% in major depression), anxiety (8.4% in generalized anxiety disorder), somatoform (7.3%) and alcohol-related disorders (4.6% in alcohol dependence), all significant at $P<0.001$, but not in eating disorders (0.15%, $P=0.172$). Independent of observed risks of unemployment [odds ratio (OR) = 1.72, $P<0.001$], we observed a significantly elevated risk of major depression associated with mortgage repayment difficulties (OR = 2.12, $P<0.001$) and evictions (OR = 2.95, $P<0.001$). About one-third of the overall risk in the consulting population's attendance with mental health disorders could be attributed to the combined risks of household unemployment and mortgage payment difficulties. **Conclusion:** Recession has significantly increased the frequency of mental health disorders and alcohol abuse among primary care attendees in Spain, particularly among families experiencing unemployment and mortgage payment difficulties.

Introduction

Nearly all European countries have been affected by the economic crisis that began in 2007, but the consequences have been among the worst in Spain. In the decade preceding 2007, Spain's economy was among the fastest growing in Europe, averaging annual gross domestic product (GDP) growth rates above 5%.[1] Signs of economic collapse were evident when the housing market fell at the end of 2007. Spain's debt-driven construction boom came to a halt, leading to a rapid reversal of fortune as the country's stock market deflated from 125% of GDP in November 2007 to 54% 1 year later[2] and its economy contracted leading to job losses, housing repossessions and large government budget deficits.[3] At the beginning of 2010, over 20% of working-age Spaniards (or 4.5 million people) were unemployed, a rise from 8.5% in 2006 and the highest rate in Western Europe.[4]

Public health officials have raised concerns that recession on this scale, and its economic consequences of unemployment, debt and losses of income, have potential health consequences.[5] The fear and insecurity generated by the anticipation of unemployment is also associated with poor physical and mental health, in some cases even more than with actual job loss.[6–8] However, some analysts suggest that there may be counter-intuitive health benefits during hard economic times, as people may smoke and drink less and potentially walk instead of drive while road traffic diminishes as transportation due to commercial purposes (cargo) declines.[9–13] One

Criterios de validación síndrome clínico

- Identificación y descripción adecuada de síntomas
- Definición de límites
- Evaluación precisa
- Subtipos clínicos bien delimitados

Criterios de validación síndrome clínico

- Seguimientos para diferenciar curso y pronóstico
- Estudios genéticos
- Ensayos clínicos terapéuticos positivos
- Eventual asociación con anomalías neurobiológicas

Criterios de validación síndrome clínico

Investigación------Respuesta clínica------50% reducción escalas o ausencia criterios diagnósticos

Investigación------Remisión sindrómica—Escalas, no criterios diagnósticos

Clinica------Remisión sintomática----Ausencia síntomas

¿Es la depresión un síndrome clínicamente validado?

Subtipos clínicos

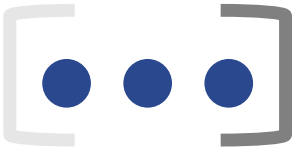
Primaria-Secundaria

Endógena-Reactiva

Psicótica-Neurótica

Subtipos clínicos

.....	Bipolar	Disfórica Premenstrual
Mayor	Crónica	
Psicótica	Recurrente	Asociada a Patologías Médicas
Atípica	Distimia	
Unipolar	Afectiva Estacional	



Subtipos clínicos
Clasificaciones

*Episodio Depresivo

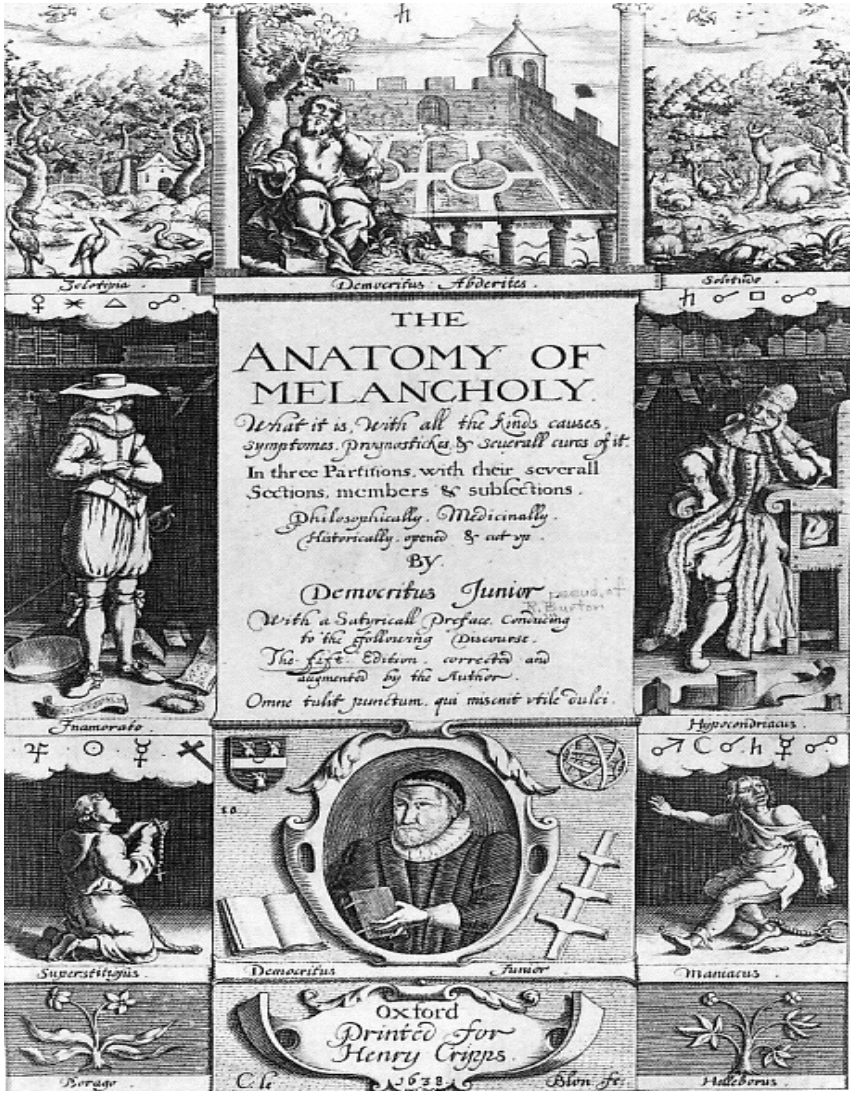
-Leve

-Moderado

-Grave

*Episodio Depresivo Único o Recurrente

*Con características melancólicas/ Con características atípicas



Anatomía de la Melancolía

(Burton, 1620)

"Causas" de la melancolía :

Brujas, magos.....
Dioses, astros...
Edad, dieta.....
Vergüenza, envidia, codicia, avaricia.....
Calumnias, los placeres inmoderados....

Depresión Melancólica

No es una tristeza,
ni la consecuencia
de una pérdida afectiva,
ni una reacción de
duelo.

(Leal, Vallejo. *Tratado de Psiquiatría,* 2012).

Afectividad

Tristeza, apatía

Anhedonia

Irritabilidad

Bajo estado de ánimo

Pensamientos suicidas

Desesperanza

Sentimiento de culpa sin motivo

Cognición

Dificultades en:

Atención y concentración

Memoria reciente y a largo plazo

Toma de decisiones

Planificación y organización

Agudeza mental

Velocidad de pensamiento

S. Somáticos

Fatiga

Cambios en el apetito / peso

Insomnio / hipersomnia

Disfunción sexual

Cefalea

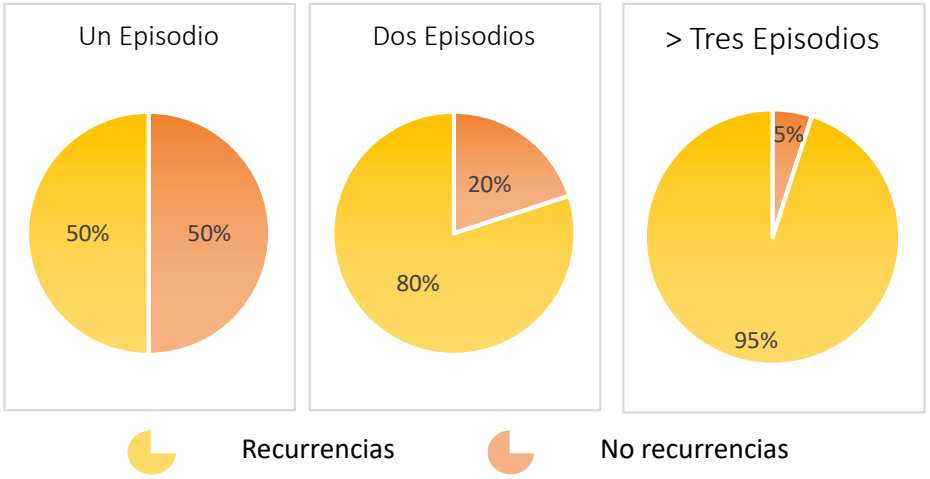
Dolor torácico, abdominal, etc

Agitación psicomotora

Riesgo de Recaída y número de episodios depresivos

- Se aconseja **mantener el tratamiento durante 6 a 9 meses** después de la recuperación de un único episodio.

