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Risk Factors for the Development of Suicidal Behavior in Patients with Withdrawal Syndrome in Alcohol Dependence

Факторы риска формирования суицидального поведения у пациентов с синдромом отмены при алкогольной зависимости

Abstract

The article presents the results of the study, the purpose of which was to determine the risk factors for the development of suicidal behavior in patients with withdrawal syndrome in alcohol dependence. All patients underwent a psychodiagnostic study using the Hamilton Depression Rating Scale (HDRS, HAM-D, 1959), designed to assess the severity of depressive symptoms.

The study showed that obligatory symptoms of depression in patients with withdrawal syndrome in alcohol dependence included marked manifestations of insomnia with impairment of the entire sleep cycle, symptoms of dysfunction of the gastrointestinal tract with loss of appetite and obsessive-compulsive disorders, which indicated disorganization of mental and somatic activity with an impairment of vital functions.

Risk factors for suicidal intent in patients with withdrawal syndrome in alcohol dependence include such depressive symptoms as depersonalization and derealization, severity of the feeling of guilt, insomnia with early morning awakenings and mental anxiety accompanied by tension, irritability and anxiety. The symptom of the loss of libido plays the role of an anti-risk factor.

It has been established that the "targets" for the prevention of suicidal behavior in patients with withdrawal syndrome with alcohol dependence are: relief of anxiety, feelings of guilt, feelings of depersonalization and derealization; normalization of sleep.

Keywords: patients, alcohol dependence, withdrawal syndrome, depressive manifestations, suicidal intentions.

Резюме

В работе изложены результаты исследования, целью которого было определение факторов риска формирования суицидального поведения у больных с синдромом отмены при алкогольной зависимости. Всем больным было проведено психодиагностическое исследование с использованием Шкалы оценки депрессии Гамильтона (HDRS, HAM-D, 1959), разработанной для оценки степени выраженности депрессивной симптоматики.

Выявлено, что облигатными симптомами при депрессии у больных с синдромом отмены при алкогольной зависимости являются выраженные проявления бессонницы с нарушением всей структуры сна, симптомы нарушения функции желудочно-кишечного тракта с потерей аппетита и обсессивно-компульсивные расстройства, что указывает на дезорганизацию психической и соматической деятельности с нарушением витальных функций.

Обозначены факторы риска возникновения суицидальных намерений у больных с синдромом отмены при алкогольной зависимости, которыми являются такие симптомы депрессии, как ощущение деперсонализации и дереализации, выраженность чувства вины, бессонница с ранними утренними пробуждениями и психическая тревога, сопровождающаяся напряжением, раздражительностью и беспокойством. Симптом утраты либидо выполняет роль фактора «антириска».

Установлено, что «мишенями» профилактики суицидального поведения у больных с синдромом отмены при алкогольной зависимости являются: купирование тревоги, чувства вины, ощущений деперсонализации и дереализации; нормализация сна.

Ключевые слова: пациенты, алкогольная зависимость, синдром отмены, депрессивные проявления, суицидальные намерения.

■ INTRODUCTION

The incidence of mental and behavioral disorders in Ukraine is characterized by prevalence of impairments caused by the use of psychoactive substances [1]. Therefore, the issue of alcohol dependence to this day remains relevant for our country [2, 3].

The problem of prevalence of alcohol dependence is extremely relevant not only in Ukraine but also throughout the world. According to the WHO, the world average alcohol consumption is 6.1 liters per person per year, and in Ukraine this figure is one of the highest in the world (15.6 liters per person per year). According to the WHO, alcohol dependence is the cause of death of more than 3 million people a year in the world [4]. In Ukraine, about 40 thousand people die every year from alcohol abuse. There is a direct link between the influence of alcohol on the prevalence of social and stress disturbances in the society, mortality rates and mental health of the population [5, 6]. Official statistics show that up to 900 thousand patients with alcohol dependence are registered in medical institutions [7], but the real figure is 3–5 times higher [5, 7, 8].

