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Anxiety and Depression in parents front of the suicidal attempt of the son.

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ABSTRACT The suicide attempt and suicide possess characteristics that differentiate them from accidents or expected deaths, family members are exposed to the development of psychopathologies such as anxiety disorders, post-traumatic stress and depressive or somatic episodes[1], without receiving medical or psychological care, so this research aimed to determine through the IDARE scale the degree of anxiety and through IDERE the level of depression presented by parents who have a child with suicidal intent. Participated 32 parents from the State of Mexico. The results show significant differences attributable to the gender in Anxiety and Depression in the Trait-Scale; In particular mothers tend to have higher levels of anxiety and depression.

KEYWORDS : suicide attempts, anxiety, depression, parents.

Introduction

The World Health Organization (WHO)[2] points the lack of actual data of suicides, attempted or parasuicidal behaviors but infers that for every recorded suicide, there are about 20 to 40 undetected attempts; Bateman[3] estimates that each year about 2 million adolescents have attempted suicide in the USA and only about 700 thousand receive medical attention; in Mexico a relevant report by Quintanar[4] suggests that the suicide attempt is up to 70 times higher and that these attempts or self-harm constitute an important predictor of new attempts and consummate suicides.

Suicide and its attempt increase considerably, administrative records of the INEGI[5] gave a standardized rate in Mexico in 2000 of 3.5 suicides per 100 thousand inhabitants, while in 2013 increased to 4.9 suicides, in the 2015 this institute reported 6337 suicides and 2292 cases of self-inflicted injuries.

Casullo[6] indicates that the causes of the suicide attempt or the suicide are multiple and are related arbitrarily; Socio-demographic factors (age, sex, marital status, socioeconomic level, among others), medical (psychopathological disorders, substance abuse, diseases, etc.) and situational/contextual factors (stressful life cycle events, access to means to commit suicide, etc.) and because in Mexico there are no real official data on suicide attempts or groups at risk, nor on the possible relationship between suicidal behaviors and psychopathological symptoms, situation that puts at risk the few programs of aid, prevention, intervention or postvention as a consequence of the real ignorance of the situation, the insufficient information and the inadequate conceptualization of the problem[7-10].

The suicidal attempt of a member affects directly and especially the family due not only to the impact of the event but also to the failure to provide information, guidance or support; Only the suicidal receive medical and/or psychiatric care, leaving the family aside.
Parents facing a situation of suicide by a child are susceptible to develop anxiety and depression being these an universal phenomena, there is a high tendency to develop one of these disorders, which becomes a risk factor for them, although there are consider that phenomenologically and biologically anxiety and depression have several features in common, widely recognized by research and clinical practice as restlessness, irritability, eating disorders and sleep, Anxiety-State is considered a transient emotional condition; while Anxiety-Trait, would be the relatively stable predisposition to remain uneasy and worried[11]; Depression-State is the subjective reflection of the subject's life situation at a given time and Depression-Trait is the propensity to suffer feelings and thoughts of emptiness, disinterest, and deep sadness as a personality quality relatively stable throughout life, they are going to be actively manifesting themselves by intrinsic factors[12].

Both anxiety and depression include psychological and physical symptoms of low detection rate in the area of health and a high negative impact on quality of life, family, social, labor, economic and physical environment[13]. The National Comorbidity Survey[14], reports that anxiety disorders are the most common in the population, doubling the numbers of depression. On the one hand depression is a disease of global consequences, WHO[15] estimates that about 350 million people have some form of depression. About anxiety, WHO[2] estimates that by 2020 anxiety is the leading cause of years of healthy life lost worldwide, and secondly depression.

Method

Participants

The sample of intentional carácter and non-probabilistic was formed by 32 participants; 19 mothers and 13 fathers with a age range of 29 to 79 years, the average age being 49.5 years, all residents of the State of Mexico, the educational level was distributed as follows: no-schooling 9%, basic 9% Mean 12%, upper-average 19%, technique 13% and superior 38%; The marital status was dispersed with 66% married, 12% single, 19% divorced and 3% widowed.

Instruments

Inventory of Trait-State Anxiety, IDARE.

Adapted to Spanish by Spielberger and Guerrero (2008); Consists of 40 reagents; The Anxiety-State scale comprises 20 Likert-type items of 4 points: (1) No, (2) A little, (3) Moderately, (4) A lot. The Anxiety-Trait scale is made up of 20 items that are graded Likert scale as follows: (1) Almost never, (2) Sometimes, (3) Frequently, (4) Almost always; Its objective is to establish two dimensions of anxiety as a transient (State) emotional condition and the other as that relatively stable anxious propensity (Trait). Consider three levels of anxiety for both scales: high, medium and low. The Cronbach's alpha for

Anxiety-Trait is 0.73 and for Anxiety-State, 0.83.

Detection Inventory of Trait-State, IDERE.