- En aquellos pacientes que han tenido **múltiples episodios,** hay evidencia de beneficio del tratamiento de **mantenimiento durante al menos 2 años.**



Taylor D et al. Maudsley Prescribing Guidelines in Psychiatry,. 13 th Edit. John Wiley & Sons Ltd,; 2018. 1–825 p.

Subtipos clínicos

Depresión Melancólica

Características clínicas

-Alteraciones psicomotoras

-Alteraciones cognitivas

-Disfunción vegetativa

-Síntomas psicóticos presentes con frecuencia

Cambios biológicos

-Hipercortisolemia

-Alteraciones psicomotoras

-Alteraciones en la estructura del sueño

Tratamiento

- Responden mejor a los antidepresivos de acción amplia (tricíclicos) que a los antidepresivos de acción selectiva (inhibidores de recaptación de serotonina).

-Responde bien a la Terapia Electroconvulsiva (TEC)

-Raramente responde a los placebos, psicoterapias o intervenciones sociales.

Parker, et al, 2010

Leal y Vallejo, 2012

OPEN ACCESS Freely available online

PLOS ONE

Clinical Patterns and Treatment Outcome in Patients with Melancholic, Atypical and Non-Melancholic Depressions

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Abstract

Objective: To assess sociodemographic, clinical and treatment factors as well as depression outcome in a large representative clinical sample of psychiatric depressive outpatients and to determine if melancholic and atypical depression can be differentiated from residual non-melancholic depressive conditions.

Subjects/Materials and Method: A prospective, naturalistic, multicentre, nationwide epidemiological study of 1455 depressive outpatients was undertaken. Severity of depressive symptoms was assessed by the *Hamilton Depression Rating Scale* (HDRS) and the *Self Rated Inventory of Depressive Symptomatology* (IDS-SR_{30}). IDS-SR_{30} defines melancholic and atypical depression according to DSM-IV criteria. Assessments were carried out after 6–8 weeks of antidepressant treatment and after 14–20 weeks of continuation treatment.

Results: Melancholic patients (16.2%) were more severely depressed, had more depressive episodes and shorter episode duration than atypical (24.7%) and non-melancholic patients. Atypical depressive patients showed higher rates of co-morbid anxiety disorders and substance abuse. Melancholic patients showed lower rates of remission.

Conclusion: Our study supports a different clinical pattern and treatment outcome for melancholic and atypical depression subtypes.

Citation: Gili M, Roca M, Armengol S, Asensio D, Garcia-Campayo J, et al. (2012) Clinical Patterns and Treatment Outcome in Patients with Melancholic, Atypical and Non-Melancholic Depressions. PLoS ONE 7(10): e48200. doi:10.1371/journal.pone.0048200

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Competing Interests: The authors have declared that no competing interests exist.

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- Se evaluó una muestra clínica de pacientes con depresión para determinar si la depresión melancólica y atípica puede diferenciarse de las condiciones depresivas residuales no melancólicas.

- Los pacientes melancólicos (16,2%) estaban más deprimidos, tenían más episodios depresivos y episodios más cortos de duración que los pacientes atípicos (24.7%) y no melancólicos.
  Los pacientes depresivos atípicos mostraron tasas más altas de comorbilidad con trastornos de ansiedad y abuso de sustancias.
  Los pacientes melancólicos mostraron tasas más bajas de remisión.

- El estudio respalda un patrón clínico y una respuesta al tratamiento diferentes para los subtipos de depresión melancólica y atípica.

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Research report

Cognitive function after clinical remission in patients with melancholic and non-melancholic depression: A 6 month follow-up study

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[c] Centro de Salud Son Serra-La Vileta, Ib-Salut., Baleares, Spain
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Cognition
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Remission
Melancholic depression

ABSTRACT

Background: Cognitive symptoms are core symptoms with an impact on functioning in depression. Remission is considered as the main objective of the management and treatment of depression. This study was aimed to compare cognitive performance between melancholic (MelD) and non-melancholic depression (NMelD) and to determine whether these cognitive alterations remain after clinical remission.

Methods: We performed a 6 month follow-up study of 88 melancholic and non-melancholic depressive patients. Sociodemographic and clinical characteristics were recorded. Depression was examined using the Hamilton Depression Rating Scale and the CORE Index for Melancholia. Cognitive performance was assessed with the Trail Making Test (TMT), the Digit Span subtest of the WAIS-III, Stroop Colour Word Test (SCWT), the Tower of London (TOL DX), the Controlled Oral Word Association Test (FAS), Semantic Verbal Fluency and Finger Tapping Test (FTT).

Results: MelD patients show worse performance than N-MelD at baseline, with significant differences at Digit Span subtest of WAIS Part I and Part II, SCWT Part I and Part II, TOL DX, Total Problem Solving, Total Execution Time and FTT- Preferred hand. Cognitive impairment remains at six months follow-up after clinical remission in MelD. In the comparison between remitted and non-remitted patients, cognitive impairment in Trail Making Test Part B and Verbal and Semantic Fluency (Animals) remains after clinical remission in MelD group but not in non-melancholic patients.

Limitations: The use of psychopharmacological treatment and the small sample of melancholic patients.

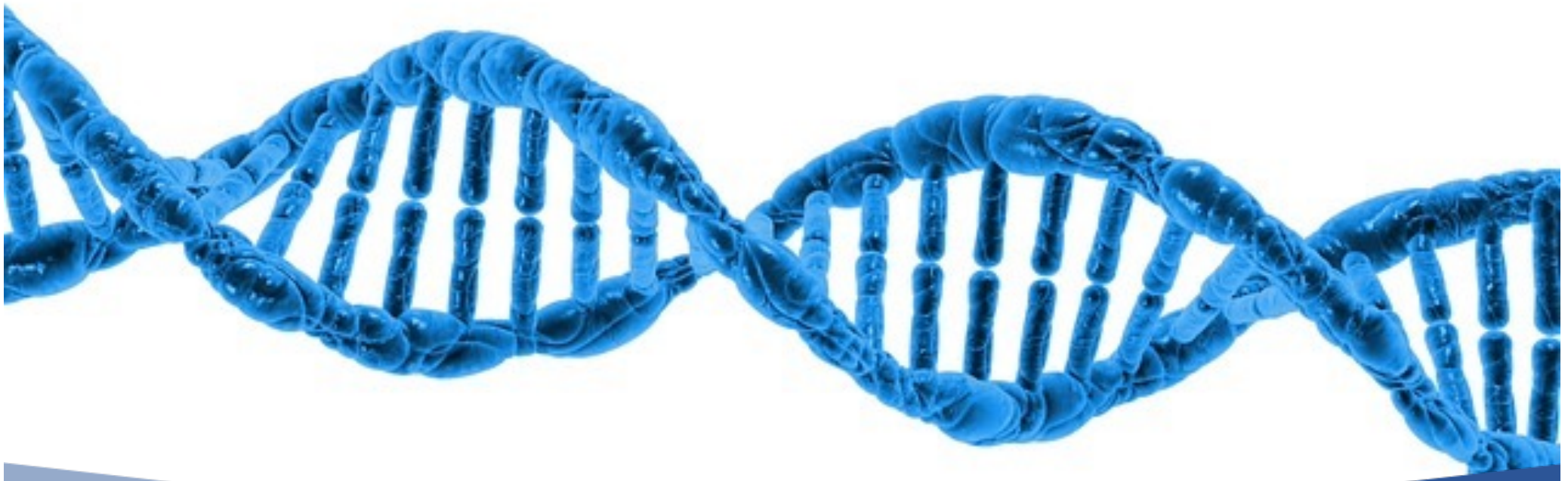
Conclusions: Patients with MelD do not improve cognitive performance despite clinical remission compared with remitted NMelD patients. The persistence of some cognitive dysfunctions in MelD remitted patients could represent a trait marker of a different depressive subtype and not be secondary to disease severity.

- El objetivo del estudio era comparar el rendimiento cognitivo entre la depresión melancólica (MelD) y no melancólica (NMelD) y determinar si estas alteraciones cognitivas permanecen después de la remisión clínica de la depresión.

- Resultados:
  -Los pacientes con MelD muestran peor desempeño que NMelD al inicio del estudio.
  -El deterioro cognitivo permanece a los seis meses de seguimiento después de la remisión clínica en MelD.

- Conclusiones:
  -Los pacientes con MelD no mejoran el rendimiento cognitivo a pesar de la remisión clínica en comparación con pacientes NMelD.
  -La persistencia de algunas disfunciones cognitivas en pacientes MelD con remisión podría representar un marcador de rasgo de un subtipo depresivo diferente y no ser secundario a la gravedad de la enfermedad.

