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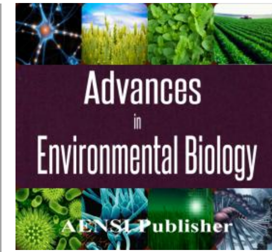

Psychological Profiles and Demographic of Suicide Attempters Compared with Normal

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ABSTRACT

The aim of study is comparison between psychological profiles and the specifications of population who committed suicide with ordinary people. The survey has been done by comparison-cause method. The statistic society of this survey contains all the people who have committed suicide and hospitalized in Loghman & Imam Khomeini hospitals in Tehran during 2012. So 60 people committed suicide and hospitalized in Loghman & Imam Khomeini and 60 other who had not have experienced committing suicide were selected by available sampling from various geographical zones of Tehran. The participants were compared by MMPI questionnaire and the demographical questionnaire created by researcher. For analyzing the data of psychological profile, the test of "MANOVA" was applied and for comparing the differences of two groups, two variable chi square tests were applied. The results has indicated that there is a meaningful difference between the two groups and in all sub-scales the suicide committers are in higher levels than the ordinary people and among the demographic specifications of two groups, there is a meaningful differences such as education level and age of two groups but there is no meaningful differences between the sex and the marital status.

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INTRODUCTION

Committing suicide and suicide is an affair related to public health and anti-social treatment [9]. Aristotle knows committing suicide as an action which one does for destroying himself but this action is not for sacrifice. In the other word, one does not commit suicide for veteranism [1]. Committing suicide is a wise and conscious action of destroying himself for several different motives. According to the world health organization report one of ten reason of death is committing suicide with statistic of annually 400000 deaths. This organization estimated every three second a committing suicide happens and every one minute a suicide is done. [39]

The searches indicates that the most of committing suicide happens in Japan, America& east of Europe [60]. According to the latest estimations of Death registration system, daily 11 people die of committing suicide in Iran. Iran is the third country in the world after India and China which its women's successful committing suicide is increasing and becoming more than men's statistic. [32] Committing suicide is a phenomenon which is made of different factors that can be classified in three categories of: Physiological, mental and social. Among these the psychological-social factors have the most interest. Despite the emphasis on the relationship among the three categories of above reasons in the incidence of suicide and Likelihood of being in a number of causes of this problem, most of the researches confirm the relation between these factors and introduce the mental diseases as the most important causes of suicide. Different social and psychological paradigms investigate the concept of suicide form various aspects. Freud believes that committing suicide is indicating a killed hope for killing a lost object and it is a kind of compensate. Sullivan knows the committing suicide as a disability for solving enter-personal psychological disorders. [22] Min Jer knows the desire to death for the one who commit suicide as a relaxing action which he/she has achieved them via social tensions (social and ethical Limitations which prevent the aggression and sexual energy from releasing and finally create internal tension) and Emil Durekhayem (1858-1917) in his popular act named "suicide" knows it as an social concept and define it such: «

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Committing suicide is any kind of death which is the direct and indirect result of victim's action with positive or negative attitude which leads to that result.

The results of survey indicates that the most of people who commit suicide has a recognizable psychological disorder. [24] It is estimated that 90 percent of people who committed suicide in that period had psychological disorders. eshnidman believes that in any situation committing suicide is made by psychological pain or "mental" pain and death by committing suicide is escaping from a pain.

Beyrami & his colleague's study [6] indicated that there is a meaningful relation between psychological disordering and committing suicide. Many researchers consider the suicide related to the behavioral differences [55] which concern to some personality specifications and since these personality specifications are stable, they can relate to one's interest to suicide. [45] Committing suicide mostly happens in autonomic, anxious, people who has problems in social communications [24].

Among psychological personality disorders: borders differences, anti-social, vainglorious, persecutor, anxious, depressed and schizophernia disordering have the most ability to commit suicide. [46,36,63,48,2].