The version of Martín, Grau, Ramírez and Grau (2005) was used. It evaluates depression as a transient emotional condition (State) and depression as that propensity to undergo depressive states as a relatively stable personality quality (Trait). It is composed of 42 reagents on a Likert scale that is rated from 1 to 4 points; 20 items comprise the Depression-State scale, this scale identifies depressive symptoms, feelings of sadness related to circumstances of loss that are not precisely structured as depressive disorder, even though they cause discomfort or incapacity; and has by options (1) No, not at all, (2) A little, (3) Moderately (4) A lot; for Depression-Trait there are 22 reactants with Almost Never (1), Sometimes (2), Frequently (3) Almost always (4), this scale identifies the tendency to suffer depressive states and the stability of depressive symptoms. It rates three levels of depression for both scales: high, medium, and low. The Cronbach´s alpha is 0.78 for Depression-State and 0.79 in Depression-Trait.

Process

Participation was voluntary, research was reported and informed consent was sought. Some participants were contacted through the Emergency Service of a Public Hospital of the State of Mexico, the administration of the battery was performed individually or in pairs, when both were present.

Statistic analysis

Frequencies and percentages were obtained for the level of Anxiety and Depression, followed by a Mann-Whitney U test to compare the results of mothers and fathers for the Anxiety-Trait and Anxiety-State scales and for Depression-Trait and Depression-State.

Results

The highest percentage for Anxiety-Trait occurs at the medium level with 46.9%; While for Anxiety-State a high level was found obtaining 87.5%.

Table 1: Percentage of Anxiety Level

Anxiety	Trait	State
High	40.6	87.5
Medium	46.9	6.3
Low	12.5	6.3

As for the Depression-Trait the medium level stood out with 40.6% and for Depression-State it dominated the high level with 81.3%.

Table 2: Percentages of Depression Level

Depression	Trait	State
High	37.5	81.3
Medium	40.6	15.6
Low	21.9	3.1

The results of the comparison between mothers and fathers indicated that there are significant differences in the Anxiety-Trait scale with a significance of 0.013 and in the Depression-Trait scale a significance of 0.026.

Table 3: Comparison of the level of Anxiety and Depression in fathers and mothers

Anxiety				
	Men Rank	Women Rank	Mann-Whitney U	P
Anxiety-Trait	11.54	19.89	59,000	.013 *
Anxiety-State	16.62	15.56	109,000	.749
Depression				
Depression-Trait	12.04	19.55	65,500	.026 *
Depression-State	12.88	18.97	76,500	.071
* It is significant at .05 level				

Discussion

It is interesting to note in this research that parents who have children with suicidal tendencies, already present average levels of Depression and Anxiety as part of their personality, which leaves them vulnerable in the presence of suicidal events, with these attempts increases Anxiety and Depression to high depressive and anxious levels.

This is confirmed as depression continuously binds to anxiety disorders such as panic, post traumatic stress, phobias, obsessive-compulsive or generalized anxiety[16,17].

Biopsychosocial factors specifically affect women, resulting in higher rates of depression in them, on the one hand constant hormonal changes affect the chemistry of the brain that regulate emotions and moods, adds that they face stress at work, home responsibilities, caring for the couple, children and elderly parents, and in some cultures gender violence and socio-economic and political inequalities prevails[18], so they tend to be continually sad, disgruntled without cause, worried and expressing coldness; when a major depression is diagnosed, they are more likely to resort to suicide attempt and express greater negligence and fail to care for themselves and/or their children to the point of not knowing if their child is well or not; Research conducted in depression, exclusively in mothers, have as result that it begins in the postpartum where there is a clear manifestation of symptoms, which affects the affective bond with their children; whereas clinical depression is a risk factor that favors child abuse, demonstrating failures in attention and causing carelessness and accident injuries[19]; Sullivan and Knutson[20], explained that in mothers in rural areas predominate depressive symptoms, high stresses and little social support.

Investigations made in Argentina[21] has found that women tend to suffer most anxiety disorders (for every 10 people attending consultation, about seven are women); due to that there is a genetic, biological, personality, developmental, cultural and personal conditioning predisposition, among others[22]; however the above factors are common to both genders, so they do not clarify the differences between women and men.

Research on depression in men; especially in parents; are so rare that it is difficult to determine the impact of this disorder in the family environment, however the usual criteria that relate to this condition are: over-demanding work or not having it, sexual and/or partner problems, illness and stress chronic[21]. In effect they consume more drugs, alcohol and/or tobacco when they are depressed or angry; others become workaholics, or show reckless and/or risky behaviors, besides to resort to suicide on a larger scale[23].

High levels of anxiety and depression in parents who have a child with suicidal intent may have consequences that prevent them from facing the situation properly, so that being an anxious and/or depressed parent could be considered a risk factor not only on a personal level, but also for the descendants. People with suicidal tendencies, endorse and share the reality of psychic pain, considering it part of their primary experiences acquired in family structure, although not perceived necessarily as hostile, can be experienced as insufficient, distant or indifferent to their emotional needs[24-27].

Therefore determining the phenomenology of the different manifestations of anxiety and depression is essential for adequate interventions not only with suicides but with those in charge of families, as well as to consider the personal way in which the individual evaluates the stressful situations and their resources or possibilities of coping.

It should be noted that although the public health areas find staff and economic limitations for these purposes, research on this topic should not be stopped, instead derived from these results there should be structured a comprehensive and interdisciplinary model of care that allows to open the possibilities of support for the family and the member.