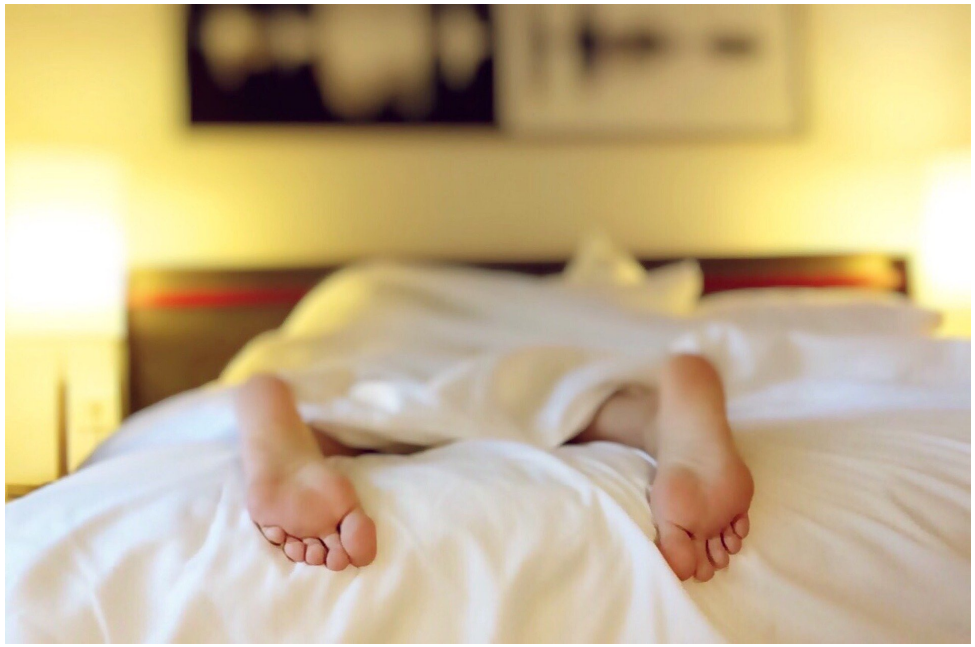
- Existe una mayor relevancia de los determinantes genéticos y biológicos y una menor de los determinantes psicosociales



2.

Datos concomitantes de un funcionamiento biológico alterado

(Dean et al, 2017)



Hipótesis monoaminérgica: serotonina, norepinefrina, dopamina

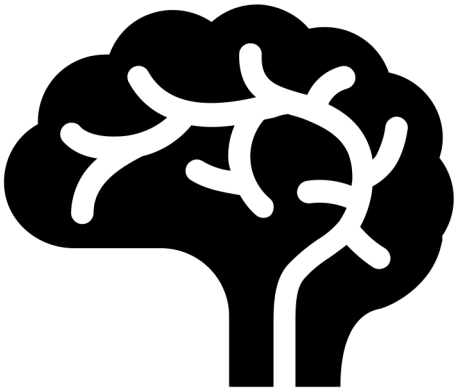
Hipótesis glutamatérgica: glutamato

Desregulación eje hipotálamo-hipofisario y respuesta al estrés

Inflamación

Neurogénesis y neuroplasticidad

Circuitos neuronales en depresión



((Demyttenaere et al, 2019; Mulinari et al, 2013; Duman et al, 2016; Strawbridge et al, 2015; Lima-Ojeda et al, 2017)

Neurobiología de la Depresión

1. Hipótesis monoaminérgica: serotonina, norepinefrina, dopamina[1-5]

- Incremento de niveles serotonina o norepinefrina mediante diferentes tipos de antidepresivos.
- Anormalidades genéticas en la transmisión serotoninérgica.
- Neuronas dopaminérgicas en áreas mesolímbicas: del área ventral tegmental y proyecciones núcleo accumbens.

1.Richelson J, et al. International Journal of Intelligence and Counter Intelligences. 2001;14:149-192; 2. Caspi A, et al. Am J Psychiatry. 2010 May;167(5):509-27; 3. Leonard CM, et al. Dev Neuropsychol. 2008;33(6):663–681; 4. Watt, DF, et al. Neuropsychoanalysis. 2009;11(1):7–51. 5. Mulinari S. J Hist Neurosci. 2012;21(4):366-92.

Neurobiología de la Depresión

2. Hipótesis glutamatérgica[1-6]

- Sistema glutamatérgico, “target” de acción antidepresivo. El ácido glutámico es el principal y más abundante neurotransmisor presente en las sinapsis excitatorias. Glutamato, involucrado en la regulación afectiva, a través del mantenimiento de la neuroplasticidad.
- Antagonistas receptores NMDA en interneuronas GABAérgicas: incremento de liberación de BNDF en neuronas piramidales del hipocampo.
- Vía más prometedora en los últimos años para el tratamiento antidepresivo.

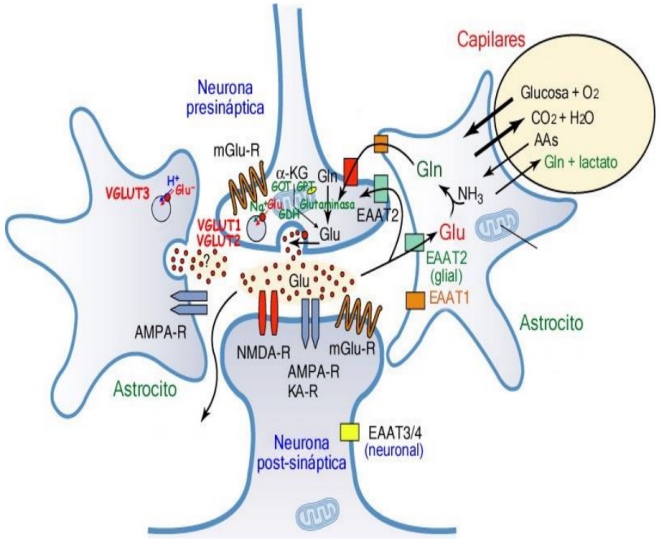


Figura. Esquema simplificado de una sinapsis tripartita para el GLU
De: Baratti CM, et al. Rev. Farm. 2015;157(1-2): 27-36

1. Racagni G, et al. Dialogues Clin. Neurosci. 2008;10(4): 385-400; 2. Barbon A, et al. Neurochemistry international. 2001;59. 896-905; 3. Machado-Vieira R, et al. Pharmaceuticals (Basel). 2010 Jan 6;3(1):19-41; 4. Ladarola ND, et al. Ther Adv Chronic Dis. 2015 May;6(3):97-114. 5. Baratti CM, et al. Rev. Farm. 2015;157(1-2): 27-36; 6. Duman RS, et al. Nat Med.2016 Mar;22(3):238-49.

Neurobiología de la Depresión

3. **Disregulación eje hipotálamo-hipofisario y respuesta al estrés**[1-4]

- Anormalidades eje HPA, asociadas a hiperactividad en la respuesta al estrés o a abusos en la infancia.

- Modelos animales: estrés crónico, asociado a síntomas como anhedonia, motivación alterada y cambios en el ritmo del sueño.

- Cortisol y estrés: síntomas depresivos.

1. Pechtel P, et al. Psychopharmacology (Berl). 2011 Mar;214(1):55-70; 2. Pruessner JC. Psychoneuroendocrinology. 2003 Oct;28(7):916-31; 3. Willner P. Neuropsychobiology. 2005;52(2):90-110. 4. Schwabe RF, et al. 2013.Nov;13(11):800-12.

Neurobiología de la Depresión

4. Inflamación[1-5]

- Marcadores inflamatorios alterados en pacientes depresivos.
- Inflamación y enfermedades crónicas: síndromes metabólicos.
- Obesidad, diabetes, hipertensión, dislipidemia.
- Hepatitis C, tratamiento con interferón y síntomas depresivos.

1. Taylor JL, et al. Semin Oncol. 1998 Feb;25(1 Suppl 1):23-9; 2. Felger JC, et al. Neuroscience. 2013 Aug 29;246:199-229;.3. Steptoe A, et al. Brain Behav Immun. 2007 Oct;21(7):901-12; 4. Uher R, et al. Depress Anxiety. 2014 Jun;31(6):459-71; 5. Strawbridge R, et al. Eur Neuropsychopharmacol. 2015 Oct;25(10):1532-43.

Neurobiología de la Depresión

5. Neurogénesis y neuroplasticidad[1-7]

- Cambios en neurogénesis y neuroplasticidad en tratamientos antidepresivos.
- Tratamiento con antidepresivos: asociado con aumento neurogénesis hipocampo.

- BNDF *(Brain-derived neurotrophic factor)* y neuroplasticidad.
- Niveles BNDF reducidos en pacientes depresivos.