"Analyzing the specifications of ones who committed self-firing" is the subject of study which had been done by Zamani& colleagues [64] and it was shown that most of them who have attempted suicide victims single, female, less educated or illiterate, housewives aged 10-30 years. The results showed significant differences between the two groups of committers and ordinary people, in terms of background personal characteristics such as hypochondriasis, depression, hysteria and mental deviations. But there is no difference between the two groups in terms of personal characteristics such as paranoid schizophrenia, mental fatigue and hypomania. Balhara&Verma [33] in a study indicated the male sex and being single increases the risk of committing suicide through the patients of schizophernia and also depression and its characteristics is accompanied with the increase in this risk.

A good relationship was found among the understanding to patient, feeling of hopelessness, and increase in the risk of suicide. Dell Osso&Colleagues [37] founded in their search the following results: The participants who showed a high probability of suicide (Thoughts, plans, intention) included women, patients with psychological disorders and especially behavioral disorders, schizophernia or the fear disorders, and sexual obsession permanent and forever. The Ascosta&Colleagues's study indicated that the mental disorders symptoms quality and having a good understanding of that can play an important role as a marker or a regulator of suicide risk in the schizophernic patients.

Max Maskouwitz's research [47] named "the relation between the intellectual-mental obsession and suicide behavior" indicated that there is a positive relationship between lots of OCD symptoms and committing suicide and the depression signs play a medium's role between OCD symptoms and suicide. Nok, Sampson&Kessler's study indicated that the psychological disordering, anxiety and drug addiction is more common among ones who committed suicide. In a survey "The suicide thoughts in schizophrenic patients" which had done by Sisk Hocaglo and his colleagues in 2009 the results of study indicated that 31.6% of these people between patients thought about suicide. The negative factors were significantly high in most of them and the group with suicide mentality had lower reasons for living in comparison to the group without these thought. In conclusion in investigation of background of committing suicide, depression and hopelessness between these patients have an important role in obstruction of suicide commitment. Shabani& his colleagues [54] indicated that the sex is the only demographic factor with significant statistic between the two groups of testers. In addition coexistence with anxious disorderings, and also common psychological events are significantly different in two groups.

Rimer's study showed that the reason of 15% of death for patients with bipolar disorders and about half of them have experienced suicide in their lives. Most of the suicide treatments of these patients were during the harsh activities of the basic anxiety and less in emotional mixed period or boring love period.

On the other hand the suicide treatment rarely happens in love happiness, light madness or swank feeling and this shows that the suicide treatment in bipolar patients is a phenomenan dependent on patients mood and extremity.

Ziyayi&colleague's survey indicated some factors such being female, Young, Singleness, Higher education, living in suburbs, narcotics, having physical complains and othe psychological problems are concerning to committing suicide. The survey "The relations between criminal adjectives and committing suicide of criminals" which done by Duglass and Colleagues in 2008 on 682 men criminals showed that the anti-social personality disordering and the specifications of lifestyle in very low anti-sociality predict the treatment related to committing suicide. High negative affectionate and low limitation in relation with social disordering and anti-social behaviors related to suicide acts as a medium. The traits of life style in anti-sociality have independent prediction affection. The Rehmir's study indicated the treatments of committing suicide in mental disorderings are a mode dependent factor and the mixed mode of depression can significantly lead to suicide. This can also be right in bipolar unknown depression cases. In the research by Towat with the article "Analyzing the semimetal of patients with unsuccessful suicide in referring to Pelonomi Hospital and the analyze of mentality and treatment from May to April 2006 the results indicated that most of the patients (68.9%) of patients were women that their average age was 22. From the main factors of their intention to suicide we can point to hard

relations (55.4%), Financial problems (22.9%), psychological problems (22.1%), Arguments (19.1), Abuse (sexual, psychological profile, physical), Low-self-confidence, hopeless, valueless, despise(16.7%) and ultimately the life modifications. Maurizio Pompeii's &colleagues indicated that some personality disordering have direct relation with suicide. Fergussen & Liskeni [40], Budemburg& Colleagues, Rey Jaks [51], Tomsson& Colleagues [56] founded that there is meaningful relationship between different antisocial treatments and suicide and Hodson & Havton & Shafered's study [43] indicated that there is a strict and powerful relation between depression and suicide.

The analyze about result of researches inside and outside the country about the role of gender in as a dangerous factor in committing suicide, indicated that suicide is more among females rather than males. [11,10,15,17,58].