Formation of depressive disorders associated with alcohol dependence is an integral part of clinical manifestations of chronic alcoholism [9–11]. The existing postulate "all depressive disorders are suicidal" increases the relevance of studying suicidal behavior in patients with alcohol dependence. Moreover, Ukraine belongs to the states with a high level of suicidal activity [12] and according to foreign authors, the problems of suicide remain relevant throughout the world [13, 14].

It should be noted that there have been a lot of studies describing patients using psychoactive substances, including the study of depressive manifestations in people with alcohol dependence, highlighting the importance of screening studies to identify depressive states at the primary care level of medical care [9, 15, 16]. Additional arguments are presented in favor of the hypothesis, according to which alcoholic suicide is predominant

among men [17]. In general, the study of patients with alcohol dependence with suicidal behavior dictates the need to use differentiated approaches in pharmacotherapy, psychotherapy and prevention [9, 18–20].

■ PURPOSE

Determination of risk factors for the formation of suicidal behavior in patients with withdrawal syndrome in alcohol dependence.

■ MATERIALS AND METHODS

The study involved 42 male patients with withdrawal symptoms in alcohol dependence. The age of the examined patients ranged from 43 to 58 years. The criteria for the inclusion of patients in the study were: diagnosed "condition of withdrawal, uncomplicated (F10.30)", which was the direct cause of the visit to an addiction medicine specialist due to marked severity of the disorder; symptoms of depression and/or suicidal thoughts; alcohol history of the examined patients ranged from 7 to 12 years. The exclusion criterion was the presence of psychotic symptoms. The study was conducted in accordance with the law on psychiatric care with the voluntary written consent of patients. As part of diagnostic measures, all patients underwent a psychodiagnostic study using the Hamilton Depression Rating Scale (HDRS, HAM-D, 1959), designed to assess the severity of depression symptoms. The results were evaluated using the standard algorithm [21]. The scale contains 21 items, the first 17 were used to quantify the patient's condition.

Statistical processing of data was carried out mainly by means of software Statistica (TIBCO Software Inc., USA). The description of qualitative data (the number of cases of manifestation of certain symptoms of depression) is presented in the form of frequency (proportion) (%) of the occurrence of a symptom in a sample or subgroup of patients ± its standard error (%). The score values for assessing the severity of depression of $HDRS_{17}$ are presented as Me [LQ; UQ], where Me is the median, LQ is the lower quartile, UQ is the upper quartile.

To identify statistically significant relationships between the development of suicidal intentions in patients and individual symptoms of depression, two-way contingency tables of these indices were analyzed, while the significance of relationships in contingency tables was evaluated on the basis of Pearson c^2 (Chi-square) test.

To assess the strength of the relationship between the severity of suicidal intentions and the severity of other symptoms of depression, a correlation analysis was performed. A rank Kendall Tau (t) correlation coefficient was used.

Comparison of $HDRS_{17}$ severity in two groups of patients, depending on whether they had thoughts of suicide, was compared using the Mann-Whitney two-samples test (in the article, exact and approximate statistics of the criterion are marked as M-W U, Z)

All calculations were carried out at a confidence probability of 95%, respectively, when obtaining calculated significance levels (p) less than 0.05, the results were considered statistically significant.

RESULTS AND DISCUSSION

Depression was detected in all the examined patients: in (2.38±2.35)% of cases – a mild depressive episode with somatic symptoms (F32.01), in (97.62±2.35)% – a moderate depressive episode with somatic symptoms (F32.11). The revealed range of clinical manifestations and the degree of their manifestation on the Hamilton scale served as the basis for studying their structure.

Analysis of the results showed that depressive mood, revealed by a direct question during a conversation with a patient, was observed in (47.6±7.7)% of the examined patients; (28.6±7.0)% had actively expressed and complained of frustration and hopelessness; and in (7.1±4.0)% of patients helplessness and reduced self-esteem were spontaneously expressed both in the complaints of the patients, and were manifested in facial expressions, voice modulations, and body position. Feeling of guilt and self-deprecation were noted in (59.5±7.6)% of patients; statements about own guilt with reflections on past mistakes in (31.0±7.1)% of cases.