- Estimulación magnética transcraneal, terapia electroconvulsiva….

1. Monteleone P, et al. Eur Neuropsychopharmacol. 2008 Oct;18(10):701-11; 2. Santarelli L, et al. Science. 2003 Aug 8;301(5634):805-9; 3. Shang Hui, et al. 2016-Journal of Systematics and Evolution 2016; 4. Rocha R, et al-2016-Journal of Evolutionary Biology.sup-2; 5. Sari C, et al. BMC Public Health. 2013; 13: 519; 6. Fagiolini M, et al. Curr Opin Neu... Apr;19(2):207-12; 7. Cole M, et al. Mar Pollut Bull. 2011 Dec...

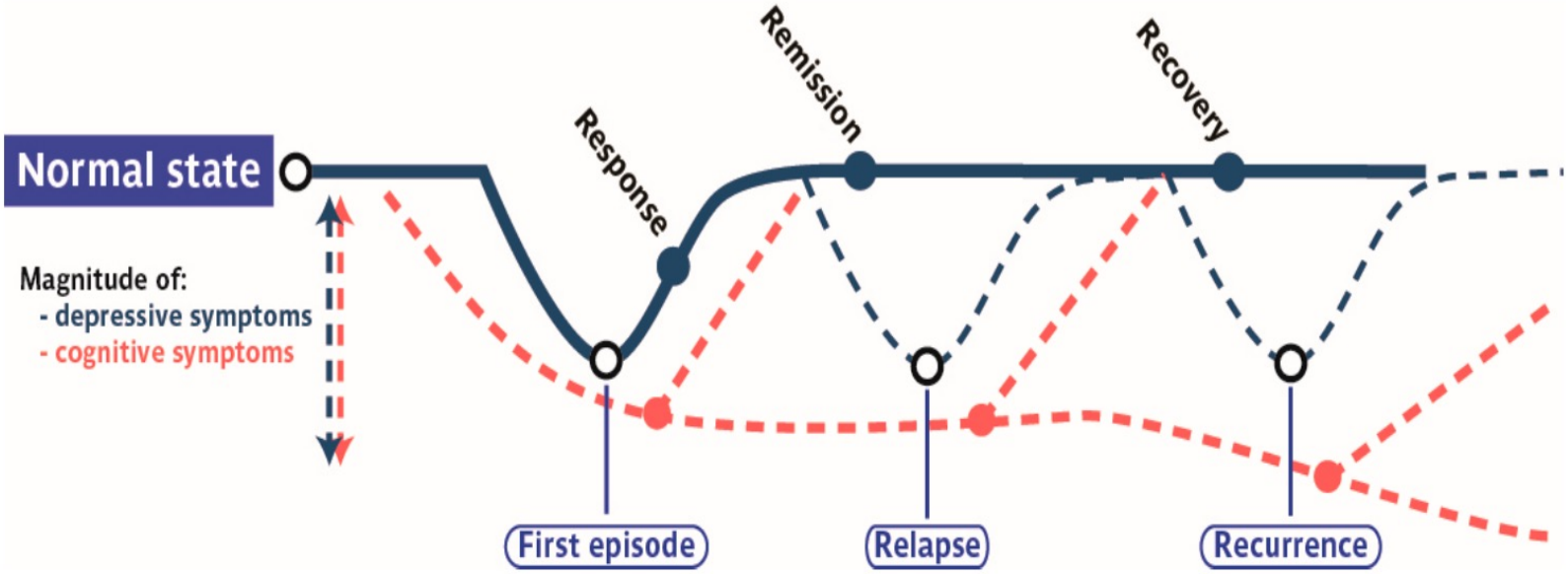
Neurobiología de la Depresión

6. Circuitos neuronales en depresión[1-6]

- Cambios en la conectividad funcional en circuitos que regulan afectividad.
- Amígdala, hipocampo, ganglios basales, áreas corteza prefrontal y córtex cingulado: papel en la regulación afectiva, emocional y cognitiva.
- Estudios neuroimagen: alteraciones volumen en córtex prefrontal, amígdala, ganglios basales o especialmente hipocampo.

Mayberg HS. Br Med Bull. 2003;65:193-207; 2. Sheline YI, et al. Am J Psychiatry. 2003 Aug;160(8):1516-8; 3. Bora E, et al. Psychol Med. 2013 Oct;43(10):2017-26; 4. Rogers K, et al. The Journal of Deaf Studies and Deaf Education. 2013;18(1):110–122; 5. Dean J, et al. The Neurobiology of Depression: an Integrated View. 2017. Asian Journal of Psychiatry. 27; 6. [illegible] al. Baghai Front Psychiatry. 2017;8:153

Curso de la depresión



3. Una superior respuesta clínica a los tratamientos biológicos, los fármacos antidepresivos frente a los tratamientos no biológicos, con una muy baja respuesta al placebo.

Eficacia comparativa de 21 antidepresivos en el tratamiento de la depresión mayor en el adulto

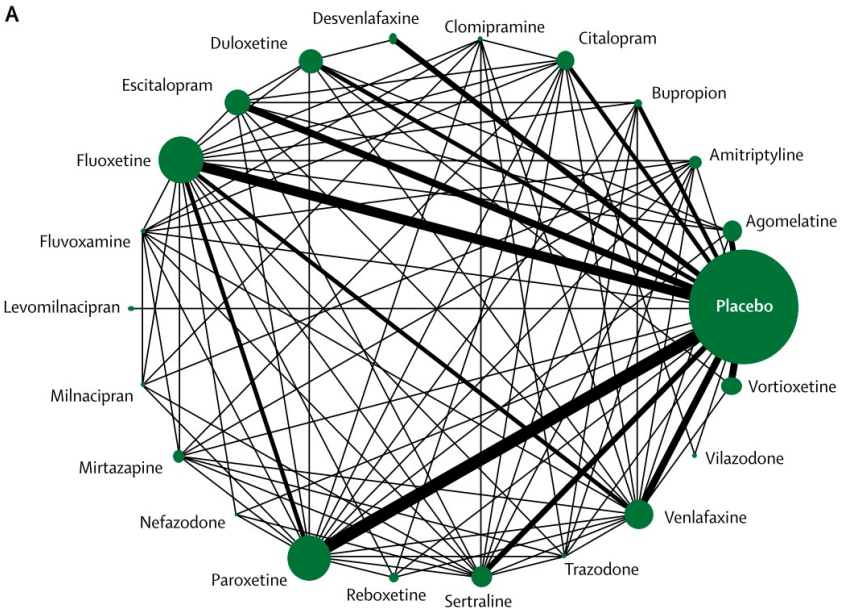
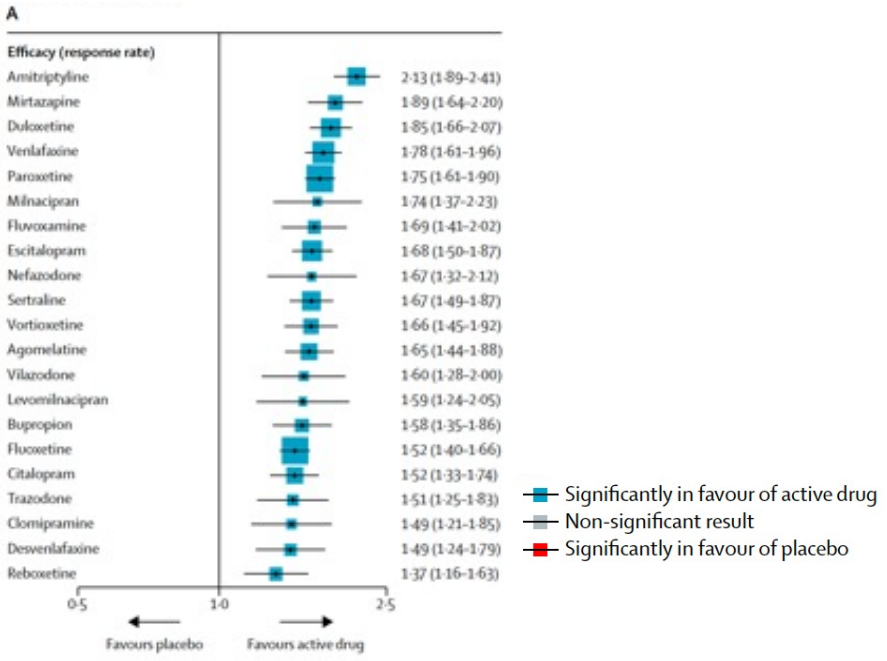


Figura de Cipriani A et al. Lancet. 2018.



Cipriani A et al. Lancet. 2018 Apr 7;391(10128):1357-1366.