Although, Panaghi & colleagues, National Center of Injuries' Prediction and Control [49] indicated in their study that suicide is more in men compared to women. The reviews in last two decades in the field of Epidemiology of suicide in Iran show that the highest rate of suicide concern teenagers and the youth. [10]

Committing suicide is the second reason of death in the range of year 21-30 after diseases and happenings and killings. [20,27,16,7]. Also researches indicate that marriage has a significant role in suicide. Khademi & Colleagues [4], all showed that marriage decrease committing suicide a lot and suicide is more among singles. The rate of suicides is 11 in 100,000 among married. In which this rate is double in singles and 0.024 percent and 0.040 percent more in divorced and widowers. [44] Regarding to represented research and theorical fundamentals that says committing suicide in psychological disorders has a high chance of prediction and prevention. Accurate and systematic investigation of psychological profile of people who committed suicide helps a lot for identifying ones who are due to commit suicide. In addition with respect to important role of demographic variables on suicide, the present research is done to compare the characteristic and demographic features of committers to suicide with ordinary people.

-The Course:

Regarding to the aim of study, this survey is a kind of applicable study and is performed in implementation (cause-comparison).

-The statistic society, sample and the method of sampling:

The statistic society of this research is containing all who committed suicide and hospitalized in Tehran hospitals, 60 people of these selected via available sampling from Imam Khomeini, Loghman Hospitals and then 60 ordinary ones were selected who had not the suicide experience. They were selected and investigated after classification with suicide committers via randomly multistage sampling from different geographical parts of Tehran.

-Device:

In this study two questionnaires were applied. The first one is researcher made for analyzing Demographical specifications (Age, Gender, marital status, Education) and seconds the test of MMPI with 71 questions. MMPI for the first time was introduced by Hatawi & Mackeley in 1943 were allied differently already. One of the forms of this exam is 71 question which is standardized by Baraheni & Okhovvat and it is near three decades which is used to analyze mental disorders. This test has three credits (K,F,L) and eight clinical factors (Hs , D, Hy, Pd, Pa, Pt, St, Ma).

-Findings of Survey:

Defining data: Abundance distribution and the percent of group samples is presented according to demographical variables of gender, population, education, age and marital status in Table 1.

Table 1: Distribution of factors and percentage of group sample according to demographical variables

Variable		Without committing Suicide (n=60)		With committing Suicide (n=60)		Total (n=120)	
		plenty	percentage	plenty	percentage	plenty	Percentage
gender	man	36	30.0	30	25.0	66	55.0
	woman	24	20.0	30	25.0	54	45.0
Education degree	Less than diploma	1	0.8	24	20.0	25	20.8
	diploma	7	5.8	23	19.2	30	25.0
	Upper than diploma	52	43.3	13	10.8	65	54.2
Age	15 – 20	1	0.8	14	11.7	15	12.5
	21 – 25	13	10.8	27	22.5	40	33.3
	26 – 30	27	22.5	7	5.8	34	28.3
	31 – 35	9	7.5	7	5.8	16	13.3

	36 – 40	1	0.8	3	2.5	4	3.3
	41 – 45	4	3.3	2	1.7	6	5.0
	46 – 50	2	1.7	0	0.0	2	1.7
	51 – 55	2	1.7	0	0.0	2	1.7
	56 - 60	1	0.8	0	0.0	1	0.8
Marital status	single	40	33.3	30	25.0	70	58.3
	married	20	16.7	26	21.7	46	38.3
	divorced	0	0.0	3	2.5	3	2.5
	Second marriage	0	0.0	1	0.8	1	0.8

Distribution of factors and percentage of group sample according to demographical variables of gender, education degree, age and marital status in Table 1 shows that the amount of suicide is higher in population below Diploma and in the ages of 21-25.

The indexes of central trend and clinical scales dispersion of MMPI test in 2 groups of study are indicated in Table 2.