Half of the examined patients (50.00±7.7)% had suicidal intentions with thoughts that they should not continue living; (7.1±4.0)% of patients were in a more severe state: desire for death or thoughts on the possibility of death.

Complaints of episodic difficulty in falling asleep (longer than ½ hour) were presented by (78.6±6.3)% of patients; inability to fall asleep every night was reported by (21.4±6.3)% of the examined patients. Restless sleep at night was observed in (14.3±5.4)% of patients; (85.7±5.4)% complained of multiple awakenings throughout the night, and the same number of patients experienced an early awakening in the morning, followed by further falling asleep. The final early morning awakening was noted in (14.3±5.4)% of patients.

According to the degree of working efficiency and activity the examined patients were distributed as follows: (31.0±7.1)% of patients expressed their thoughts on their own inconsistency, felt fatigue and weakness associated with the activity; (40.5±7.6)% of patients experienced a clear loss of interest in the activity, expressed it directly in the complaints and showed indirectly through apathy and indecision; additional efforts were required to activate the work; in (28.6±7.0)% of the examined patients, there was a decrease in real-time manifestation of activity or a decrease in productivity.

Psychic inhibition (slowness of thinking and speech, impaired ability to concentrate, decrease in motor activity) was noted in (47.6±7.7)% of patients in the form of mild retardation in conversation; 42.9±7.6% had a noticeable inhibition in the conversation and (9.5±4.5)% had marked difficulties during the survey.

Agitation (anxiety excitation) in the form of general anxiety was noted in (47.6±7.7)% of patients, in (45.2±7.7)% of patients was manifested by restless movements of hands with "shuffling" of hair and in (7.1±4.0)% of cases general mobility and restlessness.

Mental anxiety with subjective tension and irritability was observed in (52.4±7.7)% of patients, in (45.2±7.7)% anxiety developed over an insignificant occasion and in (2.4±2.3)% of cases anxiety was displayed in the facial expressions and speech.

Somatic anxiety was physiologically manifested in the examined patients by the disorders of internal organs: gastrointestinal (dry mouth, flatulence, dyspepsia, diarrhea, belching, spastic pain); cardiovascular (tachycardia, headaches); respiratory (shortness of breath, hyperventilation); polyuria and hyperhidrosis. Weak somatic anxiety was observed in (40.5±7.6)% of patients; moderate somatic anxiety in (52.4±7.7)% of patients and severe somatic anxiety in (7.1±4.0)% of cases.

In the general structure, gastrointestinal somatic symptoms with a feeling of heaviness in the abdomen and loss of appetite, but with eating without strong coercion were observed in (92.9±4.0)% of patients and (7.1±4.0)% of patients felt the need to take laxatives or drugs for the relief of gastrointestinal symptoms, and food intake was carried out only with persistent coercion.

General somatic symptoms, such as heaviness and pain in the limbs, head, back, muscle pain, feeling of loss of energy or loss of strength were noted in (97.6±2.4)% of patients and in isolated cases – (2.4±2,3)% – the above symptoms were manifested in marked intensity.

Mild genital symptoms accompanied by loss of libido were experienced by (9.5±4.5)% of the examined patients.

Hypochondriac manifestations with self-absorption were observed in (73.8±6.8)% of patients, and (14.3±5.4)% of patients expressed excessive concern about their health.

The assessment of weight loss of the examined patients was carried out according to medical history, according to which the probable weight loss due to present disease was observed in (64.3±7.4)% of patients.

One of the important criteria for the mental state of any patient is the critical attitude towards their illness; in this study (38.1±7.5)% of patients were aware that they suffered from depression or some other disease; (59.5±7.6)% regarded their state as a result of the impact of various pathogenic factors: low-quality food, climate, overworking, viral infections, the need for rest and a complete absence of awareness of the disease was found in (2.4±2,3)% of cases.