Esquema de tratamiento secuencial en la depresión

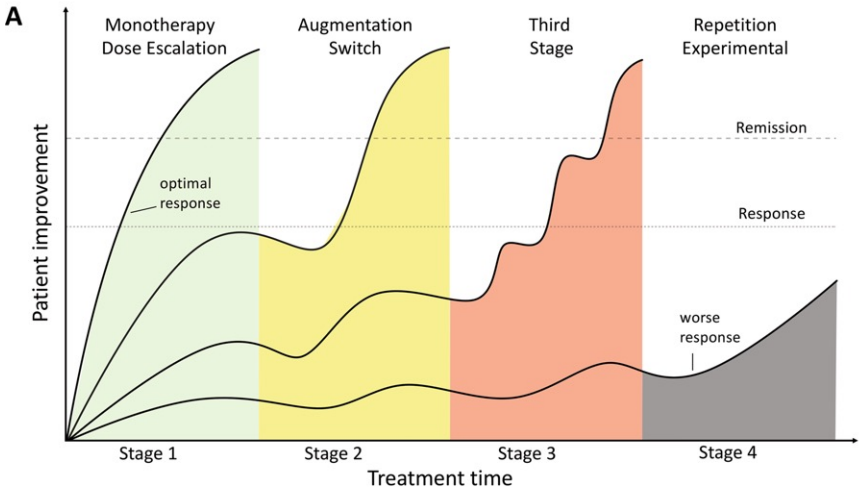


Figura de Kraus C et al. Transl Psychiatry. 2019.

Stage 1 – monotherapy / dose escalation

- Reuptake inhibitor (SERT, NET, DAT) – multiple substances
- Receptor antagonist (NE alpha-2, 5-HT2, 5-HT3) – mirtazapine
- Reuptake inhibitor (SERT and NET), receptor antagonist (5-HT2) – amitriptyline
- Reuptake inhibitor (SERT), receptor partial agonist (5-HT1A), receptor antagonist (5-HT3) – vortioxetine
- Reuptake inhibitor (SERT), receptor agonist (5-HT1A), receptor antagonist (5-HT2) – trazodone
- Receptor antagonist (5-HT2 and D2) – trimipramine
- Receptor agonist (Mel1, Mel2), receptor antagonist (5-HT2B, 5-HT2C) – agomelatine
- rTMS, TBS

Stage 2 – augmentation / switch

- Augmentation
  - Receptor antagonist (D2, 5-HT2) – quetiapine, olanzapine
  - Receptor partial agonist (D2, 5-HT1A) – aripiprazole
  - Enzyme interactions – lithium
- Combining two classes with complementary mechanisms
- Switch – within class of reuptake inhibitors
- ECT/Ketamine in recurrent/severe episodes, suicidal ideation
- rTMS, TBS

Stage 3

- Enzyme inhibitor (MAO-A and -B), releaser (DA, NE) – tranylcypromine
- ECT
- Ketamine
- rTMS, TBS
- Vagus nerve stimulation

Stage 4 – experimental

- Repetition of previous stages
- Experimental treatments (DBS)
- Augmentation (buprenorphine)
- Consider clinical trials for novel substances

Kraus C et al. Transl Psychiatry. 2019

Subtipos clínicos

Depresión Melancólica

El diagnóstico de depresión melancólica tiene validez predictiva para el pronóstico y el tratamiento y representa una categoría más homogénea para la investigación

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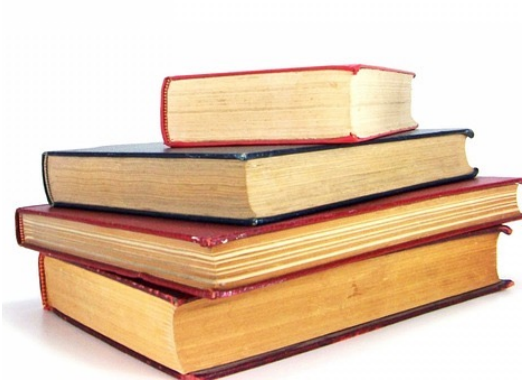
- Sickness
- Disease
- Illness

Melancolía como condición creativa, Como enfermedad

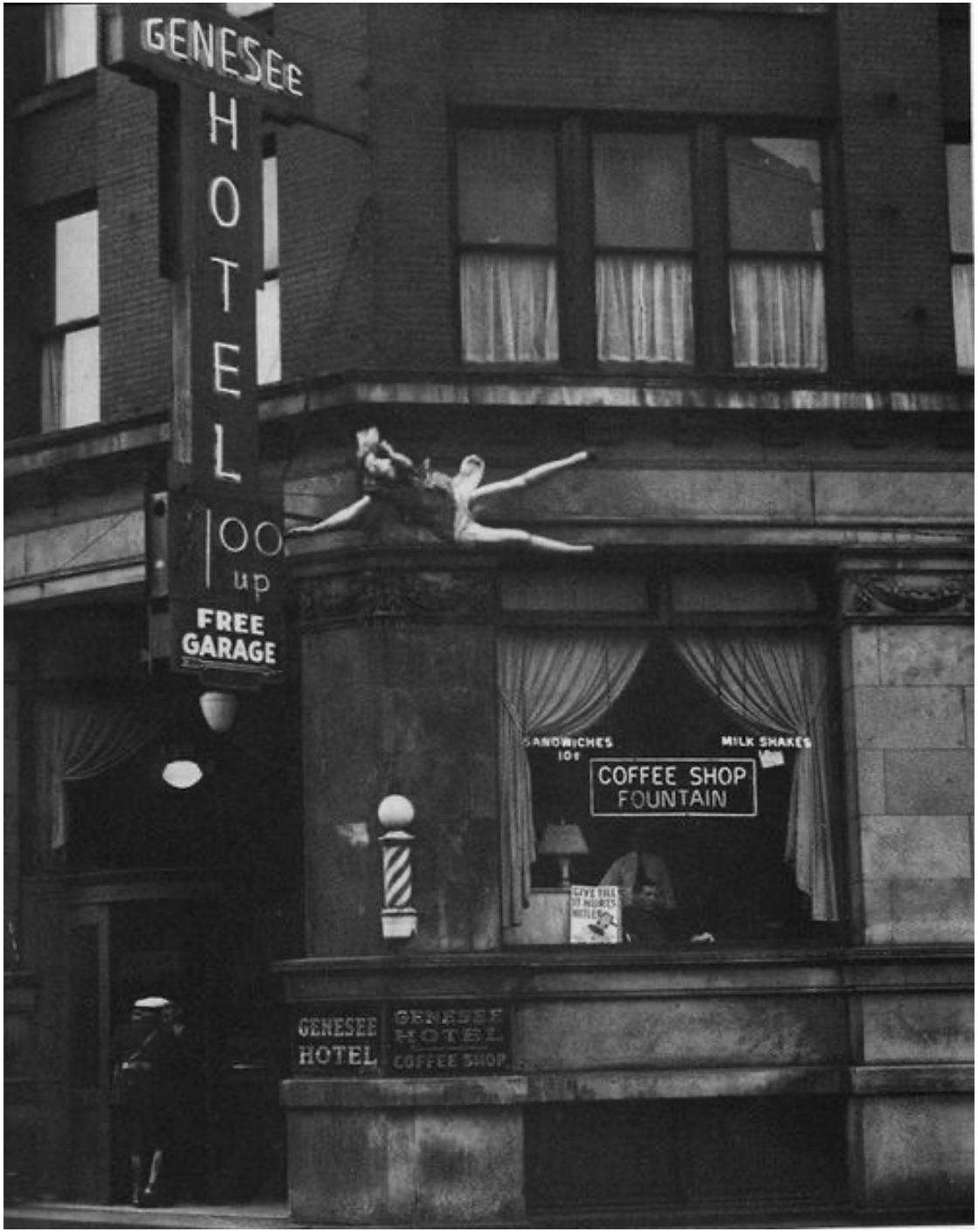
Melancolía. Arte y literatura



Baudelaire, Montaigne, Cioran, Céline, Keats, Churchill, Pla.....

Dürer, Cranach, Sandys, De Chirico, Kieffer.....

Russell Sorgi, The 1942 Genesee Hotel Suicide



Journal of Affective Disorders 245 (2019) 152–162

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journal homepage: www.elsevier.com/locate/jad

Review article

Mental disorders as risk factors for suicidal behavior in young people: A meta-analysis and systematic review of longitudinal studies

Margalida Gili[a,b,*], Pere Castellví[c,d], Margalida Vives[a,b], Alejandro de la Torre-Luque[e,i], José Almenara[f], Maria J Blasco[c,d,g], Ana I Cebrià[h,i], Andrea Gabilondo[j,k], Mª Angeles Pérez-Ara[a], Carolina Lagares[l], Oleguer Parés-Badell[c], José A Piqueras[m], Tiscar Rodríguez-Jiménez[m], Jesús Rodríguez-Marín[m], Victoria Soto-Sanz[m], Jordi Alonso[c,d,g], Miquel Roca[a,b]

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[c] Health Services Research Group, IMIM (Hospital del Mar Medical Research Institute), Barcelona, Spain
[d] CIBER en Epidemiología y Salud Pública (CIBERESP), Spain
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[g] Department of Health & Experimental Sciences, Pompeu Fabra University (UPF), Barcelona,

A B S T R A C T

Background: Suicide is the second leading cause of death for young people. Objective: To assess mental disorders as risk factors for suicidal behaviour among adolescents and young adults including population-based longitudinal studies.

