



Family history of suicide and interpersonal functioning in suicide attempters



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ABSTRACT

Difficulties in interpersonal relationships are associated with a wide range of psychiatric diagnoses and have been reported as a trigger for suicidal behavior, too. The aim of this study was to examine the relationship between interpersonal problems and family history of suicide in suicide attempters and to describe relevant patterns of interpersonal problems in this patient group. The study involves 181 patients having their clinical follow-up after a suicide attempt. Family history of suicide was assessed by using the Karolinska Self Harm History Interview or retrieved in patient records. The Inventory of Interpersonal Problems was used to assess personal style in an interpersonal context. Suicide attempters with a family history of suicide had significantly more often an intrusive personal style. The results remained significant after adjustment for personality disorder. The specific interpersonal patterns associated with family history of suicide may interfere with the ability to create stable, long-lasting relationships. In regards to treatment, these personal qualities could cause difficulties in the alliance with health care personnel and make it harder for suicide attempters to accept or benefit from treatment. Attention to suicide attempters' interpersonal problems is of importance to lower their distress.

1. Introduction

Every forty seconds a suicide occurs worldwide. The understanding of suicide and suicide attempt remains a huge challenge for society and health care services. With suicide being a complex, multifactorial event, suicide research includes several approaches. However, no singular model has yet captured the complexity of suicidal behavior. After a long time of seemingly low focus on social and interpersonal factors within suicide research, the individual predisposition for suicidal behavior, as it is expressed in personality and behavior is of interest (Hawton et al., 2005).

One of the main reasons why people first seek help within psychiatric care is in fact interpersonal problems such as a conflict or a pending separation, and interpersonal problems have been reported as a main trigger for suicidal behavior (Wang et al., 2015). Even though suicide sometimes occurs in the absence of a diagnosable Axis-I or Axis-II condition (Milner et al., 2012; Verrocchio et al., 2016), the presence of a psychiatric disorder has a strong association with suicide

(Cavanagh et al., 2003; Hawton and van Heeringen, 2009). Both affective disorders and borderline personality disorder (BPD) have been recognized as diagnoses with a strong connection to suicidal behavior (Doyle et al., 2016; Harris and Barraclough, 1997; Rihmer and Kiss, 2002). Affective disorders, especially major depressive disorder, have been linked with a number of interpersonal problems like social isolation, avoidance, and submissiveness (Quilty et al., 2013). BPD, in turn, is characterized by interpersonal problems with difficulties in keeping stable relationships, instability in self-perception, a black-and-white perception of reality and sensitivity of criticism (Lazarus et al., 2014; Salzer et al., 2013; American Psychiatric Association, 2013). Suicidal patients, similarly to psychiatric patients in general, also report a high presence of interpersonal behaviors that are problematic (Hawton and van Heeringen, 2009).

Having a family history of suicide is recognized as both a biological and a psychological risk factor for familial transmission of suicidal behavior (Johnson et al., 2002; Roy, 2011; Rajalin et al., 2013; Tidemalm et al., 2011). The offspring of suicide attempters has been

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found to have more impulsive aggression (Brent et al., 2003) and cluster B traits (McGirr et al., 2009). In the McGirr study, the co-occurrence of cluster B personality psychopathology (e.g. BPD) and impulsive aggression was strongly associated with familial aggregation of suicide. Personality traits like aggression and impulsivity have been connected to suicidal behavior in several other studies (Diaconu and Turecki, 2009; Lopez-Castroman et al., 2015; Roy, 2006). Cluster B traits and impulsive-aggressive behavior are to be considered behavioral endophenotypes of suicide.

Studies that examined life events occurring close in time prior to a suicide, found that interpersonal conflict leading to rejection and isolation was the main trigger factor for suicidal behavior (Heikkinen et al., 1994, 1997; Zouk et al., 2006). Also in the Interpersonal Theory of Suicide (Joiner, 2005), interpersonal constructs such as thwarted belongingness and perceived burdensomeness have been introduced as part of the explanation for suicidal acts. In a large population-based study in France, poor social support and lack of connectedness were associated with non-disclosure of suicidal ideation (Husky et al., 2016). Furthermore suicide attempters have shown deficits in active interpersonal problem solving (Linehan et al., 1987). Interpersonal style is indeed of importance in interpersonal functioning and psychological well-being and seems connected to suicidal behavior too.