Daily fluctuations of depressive symptoms with aggravation in the evening occurred in (40.5±7.6)% of patients; signs of depersonalization and derealization with a sense of the unreality of the environment were experienced by (61.9±7.5)% of patients; suspiciousness and ideas of attitude towards others showed (69.0±7.1)% and (2.4±2.3)% of patients, respectively. Mild obsessional and compulsive disorders were observed in the majority of examined patients in (95.2±3.3)% of cases.

The results obtained in the process of the study differed in their diversity, which was the rationale for grouping them. The most common symptoms in the examined patients (>85%) comprised general somatic symptoms, namely heaviness and pain in the limbs, head, back, muscle pain, feeling of loss of energy or loss of strength; gastrointestinal symptoms with loss of appetite; obsessive compulsive disorder; manifestations of insomnia were characterized by an impairment of the entire sleep cycle, and sleep disorders were severe. It is noteworthy that the above symptoms reflect disorganization of both mental and somatic activity with impairment of vital functions.

The next group is represented by such symptoms as depressive mood, manifested by frustration and hopelessness; feeling of guilt with ideas of

self-deprecation; suicidal intent with the feeling that life is not worth it; difficulty falling asleep; slight retardation in conversation; agitation with general anxiety and stereotyped hand movements; internal stress and irritability on minor occasions, somatic anxiety with an imbalance in the functioning of the cardiovascular system, gastrointestinal tract, respiration; suspicion in relation to others, symptoms of depersonalization and derealization with a sense of unreality of the environment; hypochondriac manifestations with body-oriented sensations; all of the above was accompanied by weight loss and lack of a critical attitude towards their state. The range of prevalence of these symptoms in the examined patients was 45–85%.

Less frequent impairments (prevalence range from 20 to 45%) were more severe symptoms of depression and anxiety, reduced performance and activity to the level of psychic inhibition. Daily fluctuations were manifested by deterioration in the evening; patients retained formal critical thinking.

In order to clarify the factors of the development of suicidal behavior, the process of statistical analysis implied the study of the connection of the above symptoms of depression with the severity index of suicidal manifestations in the examined patients. The correlation analysis (Tab. 1) revealed five symptoms of depression with statistically significant correlations with the severity of suicidal intentions. Thus, manifestations of depersonalization and derealization positively correlated with the degree of suicidal intentions (t=0.45, p=0.000027). Slightly smaller positive correlations are observed with the severity of mental anxiety (t=0.25, p=0.020891) and the severity of late insomnia (t=0.23, p=0.032337). This allows us to formulate an assumption that the elimination of feelings of depersonalization and derealization, reduction of internal stress and mental anxiety and normalization of sleep (especially in the early morning hours) to some extent contributes to the de-actualization of suicidal behavior in patients with alcohol withdrawal syndrome.

Negative correlations of the severity of suicidal intentions were found for symptoms associated with loss of libido (t=–0.35, p=0.001092) and the severity of guilt felt by the patient (t=–0.32, p=0.003104). Such patterns suggest that the existence of problems with sexual potency, to some extent, switched the examined patients from thoughts about suicide. Consideration of this interdependence is possible from the standpoint of the protective mechanisms of mental activity, when the latter (instinct) prevails in the structure of the cortical-subcortical interaction. The negative correlation of the indicator of increased feeling of guilt in this category of patients, obtained in the course of the study, should testify in favor of reducing the severity of suicidal intentions. However, the hypothetical version contradicts to practical experience. According to the authors, this phenomenon deserves attention and further study, since the symptom of "feeling of guilt" is highly dangerous for patients with suicide ideation.