Method: We conducted a systematic literature review. Bibliographic searches undertaken in five international databases and grey literature sources until January 2017 yielded a total of 26,883 potential papers. 1701 full-text articles were assessed for eligibility of which 1677 were excluded because they did not meet our eligibility criteria. Separate meta-analyses were conducted for each outcome (suicide death and suicide attempts). Odds ratio (OR) and 95% confidence intervals (95%CI) and beta coefficients and standard errors were calculated.

Results: 24 studies were finally included involving 25,354 participants (12–26 years). The presence of any mental disorder was associated with higher risk of suicide death (OR = 10.83, 95%CI = 4.69–25.00) and suicide attempt (OR = 3.56; 95%CI 2.24–5.67). When considering suicidal attempt as the outcome, only affective disorders (OR = 1.54; 95%CI = 1.21–1.96) were significant. Finally, the results revealed that psychiatric comorbidity was a primary risk factor for suicide attempts.

Limitations: Data were obtained from studies with heterogeneous diagnostic assessments of mental disorders. Nine case-control studies were included and some data were collected in students, not in general population.

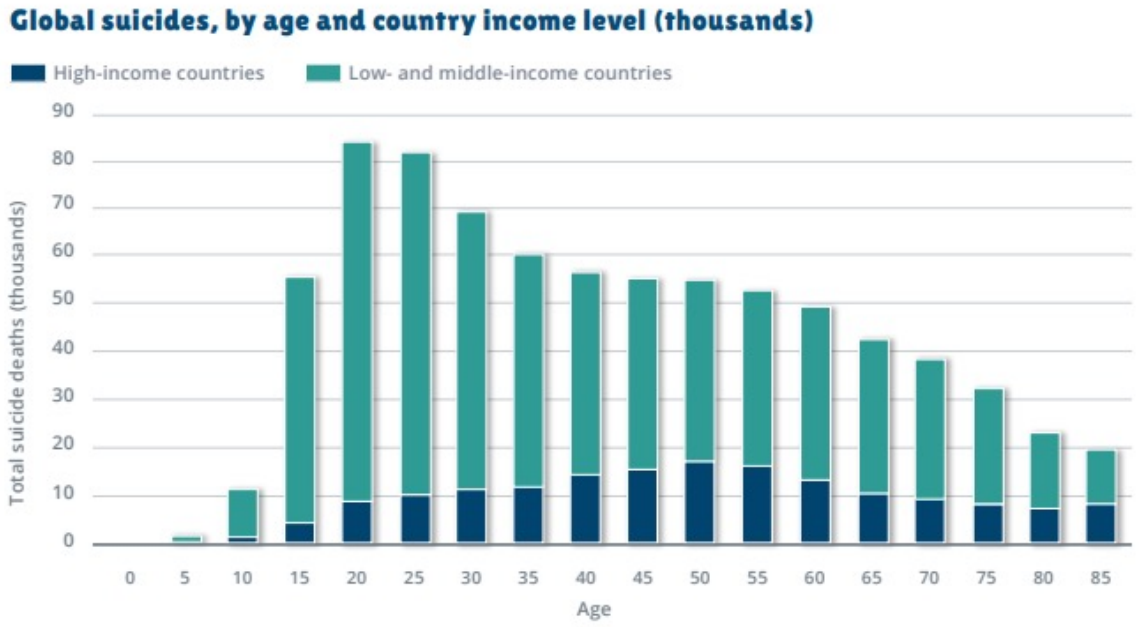
Conclusions: Mental disorders and comorbidity are strong predictors of suicide behaviour in young people. Detection and management of the affective disorders as well as their psychiatric comorbidity could be a crucial strategy to prevent suicidality in this age group.

Organization, 2016; Lozano et al., 2012) In some geographical areas,

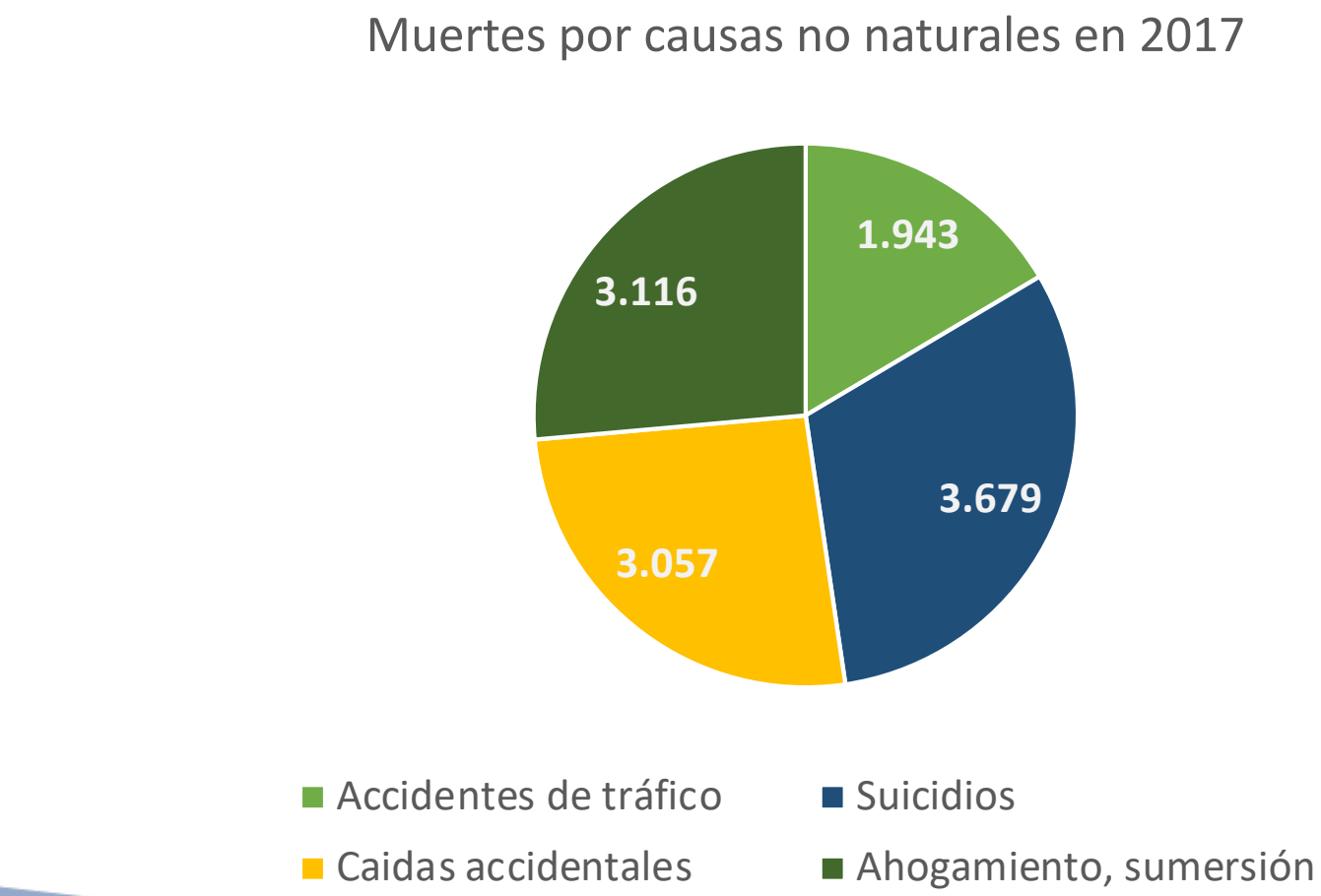
De acuerdo con la OMS, en el año 2015, se estima que 788 000 personas murieron por suicidio; y un número más alto lo intentaron.

El suicidio es la segunda causa de muerte en jóvenes de 15 a 29 años (OMS, 2017).

En comparación con la población general, el intento de suicidio es tres veces superior en pacientes diagnosticados de TDM.