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References

1. Grad, O. (1996). Suicide: How to survive as a survivor? Crisis. The Journal of Crisis Intervention and Suicide Prevention 17(3), 136-142. Retrieved from http://psycnet.apa.org/journals/cri/17/3/
2. World Health Organization. WHO. (2012). Prevención del suicidio: Recursos. Instrumentos dirigidos a grupos específicos sociales y profesionales particularmente relevantes para la prevención del suicidio. Retrieved from http://www.who.int/publications/list/9241545941/es/
3. Bateman, K., Hansen, L., Turkington, D., Kingdon, D. (2007). Cognitive behavioral therapy reduces suicidal ideation in schizophrenia: results from a randomized controlled trial. Suicide Life Threat Behav 37(3), 284- 90.
4. Quintanar, F. (2007). Comportamiento suicida. Perfil psicológico y posibilidades de tratamiento. México: Pax México.
5. Instituto Nacional de Estadística y Geografía. INEGI. (2015). Estadísticas a propósito del Día nacional y mundial para la prevención del suicidio. México.
6. Casullo, M.M. y Scheinsohn, M.J. (2006). Comportamientos suicidas en situaciones de internación psiquiátrica. RIDEP, 22(2), 29-48.
7. Bridge, S. (2006). Suicide prevention - targeting the patient at risk. Australian Family Physician, 35(5), 35-38.
8. Vijayakumar, L. (2004). Suicide prevention: the urgent need in developing countries. World Psychiatry, 3 (3), 158–159.
9. Phillips, M. (2004). Suicide prevention in developing countries: where should we start? World Psychiatry, 3 (3), 156–157.
10. Bertolote, J.M. (2004). Suicide prevention: at what level does it work?. World Psychiatry, 3 (3), 147–151.
11. Spielberger, C. y Diaz, R. (2008). Inventario de ansiedad: Rasgo-Estado. México: Manual Moderno.
12. Martín, M., Grau, J. y Ramírez, V. (2001). El Inventario de Depresión Rasgo-Estado (IDERE): desarrollo y potencialidades. Retrieved from //www.psiquiatria.com/diagnostico47/el-inventario-de-depresion-rasgo-estado-idere-desarrollo-y-potencialidades/#
13. Riquelme, M., Martín, M., Ortigosa, J. y Lechuga, M. (2008). Depresión y envejecimiento: algunas cuestiones de interés respecto a la investigación epidemiológica. Revista Multidisciplinar de Gerontología, 18(1), 76-80.
14. National Comorbidity Survey. (2005). About the National Comorbidity Survey. Family. Retrieved from https://www.hcp.med.harvard.edu/ncs/
15. World Health Organization. WHO. (2017). Media centre. Depression. Retrieved from http://www.who.int/mediacentre/factsheets/fs369/en/
16. Regier, D.A., Rae, D.S., Narrow, W.E., Kaebler, C.T. y Schatzberg, A.F. (1998). Prevalence of anxiety disorders and their comorbidity with mood and addictive disorders. British Journal of Psychiatry, 173 (Suppl. 34): 24-28.
17. Devane, C.L., Chiao, E., Franklin, M. y Kruep, E.J. (2005). Anxiety disorders in the 21st century: status, challenges, opportunities, and comorbidity with depression. American Journal of Managed Care, 11(Suppl. 12): S344-353.
18. Rubinow, D.R., Schmidt, P.J. & Roca, C.A. (1998). Estrogen-serotonin interactions: implications for affective regulation. Biological Psychiatry, 44(9): 839-850.
19. Pérez, J.R., Ampudia, A., Jiménez, F. y Sánchez, G. (2005). Evaluación de la Personalidad Agresiva y Violenta de madres maltratadoras y mujeres delincuentes. RIDEP, 20 (2), 35-58.
20. Sullivan, P. & Knutson, J. (2000). The prevalences of disabilities and maltreatment among runaway children. Child abuse and Neglect, 24 (10), 1275- 1288.
21. Centro de Investigaciones Médicas en Ansiedad. CentroIMA. (n.d.). Información. Estadísticas de interés. Retrieved from http://www.centroima.com.ar/informacion_estadisticas.php
22. National Institute of Mental Health. (2012). Men and depression. Retrieved from https://infocenter.nimh.nih.gov/pubstatic/SP%2012-5300/SP%2012-5300.pdf
23. Cochran, S.V. y Rabinowitz, F.E. (2000). Men and Depression: clinical and empirical perspectives. San Diego: Academic Press.
24. Shneidman, E. (1977). The psychological autopsy. In: Guide to investigation and reporting of drog-abuse deaths. Rockeville: Gottschalk & McGuire.
25. Lester, D. (1997). Making sense of suicide: An in-depth look at why people kill themselves. USA: Charles Press.
26. Leenaars, A. & Lester, D. (1996). Suicide and the unconscious (1 ed.). New Jersey: Jasson Aronson Inc.
27. Pfeffer, C. (1981). Parental suicide, an organizing event in the development of latency age children. Suicide and Life-Threatening Behavior, 11(1), 43-49.