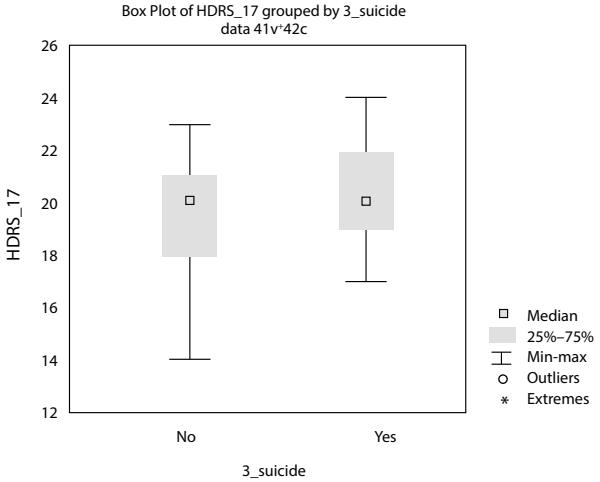
At the second stage of the study, the patients were divided into two groups. The first group consisted of those who did not show any suicidal intentions (18 men, (42.9±7.6)%. The second group included 24 patients (57.1±7.6)%) with varying degrees of suicidal activity. The values of the quantitative severity of depression $HDRS_{17}$ (the sum of the points on the

Table 1
T-Kendal's correlation of the degree of expressiveness of suicidal intentions with other symptoms of depression on the Hamilton scale obtained from the enrolled patients

Pair of Variables	Kendall Tau Correlations (data)				
	MD pairwise deleted Marked correlations are significant at p <.05000				
	Valid N	Kendall Tau	Z	p-value	p-exact 1-tailed
3_Suicide & 1_Depressed mood	42	–0.082047	–0,76558	0.443927	–
3_Suicide & 2_Feelings of guilt	42	–0.316927	–2,95724	0.003104	–
3 Suicide & 4 Insomnia-Initial	42	0.148660	1.38714	0.165398	–
3 Suicide & 5 Insomnia-Middle	42	0,128446	1.19853	0,230712	–
3_Suicide & 6_Insomnia-Delayed	42	0.229367	2,14023	0.032337	–
3 Suicide & 7 Work and Interests	42	–0.050347	–0.46979	0,638507	–
3 Suicide & 8 Retardation	42	0.000000	0,00000	1,000000	–
3_Suicide & 9 Agitation	42	0.088710	0.82775	0.407812	–
3_Suicide & 10_Anxiety-Psychic	42	0.247556	2,30994	0.020891	–
3_Suicide & 11_Anxiety-Somatic	42	0,186614	1,74129	0,081632	–
3 Suicide & 12_Gasrtointenstinal somatic symptoms	42	–0,137126	–1,27952	0.200715	–
3 Suicide & 13_General somatic symptoms	42	–0.168468	–1.57197	0.115957	–
3 Suicide & 14_Genital symptoms	42	–0.349983	–3.26569	0.001092	–
3 Suicide & 15 Hypochondriasis	42	–0,210016	–1.95966	0.050036	–
3 Suicide & 16_Weight loss	42	0,053602	0,50016	0.616962	–
3 Suicide & 17_Insight	42	–0.175506	–1,63765	0.101496	–
3 Suicide & 18 Diurnal variation	42	0.098110	0,91547	0.359946	–
3 Suicide & 19 Depersonalization&Derealization	42	0.449553	I 4,19478	0.000027	–
3 Suicide & 20 Paranoid symptoms	42	–0.045578	–0.42529	0.670629	–
3 Suicide & 21 Obsessional symptoms	42	0.045227	0.42201	0.673018	–
3 Suicide &HDRS 17	42	0.151396	1,41268	0.157750	–
3_Suicide & Depression Severity	42	0.125876	1.17455	0.240176	–

first 17 points of the Hamilton scale) were compared in two groups (Figure), but it was not informative in terms of detecting the presence of suicidal intentions (which confirmed once again the assumption that the danger of suicide does not depend on the severity of depression), because there were no statistically significant differences in its values between the two compared groups (M-W U=176, Z=1.01714, p=0.309088>0.05). In the first group of patients (without suicidal intent), the $HDRS_{17}$ depression severity index ranged from 14 to 23 points and averaged 20 [18; 21] points. In the second group of patients with thoughts about suicide, it varied from 17 to 24 points and averaged 20 [19; 22] points.