Table 2: The indexes of central tendencies and dispersion of clinical scales

Scale	Group	Number	Average	median	mode	Standard deviation	Minimum	Maximum
hypocondria Hs	Without committing suicide	60	4.93	5.0	4	2.246	1	9
	With committing suicide	60	7.15	7.0	6	2.328	3	12
	total	120	6.04	6.0	4	2.535	1	12
Depression D	Without committing suicide	60	7.10	7.0	8	2.880	2	13
	With committing suicide	60	11.20	11.0	11	2.723	5	18
	total	120	9.15	10.0	11	3.468	2	18
hysteria Hy	Without committing suicide	60	11.30	11.0	11	2.776	4	16
	With committing suicide	60	13.75	13.0	13	2.832	8	20
	total	120	12.53	13.0	13	3.051	4	20
pd	Without committing suicide	60	6.63	7.0	6	2.538	2	12
	With Committing suicide	60	10.50	11.0	11	2.652	5	15
	total	120	8.57	8.0	7	3.233	2	15
paranoia Pa	Without committing suicide	60	4.90	4.0	4	2.014	1	10
	With committing suicide	60	7.20	7.5	8	1.858	2	10
	total	120	6.05	6.0	4	2.249	1	10
Psycastenia Pt	Without committing suicide	60	6.45	6.0	5	3.539	0	15
	With committing suicide	60	11.57	12.0	13	2.593	4	16
	total	120	9.01	9.0	9	4.018	0	16
schizophernia Sc	Without committing suicide	60	7.70	7.0	7	3.495	1	16
	With committing suicide	60	13.7	13.0	13	3.272	5	19
	total	120	10.38	11.0	7	4.316	1	19
hypomania Ma	Without committing	60	4.97	5.0	4	2.224	1	10

	suicide							
	With committing suicide	60	6.93	7.0	8	1.582	3	10
	total	120	5.95	6.0	7	2.161	1	10

Most of the Average, middle, mode is related to schizophrenia & Hysteria of suicide committers. The highest difference of scale to Psycastenia is for ordinary group which had not have the experience of suicide.

2-The Inference of statistical data:

In this part for analyzing hypothesis of study and giving solution for research guestions depending on applied conditions, appropriate statistical tests are used that the results classified in searching hypothesis are reported in the following.

  The first hypothesis of survey

  There is difference between psychological profile of suicide committers and (ordinary people) without suicide. For examining this hypothesis concerning to this semi-mental has different levels (clinical factors of MFFI test). In condition of meaningfulness of the relationship between dependent layers factor multivariable variance analysis is applied. The correlation indexes of tests and results of statistical test are presented in in table 3.

Table 3: The correlation indexes and the results of correlational index statistical test among clinical indexes of MMPI test

	Hs	*D*	*Hy*	*Pd*	*Pa*	*Pt*	*Sc*	*Ma*
Hs	1.000							
D	0.682 **	1.000						
Hy	0.708 **	0.630 **	1.000					
Pd	0.572 **	0.714 **	0.511 **	1.000				
Pa	0.619 **	0.641 **	0.449 **	0.640 **	1.000			
Pt	0.603 **	0.827 **	0.422 **	0.740 **	0.736 **	1.000		
Sc	0.698 **	0.722 **	0.412 **	0.791 **	0.786 **	0.885 **	1.000	
Ma	0.511 **	0.481 **	0.263 **	0.594 **	0.504 **	0.636 **	0.718 **	1.000

AS it is obvious all the correlations among 8 clinical scales of test are meaningful with 99 confidences. Therefore the variance multivariable analysis can be used to test the hypothesis. The results of multivariable test and simple variable are presented in table 4.

Table 4: Analyze of multivariable and one variable variance of psychological profile based on committing suicide

	Analyze of variance for multi variable Psychological profile	Analyze of variance for simple variable							
		Ma	*Sc*	*Pt*	*Pa*	*Pd*	*Hy*	*D*	*Hs*
Source of modifications	$F_{(8,111)}$	$F_{(1,118)}$	$F_{(1,118)}$	$F_{(1,118)}$	$F_{(1,118)}$	$F_{(1,118)}$	$F_{(1,118)}$	$F_{(1,118)}$	$F_{(1,118)}$
Group without committing & group committing	12.080**	28.17**	64.19**	22.90**	66.58**	42.27**	81.61**	75.39**	31.14**
Thee rate The multiply complex	0.465	0.193	0.352	0.163	0.361	0.264	0.409	0.390	0.209

P**<0/01

Attention: the amount of multi variable F is achieved by LambdayWeeklz

3-Statistic results:

**multi variables:*

Regarding this the amount of accounted F (12.080) is bigger than F with the freedom rates of 8 and 111, therefor the zero hypothesis of equivalence of psychological profile in both groups would be rejected with 99% confidence.