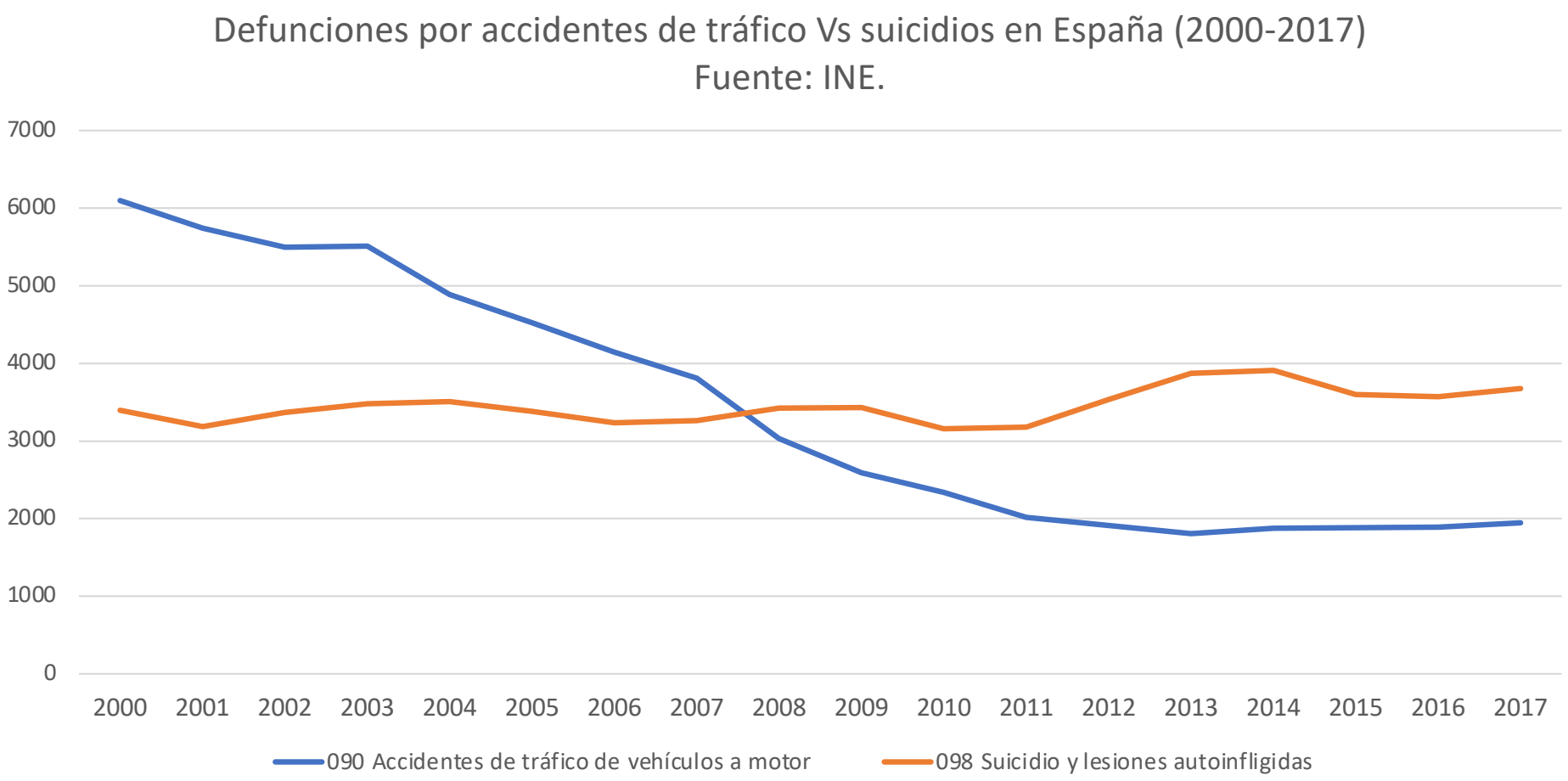
Suicidios España



	TOTAL	HOMBRES	MUJERES
2007	3.263	2.463	800
2008	3.421	2.649	772
2009	3.429	2.666	763
2010	3.158	2.468	690
2011	3.180	2.435	745
2012	3.539	2.724	815
2013	3.870	2.911	959
2014	3.910	2.938	972
2015	3.602	2.680	922
2016	3.569	2.662	907
2017	3.679	2.718	961
2018	3.539	2.619	920

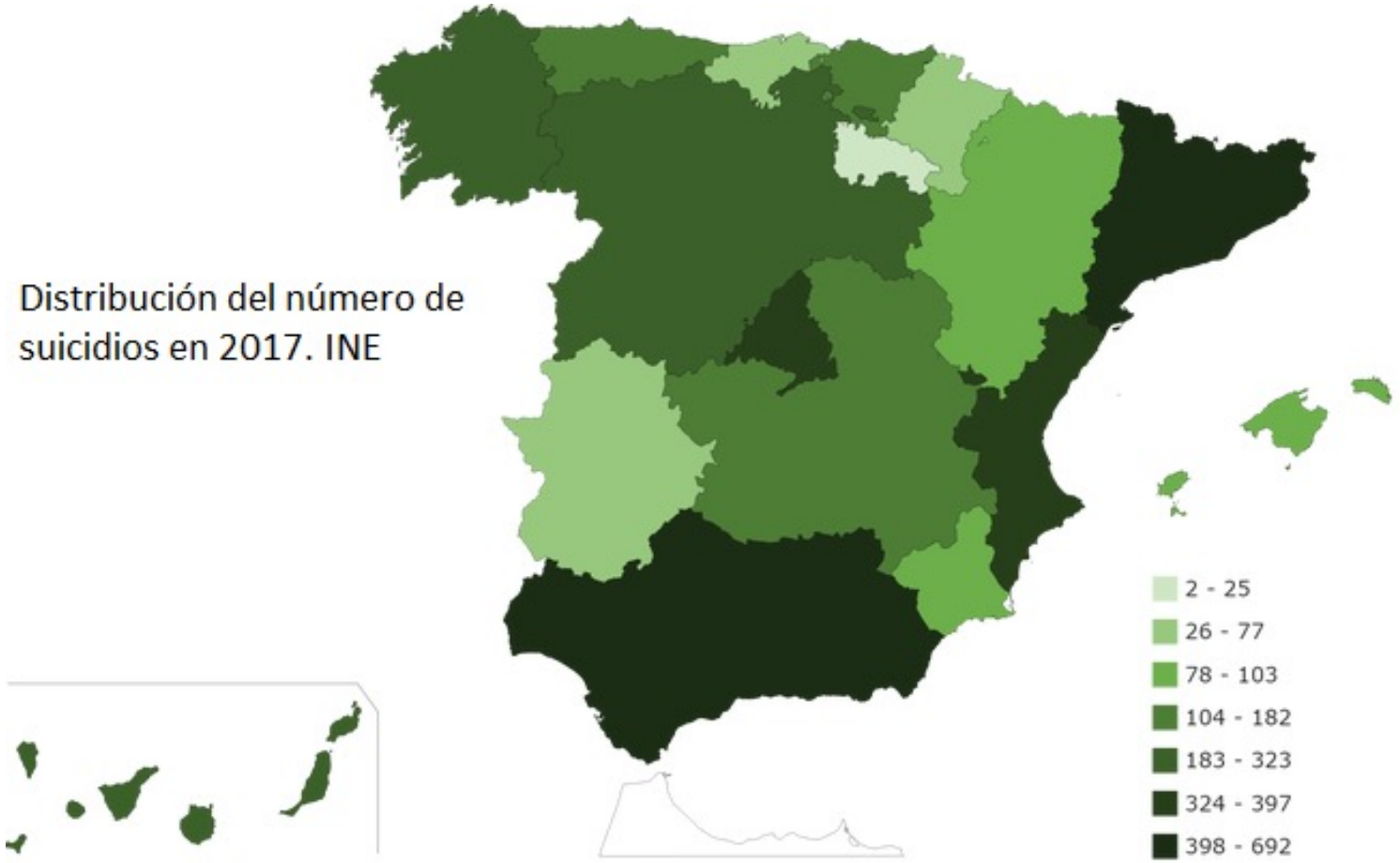
Suicidios España

Suicidios España



Suicidios España

Distribución del número de suicidios en 2017. INE



Roca et al. BMC Psychiatry (2019) 19:253
https://doi.org/10.1186/s12888-019-2233-1

BMC Psychiatry

STUDY PROTOCOL Open Access

Suicidal risk and executive functions in major depressive disorder: a study protocol

Miquel Roca[1*], Antonio Riera-López del Amo[2], Pau Riera-Serra[2], Mª. Angeles Pérez-Ara[1], Adoración Castro[1], J. Roman Juan[2], Mauro García-Toro[1], Patricia García-Pazo[3] and Margalida Gili[1]

Abstract

Background: Suicide is a serious public health concern. Depression is the main gateway to suicidal behavior. The already established relationship between depression and suicidal risk should now focus on the investigation of more specific factors: recent studies have suggested an association between vulnerability to suicidal behavior and neurocognitive alterations, a nuclear symptom of depression. This project aims to identify alterations in the Executive Functions (EF) of patients suffering a first depressive episode that might constitute a risk factor for suicidal ideation, suicidal attempts and suicide, to allow for more adequate suicide prevention.