The connection of suicidal intent with other symptoms of depression was investigated. At the same time, the two-way contingency tables of the sign "presence of suicidal intentions" with signs responsible for the manifestation of certain depressive symptoms were analyzed. The results of the analysis (Table) confirmed the presence of statistically significant associations of the development of suicidal intentions with symptoms of depersonalization and derealization, with genital symptoms (loss of libido) and a feeling of guilt.



Box and whisker plot of the $HDRS_{17}$ depression severity index values in two patient groups: without suicidal intent and with such

Table 2
The prevalence of symptoms of depression in the examined patients, depending on the presence of suicidal intent

Indicator	Indicator value	Prevalence (M±m)% of the symptom in two groups of patients		The results of verification of statistical significance of the relationship of the indicator with the presence of suicidal intents
		Group 2 (with suicidal intent)	Group 1 (without suicidal intent)	
Depressive mood	0	(25.0±8.8)%	(5.6±5.4)%	χ^2=3.656. p=0.30114>0.05
	1	(37.5±9.9)%	(61.1±11.5)%	
	2	(29.2±9.3)%	(27.8±10.6)%	
	3	(8.3±5.6)%	(5.6±5.4)%	
Feeling of guilt *	0	(12.5±6.8)%	(5.6±5.4)%	χ^2=4.80. p=0.0285<0.05
	1	(70.8±9.3)%	(44.4±11.7)%	
	2	(16.7±7.6)%	(50.0±11.8)%	
Early insomnia	1	(70.8±9.3)%	(88.9±7.4)%	χ^2=1.992. p=0.15818>0.05
	2	(29.2±9.3)%	(11.1±7.4)%	
Middle insomnia	1	(8.3±5.6)%	(22.2±9.8)%	χ^2=1.620. p=0.20304>0.05
	2	(91.7±5.6)%	(77.8±9.8)%	
Late insomnia	1	(79.2±8.3)%	(94.4±5.4)%	χ^2=1.961. p=0.16144>0.05
	2	(20.8±8.3)%	(5.6±5.4)%	
Working efficiency and activity	1	(29.2±9.3)%	(33.3±11.1)%	χ^2=0.705. p=0.70302>0.05
	2	(45.8±10.2)%	(33.3±11.1)%	
	3	(25.0±8.8)%	(33.3±11.1)%	
Psychic inhibition	1	(50.0±10.2)%	(44.4±11.7)%	χ^2=0.9625. p=0.61801>0.05
	2	(37.5±9.9)%	(50.0±11.8)%	
	3	(12.5±6.8)%	(5.6±5.4)%	
Agitation	1	(41.7±10.1)%	(55.6±11.7)%	χ^2=2.098. p=0.35030>0.05
	2	(54.2±10.2)%	(33.3±11.1)%	
	3	(4.2±4.1)%	(11.1±7.4)%	