Advances in Environmental Biology, 8(12) July 2014, Pages: 344-353

**simple variable:*

Regarding to this the index counted F (In eight indexes of clinical test) is bigger than F0/01 with freedmen scales of 1, 118. & (6.84), therefore the zero hypothesis of equivalence of 8 clinical MMPI test scales in both groups is rejected by 99% confidence. Therefor regarding to this, the

Average of these scales in suicide committers is bigger than ordinary people.

□ □ The second hypothesis ofsearch

□ □ There are differences in specification personalities between suicide committers and ordinary people. For proving this hypothesis, two-factor Chi-square test it is applied. The results of test regarding to demographical specification (Gender, Education, Age, marital status) are reported in tables 5-8.

-Gender:

Table 5: Two variablesChi-square test for examining therelationship between variables of sex andsuicide attempts

gender	f	Without committing suicide	With committing suicide	total	Pierson square Chi x	df	mf	Fay Consideration Scale
man	observed	36	30	66	1.212	1	0.27 1	---
	expected	33.0	33.0	66.0				
woman	observed	24	30	54				
	expected	27.0	27.0	54.0				
total	observed	60	60	120				
	expected	60.0	60.0	120.0				

According to this the counted Chi (1.212) which is lower than critical Chi with consideration of 5 percent error with freedom scale of one (3/84), therefore the zero hypothesis would be admitted with 95 confidence based on equivalence of expectancy and observed abundants. Therefore three's no difference between the gender of ones who committed or ones who did not.

-Education level:

Table 6: Two variable Chi (x) square testsfor examining therelationship betweeneducation level andattempted suicide

Fay Consideration scale	mf	df	Pierson square chi<x>	total	With committing suicide	Without committing suicide	f	Education degree
0/665	/001 0	2	53/093 **	25	24	1	Observed	Less than diploma
				25.0	12.5	12.5	Expected	
				30	23	7	Observed	diploma
				30.0	15.0	15.0	Expected	
				65	13	52	Observed	Upper than diploma
				65.0	32.5	32.5	Expected	
				120	60	60	Observed	total
				120.0	60.0	60.0	Expected	

** P<0/01

According to that the counted chi (53.093) is lower than critical chi with 1 % error and 2 degrees of freedom, (9.21) therefore the zero hypotheses would be admitted with 99 percent confidence based on equivalence of expectancies and observed abundant. Therefore there is difference between the education level of ones who committed suicide and ones who did not.

Table 7: Two variables Chi (x)-square testfor examining therelationship betweentwovariables, age and suicide attempts

age	F	Without committing suicide	With committing suicide	total	Pierson square khey<x>	df	mf	Fay Consideration scale
Less than 26	observed	14	41	55	26.600**	2	0.001	0.471
	expected	27.5	27.5	55.0				
26 – 30	observed	27	7	34				
	expected	17.0	17/0	34.0				
More than26	observed	19	12	31				
	expected	15.5	15.5	31.0				
total	observed	60	60	120				
	expected	60.0	60.0	120.0				

** P<0/01

-Age:

According to that the counted Chi (26.600) is lower than critical Chi with 1 % error and 2 degrees of freedom (9/21), therefore the zero hypotheses would be admitted with 99 percent confidence based on equivalence of expectancy and observed abundant. Therefore there is difference between the ages of ones who committed or ones who does not

-Marital status:

Table 8: Two variables Chi (x) square testsfor examining therelationship betweenmarital statusandsuicide attempts

Fay Consideration scale	mf	df	Pierson square khey<x>	total	With committing suicide	Without committing suicide	F	marital status
---	0.150	1	2.076	70	30	40	observed	single
				70.0	33.8	36.2	expected	
				46	26	20	observed	married
				46.0	22.2	23.8	expected	
				116	56	60	observed	total
				116.0	56.0	60.0	expected	

According to that the counted Chi (2.076) is lower than critical Ci with 1% error and 2 degrees of freedom (3.84) therefore the zero hypotheses would be admitted with 95 percent confidence based on equivalence of expectancy and observed abundant. Therefore there is difference between the gender of ones who committed or ones who did not.