There are few studies using structured inventories of interpersonal problems in suicide attempters and the measurements apply different angles of interpersonal interaction. In 2015, Wang and colleagues conducted a study on gay men that had attempted suicide that included one open question about causes for the attempt. Interpersonal problems were the most reported cause for a suicide attempt. Hagan and Joiner (2016), who recently developed the Interpersonal Needs Questionnaire (INQ), used it in a sample of college students with a prior history of suicide attempt, and found that perceived criticism from parents and friends had an indirect effect on suicidal behavior. The INQ has also been used in depressed patients and in a military population to examine their perceived sense of belonging but the findings did not support a strong relationship between sense of belonging and suicidal behavior (Bryan et al., 2010; Fisher et al., 2015). The Temperament and Character Inventory (TCI) has been used in a Korean study of patients with adjustment disorder (Na et al., 2013) and results showed lower cooperativeness in the group of patients with previous suicide attempts. As for the Inventory of Interpersonal Problems, which is used in the present study, a study has been performed on depressed elderly with a shorter version (Harrison et al., 2010). Depressed, suicidal elderly reported a higher degree of chronic interpersonal problems compared to non-suicidal depressed and non-depressed elders.

Bearing in mind the complexity of suicidal behavior and the role of distal risk factors, we wanted to investigate if the distal risk factor of family history of suicide was associated with certain types of interpersonal problems in suicide attempters. The aim of the present study was therefore to examine if there are specific patterns of interpersonal problems in suicide attempters in relation to aggregation of a family history of suicide.

2. Methods

2.1. Study setting

Between the years of 1993–2005, patients having their clinical follow-up after a suicide attempt at the Suicide Prevention Clinic at the Karolinska University Hospital were invited to participate in two clinical cohort studies. The studies aimed to observe biological and psychological factors for suicidal behavior. The Regional Ethical Review Board in Stockholm approved of the study protocols (Dnr 93–211 & Dnr 00–194) and participants gave their written informed consent to participate in the research study.

2.1.1. Participants

The participants in the two cohort studies study consist of 181 suicide attempters, 81 and 100 respectively. One hundred thirteen (62%) were women. Inclusion criteria were a recent suicide attempt, ability of verbal and written communication in Swedish, and an age of 18 years or older. Suicide attempt was defined as any non-fatal, self-injurious behavior with some intent to die (WHO, 2014). Exclusion criteria were schizophrenia spectrum psychosis, dementia, and mental retardation. Participants were diagnosed according to DSM-IV with the research version of SCID-I, performed by trained psychiatrists. Trained clinical psychologists performed the SCID-II interview to establish any occurrence of Axis-II diagnosis. At least one current Axis-I diagnosis could be diagnosed in 91% of the patients. The criteria for mood disorder were met by 76%; criteria for anxiety disorder and adjustment disorder were met by 5% each. Substance-related disorder was found in 3% as the primary Axis-I diagnosis, one individual had anorexia nervosa and another had an unspecified psychiatric disorder. Twenty-three per cent of the patients had a comorbid substance-related disorder (mostly alcohol dependence). Regarding Axis-II disorders, 33% of the patients met criteria for personality disorder; of these patients 35% were diagnosed with borderline personality disorder, 11% were diagnosed with dependent personality disorder, and 9% with avoidant personality disorder. Antisocial personality disorder was found in 6% and 39% had a personality disorder not otherwise specified. Table 1 shows the characteristics of the original and the included samples. Regarding number of patients, assessment of family history of suicide, and missing data, the two cohorts are described in a flowchart, Fig. 1.

2.2. Assessment of family history of suicide

In the first study (n=81) information about family history of completed suicide was extracted from reviewing patient files. In the second study (n=100) family history of completed suicide was assessed with a structured clinical interview (Karolinska Self Harm History Interview) containing specific questions regarding family history of suicide and suicidal behavior. In 48 cases (26.5%) of the total clinical cohort this information was missing and therefore they have been excluded from the analysis. Twenty suicide attempters reported a first or a second degree relative who has committed suicide was 20/133 (15%). Seven patients reported third (n=5) or fourth degree (n=2) relatives who had committed suicide (first cousin, great grandparent or great-grandchild, cousin's son and great uncle).

2.3. Assessments

2.3.1. Inventory of Interpersonal Problems

Inventory of Interpersonal Problems (IIP) (Horowitz et al., 1988) was used to assess interpersonal problems. IIP is a 64-item self-report inventory with a well-established reliability (0.78) and validity (Horowitz et al., 2000), that identifies the most apparent interpersonal problems of an individual. The scale is available in a Swedish version and has been validated in Sweden (Weinryb et al., 1996). Interpersonal problems are organized in eight scales which each describes different interpersonal problems (new denomination in parenthesis):

Table 1
Characteristics of the original and the included samples.

	Original sample n=181	Included sample n=121
Mean age, range	35.4 (18–69)	35 (18–65)
Gender % Female	62% 113/181	60% 72/121
Mood disorder	76% 138/181	80% 97/121
Personality disorder	34% 57/166	36% 41/115
Substance use disorder	24% 41/174	23% 28/121

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