Methods: Prospective longitudinal design involving two groups (first depressive episodes with and without alterations in their EF) and four repeated measures (0, 6, 12 and 24 months). The estimated minimum sample size is 216 subjects. The variables and measurement instruments will include socio-demographic variables, clinical variables (age of illness onset, family and personal antecedents, psychopathological and medical comorbidity, suicidal ideation, suicide attempts and completed suicides, severity of depression, including melancholic or atypical, remission of the depressive episode), and neuropsychological variables (EF and decision-making processes evaluated through the Cambridge Neuropsychological Test Automated Battery (CANTAB)).

Discussion: First and foremost, the identification of clinical and neuropsychological risk factors associated with suicidal behavior will open the possibility to prevent such behavior in patients with a first depressive episode in the context of clinical practice. Secondly, interventions aimed at cognitive impairment (in particular: EF) derived from the study may be incorporated into strategies for the prevention of suicidal behavior. Finally, impaired neurocognitive function (even in early stages) could become an identifiable endophenotype or "marker" in clinical and neurobiological studies about suicidal behavior in depressive patients.

Keywords: Major depressive disorder, Suicide, Suicidal attempt, Suicidal ideation, Executive functions, Longitudinal study

- El objetivo es identificar, en pacientes con un primer episodio depresivo, alteraciones en las funciones ejecutivas que podrían constituir un factor de riesgo para la ideación suicida, los intentos de suicidio y el suicidio.

Alteraciones cognitivas como *marcador* de riesgo suicida

Hacia una anatomía de la melancolía y el suicidio

Prevención en Psiquiatría?
Prevención en Depresión
Prevención en conducta suicida?

Proyecto UNIVERSAL

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journal homepage: www.elsevier.com/locate/jad

Research paper

First-onset and persistence of suicidal ideation in university students: A one-year follow-up study

Maria Jesús Blasco[a,b,c], Gemma Vilagut[a,c], Itxaso Alayo[a,c], José Almenara[d], Ana Isabel Cebrià[e,f], Enrique Echeburúa[g], Andrea Gabilondo[h], Margalida Gili[i], Carolina Lagares[d], José Antonio Piqueras[j], Miquel Roca[i], Victoria Soto-Sanz[j], Laura Ballester[a,c,k], Arantxa Urdangarin[a], Ronny Bruffaerts[l], Philippe Mortier[l], Randy P. Auerbach[m], Matthew K. Nock[n], Ronald C. Kessler[o], Jordi Alonso[a,b,c,*], on behalf of the UNIVERSAL study group[1]

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[h] Outpatient Mental Health Care Network, Osakidetza-Basque Health Service, Basque Country, San Sebastián, Spain
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[j] Miguel Hernández University (UMH), Elche, Spain
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[l] Center for Public Health Psychiatry, KU Leuven, Leuven, Belgium

- Se evaluaron primeras apariciones y persistencia de ideas suicidas en universitarios españoles entre su primer y segundo año de universidad y la asociación entre factores distales/proximales de riesgo y protectores durante un periodo de 12 m.

- Factores de riesgo:
  -En T1 (final del 1º año de Univ.): otros intentos de suicido previos, ideación y planeación suicida a lo largo de la vida, otros trastornos mentales a lo largo de la vida.
  -En T2 (a los 12 m.): con trast. del estado del ánimo, adversidades en infancia/adolescencia anteriores a los 17 años y cualquier experiencia estresante en los últimos 12 m., otros trastornos mentales en los últimos 12 m., agresión física o sexual.

- Factores de protección: experiencias positivas infancia/adolescencia anteriores a los 17 años y sentimiento de pertenencia grupal en la universidad en T2.

Research

JAMA | Original Investigation

Effect of Multinutrient Supplementation and Food-Related Behavioral Activation Therapy on Prevention of Major Depressive Disorder Among Overweight or Obese Adults With Subsyndromal Depressive Symptoms

The MooDFOOD Randomized Clinical Trial

Mariska Bot, PhD; Ingeborg A. Brouwer, PhD; Miquel Roca, PhD; Elisabeth Kohls, PhD; Brenda W. J. H. Penninx, PhD; Ed Watkins, PhD; Gerard van Grootheest, MSc; Mieke Cabout, MSc; Ulrich Hegerl, PhD; Margalida Gili, PhD; Matthew Owens, PhD; Marjolein Visser, PhD; for the MooDFOOD Prevention Trial Investigators

IMPORTANCE Effects of nutritional interventions on the prevention of major depressive disorder (MDD) in overweight adults are unknown.

OBJECTIVE To examine the effect of 2 nutritional strategies (multinutrient supplementation, food-related behavioral activation therapy) and their combination for prevention of a new MDD episode in overweight adults with subsyndromal depressive symptoms.

DESIGN, SETTING, AND PARTICIPANTS This multicenter 2 × 2 factorial randomized clinical trial included overweight adults (body mass index, 25-40) with elevated depressive symptoms (Patient Health Questionnaire-9 [PHQ-9] scores ≥5) and no MDD episode in the past 6 months from 4 European countries. A total of 1025 adults were randomized (July 30, 2015-October 12, 2016) and followed up for 1 year (October 13, 2017).

INTERVENTIONS Daily multinutrient supplements (1412-mg omega-3 fatty acids, 30-µg selenium, 400-µg folic acid, and 20-µg vitamin D_3 plus 100-mg calcium) vs placebo and 21 individual or group therapy sessions vs none (blinded to researchers) for 1 year. Participants were allocated to placebo without therapy (n = 257), placebo with therapy (n = 256), supplements without therapy (n = 256), and supplements with therapy (n = 256).

MAIN OUTCOME AND MEASURES Cumulative 1-year onset of MDD via the Mini International Neuropsychiatric Interview at 3, 6, and 12 months. Logistic regression using effect-coded variables (−1 indicating control, 1 indicating intervention) evaluated intervention effects both individually and in combination (interaction) on MDD onset.

RESULTS Among 1025 participants (mean age, 46.5 years; 772 women [75%]; mean BMI, 31.4), 779 (76%) completed the trial. During the 12-month follow-up, 105 (10%) developed MDD: 25 (9.7%) patients in the placebo without therapy, 26 (10.2%) in the placebo with therapy, 32 (12.5%) in the supplement without therapy, and 22 (8.6%) in the supplement with therapy group. None of the treatment strategies affected MDD onset. The odds ratio (OR) for supplements was 1.06 (95% CI, 0.87-1.29); for therapy, 0.93 (95% CI, 0.76-1.13); and for their combination, 0.93 (95% CI, 0.76-1.14; *P* for interaction, .48). One person in the supplementation with therapy group, died. Twenty-four patients in each of the placebo groups and 24 patients in the supplementation with therapy group were hospitalized, and 26 patients in the supplementation-only group were hospitalized.

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Related article page 869
Supplemental content
CME Quiz at jamanetwork.com/learning and CME Questions page 897

Author Affiliations: Author affiliations are listed at the end of this article.

- El objetivo era examinar el efecto de 2 estrategias nutricionales (suplementos multinutrientes y terapia de activación conductual relacionada con la alimentación) y su combinación para la prevención de un nuevo episodio de TDM en adultos con sobrepeso con síntomas depresivos subsindrómicos.

- Resultados:
  - Durante el seguimiento de 12 meses, 105 participantes (10%) desarrollaron TDM: 25 (9.7%) en el placebo sin terapia, 26 (10.2%) en el placebo con terapia, 32 (12.5%) en el suplemento sin terapia, y 22 (8.6%) en el suplemento con grupo de terapia.
  - El odds ratio (OR) para los suplementos fue de 1,06 (IC del 95%, 0.87-1.29); para terapia, 0,93 (IC 95%, 0,76 1,13) y para su combinación, 0,93 (IC 95%, 0,76-1,14; P para interacción, .48).
  - Los hallazgos no respaldan el uso de estas intervenciones para la prevención del TDM.

Conclusiones

*Depresión, enfermedad prevalente, con frecuencia curso crónico, recurrencias y alta comobilidad
*Depresión, constructo “débil”, pendiente de resolver graves problemas de validación como síndrome clínico
*Necesidad de delimitar subtipos depresivos homogéneos y replantear relación con eventuales anomalías neurobiológicos de estos subtipos
*Subtipo melancólico, patrón diferenciado de sintomatología, mayores alteraciones biológicas, menor respuesta a tratamientos, superior validez predictiva
*Mayor riesgo de suicidio
*Sintomas cognitivos en depresión melancólica, ¿perfil de riesgo en conducta suïcida?

Hacia una anatomía de la melancolía y el suicidio

Ciencia, investigación:

“La incerteza es un estado incómodo, poco confortable; la certeza absoluta es una condición extraordinariamente ridícula”

Institut Universitari d' Investigació en Ciències de la Salut (IUNICS/IDISBA). Rediapp (I. Salud Carlos III). Facultad de Medicina. Hospital Universitario Son Espases. Universitat de les Illes Balears

M. Gili, M. García-Toro, J. Salvá, R. Molina, C. Vicens, C. Fiol, A. Castro, A. Riera, M. Pérez-Ara,
V. Coronado, L. Castillo, M. Vives

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