Conclusion:

The present research has been done to compare personality and demographic specifications of ordinary people who did not committed suicide and suicide committers. The results showed that there are differences between psychological profiles of these people with (ones who do not commit suicide) and the committer. Committers have higher specifications (Hypochonria, Depression, Psychopathy, paranoia, psychastenia schizophernia, Hypomany) that ordinary ones. Also these results indicated that there is no difference between gender and marital status for both groups. But the education degree and age of committer are different from ordinary people.

For analyzing the results of study we can refer to eshnidman who believes that committing suicide take place when unsustainable psychological pain is felt and one is looking for death to stop suffering non-stoppable consciousness. The wide review on literature of study indicates that the findings of present study is in relation with [6] which showed that there is a positive relationship between psychological disordering and committing suicide and the research of Zare& Colleagues which its results showed that self-debases is the most important disorder among suicide committers and with the foundings of Ghlambar & Colleagues [25] which say that the experience of depression and illiteracy are very dangerous factors in self-firing and findings of the research by Akbari& zard khane [2] and colleagues which showed that adverse personality pattern, personal disorders, anti-social, vainglorious, persecutor anxious and depressed is more in suicide committers than ordinary people and the findings of Sadeghpour's research that indicated that the education level and depression is harmonically related to high level of suicide committing.

The findings of research by molavi & Colleagues [29] which indicated that low literacy, age and psychological disorders are important in committing suicide and according to their psychological profile, these people are pessimistic and suspicious; with high level of Intellectualities andDesire for isolation, are consistent with the present study's results.

Also Max Moulere's results of investigations which indicated that there is a positive and meaningful relationship among many signs of OCD and suicide and research by Nok, Hauk, Sompson, Kessler(2010) which indicated that mental disordering and anxiety is more in group which commit suicide, and findings of study by Zoltan Rihmer's which indicated that committing suicide is the cause of 15 percent of death of people with bipolar disordering and the findings of Ziyai& Colleagues' study which found that some factors such as being young, higher education level, Physical complaints and having some other psychological disordering is in relationship with committing suicide and results of Mau Ritzi & Pampli which showed that some personality disordering have a strong relation with committing suicide and Barski& colleagues' study [34] which found that people having Mitokendera, commit suicide more , all these findings are consistent with the present research's results.

The results of present research agree with the study by Fergusen & linski, Bud Burg & Colleagues, Rey Jakson& Colleagues and Tompsom & Colleagues [56] who found that there is a meaningful relation between anti-social treatments and committing suicide and the findings of researches of Houdson, Hauvton & Shaferd which indicated that there is a direct relation between depression and committing suicide.

The results of study indicate that the amount of suicide among people with education level lower than diploma and with age within the range of 21 to 25, is more. Based on the cognitive theory the ones' attempt to suicide is because of disability of person to find and solve the problem in time of encounter [41]. To state the findings above, it can be said that young people especially from 21 to 25 encounters with educational depression, job selecting, and decision about life goals. Illiteracy and lower educational level cause them not to find a proper job and become dependent on their family. On the other hand these people do not find home environment secure, searching relaxation and security they join to groups and trend to opposite sex and because of unfamiliarity with life skills, weak enter-relations with others and weakness in self-identification and knowing others, they encounter to mental and emotional problems and since they do not know the way to stop stress and do not have the art and power to make the correct decision, they surrender to the problems and find diminishment the best choice, especially when the mental background is provided. The results of present study are confronting with Zohor&Aflatounian [20], Poshtmashhadi & Asgharzadeh Amin, Malakouti& Colleagues [27], Sharghi & Colleagues [16], Panaghi & Colleagues [7], which they indicated committing suicide as the second reason of death in ages 21-30 after group of diseases and accidents and happenings & murders.

Regarding the results of study, more attention to psychological health and hygiene in society, identifying ones who are suffering from mental and behavioral disorders, opposing illiteracy and teaching life skills, relationship skills and teaching the ways of opposing with stress to youth, awarding by medias (national Television & newspapers) about consequences of committing suicide could be the preventive actions in reducing suicide commitment.

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