Continuation of the table 2

Mental anxiety	1	(41.7±10.1)%	(66.7±11.1)%	χ^2=2.964. p=0.22717>0.05
	2	(54.2±10.2)%	(33.3±11.1)%	
	3	(4.2±4.1)%	(0.0±0.0)%	
Somatic anxiety	1	(33.3±9.6)%	(50.0±11.8)%	χ^2=1.196. p=0.54997>0.05
	2	(58.3±10.1)%	(44.4±11.7)%	
	3	(8.3±5.6)%	(5.6±5.4)%	
Gastrointestinal somatic symptoms	1	(95.8±4.1)%	(88.9±7.4)%	χ^2=0.748. p=0.38715>0.05
	2	(4.2±4.1)%	(11.1±7.4)%	
General somatic symptoms	1	(100.0±0.0)%	(94.4±5.4)%	χ^2=1.366. p=0.24253>0.05
	2	(0.0±0.0)%	(5.6±5.4)%	
Genital symptoms *	0	(100.0±0.0)%	(77.8±9.8)%	χ^2=5.895. p=0.01519<0.05
	1	(0.0±0.0)%	(22.2±9.8)%	
Hypochondria	0	(16.7±7.6)%	(5.6±5.4)%	χ^2=2.466. p=0.29137>0.05
	1	(75.0±8.8)%	(72.2±10.6)%	
	2	(8.3±5.6)%	(22.2±9.8)%	
Loss of weight	0	(33.3±9.6)%	(38.9±11.5)%	χ^2=0.138. p=0.71001>0.05
	1	(66.7±9.6)%	(61.1±11.5)%	
Critical attitude to the disease	0	(45.8±10.2)%	(27.8±10.6)%	χ^2=2.484. p=0.28887>0.05
	1	(54.2±10.2)%	(66.7±11.1)%	
	2	(0.0±0.0)%	(5.6±5.4)%	
Daily fluctuations	0	(54.2±10.2)%	(66.7±11.1)%	χ^2=0.667. p=0.41408>0.05
	2	(45,8±10,2)%	(33,3±11,1)%	
Depersonalization and derealization *	0	(16.7±7.6)%	(66.7±11.1)%	χ^2=10.904. p=0.00096<0.05
	1	(83.3±7.6)%	(33.3±11.1)%	
Paranoid symptoms	0	(33.3±9.6)%	(22.2±9.8)%	χ^2=1.542. p=0.46252>0.05
	1	(62.5±9.9)%	(77.8±9.8)%	
	2	(4.2±4.1)%	(0.0±0.0)%	
Obsessive and compulsive	0	(4.2±4.1)%	(5.6±5.4)%	χ^2=0.044. p=0.83432>0.05
	1	(95.8±4.1)%	(94.4±5.4)%	
Depression Severity (based on $HDRS_{17}$)	moderate	(16.7±7.6)%	(27.8±10.6)%	χ^2=0.864. p=0.64915>0.05
	severe	(66.7±9.6)%	(61.1±11.5)%	
	very severe	(16.7±7.6)%	(11.1±7.4)%	

Notes: M is the prevalence of the sign in the group (%),
m is the standard error;
* is statistical significance due to the presence of suicidal intentions;
χ^2 is the calculated value of criterion c^2statistics,
p – achieved level of significance.

The obtained frequency distribution of the occurrence of depressive symptoms in groups of patients indicates a direct link between the symptoms of depersonalization and derealization with suicidal intentions. Indeed, the majority of these symptoms are present in the group of suicidal patients, while in the majority of patients from the group who do not show suicidal tendencies, symptoms of depersonalization and derealization are not observed. This relationship allows us to consider the presence of symptoms of depersonalization and derealization in patients with withdrawal syndrome in alcohol dependence as diagnostic potential of hidden suicidal intentions.

The interrelation of suicidal intentions with genital symptoms revealed in the process of research is not so unambiguous. According to our research, the symptom of loss of libido was observed only in 20% of patients in the group without suicidal intent. It should be assumed that the presence of problems with libido in patients with withdrawal syndrome with alcohol dependence is mutually exclusive for the occurrence of suicidal intentions. However, this assumption requires clarification by conducting a larger study.

Thus, the analysis of the results of the study showed a statistically significant relationship between the occurrence of suicidal intentions in the examined patients with other symptoms of depression, namely, depersonalization and derealization, severity of the feeling of guilt, insomnia with early morning awakenings and mental anxiety with tension, irritability and discomfort.

■ CONCLUSIONS

1. Obligatory symptoms of depression in patients with withdrawal syndrome in alcohol dependence include marked manifestations of insomnia with a disruption of the entire sleep cycle, symptoms of dysfunction of the gastrointestinal tract with loss of appetite and obsessive-compulsive disorders, indicating a disorganization of mental and somatic activity with an impairment of vital functions.
2. The risk factors for suicidal intent in patients with withdrawal syndrome in alcohol dependence include depressive symptoms such as depersonalization and derealization, feelings of guilt, insomnia with early morning awakenings and mental anxiety accompanied by tension, irritability and anxiety. The symptom of the loss of libido plays the role of an anti-risk factor.
3. The "targets" for the prevention of suicidal behavior in patients with withdrawal syndrome in alcohol dependence are: relief of anxiety, feelings of guilt, feelings of depersonalization and derealization; normalization of sleep.

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